



American General Life Insurance Company of Delaware\*

Wilmington, Delaware

Administrative Office P.O. Box 30083, Tampa, FL 33630-3083

\*This company does not solicit business in New York.

Application is hereby made for a plan of accident and sickness insurance based on the following statements and representations:

1. Identification of Policyholder: Policy Number \_\_\_\_\_

Name of Policyholder: \_\_\_\_\_

Address of Policyholder: \_\_\_\_\_ City State ZIP

Contact Name and Title: \_\_\_\_\_ E-Mail: \_\_\_\_\_

Type of Organization: \_\_\_\_\_ Nature of Business: \_\_\_\_\_

SIC Code: \_\_\_\_\_ Number of Eligible Persons: \_\_\_\_\_

Name(s) of Affiliates(s) or Subsidiary(ies) to be covered: \_\_\_\_\_

2. Classification of Eligible Persons:

3. Policy Benefits and Coverage:

Please include the sold proposal output material.

Accident and Sickness

Group HospitalCare A B C D E Other

Accident Only

Group EmergencyCare A B C Other

4. Premiums:

The Policyholder agrees to pay the required premium for these coverages.

5. Policy Effective Date: \_\_\_\_\_

6. Contribution Information:

Will Eligible Persons contribute to the cost of insurance? Yes No

If Yes, please provide percentage of each coverage that the Policyholder will pay. \_\_\_\_\_ %

7. Replacement Coverage:

Will this Group Policy replace a Policy providing similar benefits? Yes No

Signed for the Policyholder

Title

8. Producing Agent Declaration

Producer #: \_\_\_\_\_ Tax ID: \_\_\_\_\_ % of commission to split with other agent: \_\_\_\_\_

Name as licensed: \_\_\_\_\_ License Number: \_\_\_\_\_

Address: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Fax number: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

City and state where signed: \_\_\_\_\_

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.