

**American General Life Insurance Company of Delaware\***  
 Wilmington, Delaware

Administrative Office: PO Box 30066, Tampa, FL 33630-3066  
 Phone: 1-877-672-1648 Fax: 1-877-672-1650

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

**Application for Reinstatement applies only if your group policy was terminated due to non-payment of premium.**

**NOTE:** American General Life Insurance Company of Delaware will **only** review this application IF THE EMPLOYER:

1. Completes all the information requested below, and
2. Remits a premium payment equal to the amount which:
  - was due on the date insurance ended, PLUS
  - would have been due from the date insurance ended to the date this application is signed.

*Please print or type all information requested.*

**EMPLOYER DATA**

1. Name of Employer: \_\_\_\_\_
2. Group Policy No.: \_\_\_\_\_
3. Amount Remitted: \$ \_\_\_\_\_

**CLAIMS DATA**

4. Since the date insurance ended, has any eligible person:
 

	YES	NO		YES	NO
a. become disabled?	<input type="checkbox"/>	<input type="checkbox"/>	b. incurred dental/vision expenses?	<input type="checkbox"/>	<input type="checkbox"/>
c. been hospitalized or died?	<input type="checkbox"/>	<input type="checkbox"/>	d. incurred medical expenses?	<input type="checkbox"/>	<input type="checkbox"/>

If "yes" to any part of this question, give details below (include names, dates and causes): \_\_\_\_\_  
 \_\_\_\_\_

**EMPLOYEE ELIGIBILITY**

A FULL TIME EMPLOYEE IS ONE WHO:
 

- works at least 30\* hours per week
- performs his job for full pay
- works your regular work schedule, and
- works at your place of business

5. How many full-time employees do you have? \_\_\_\_\_
6. How many full-time employees are eligible for coverage? \_\_\_\_\_
7. What class(es) of employees are excluded from coverage? \_\_\_\_\_
8. For which coverage(s) do the employees pay part of the cost?

	YES	NO		YES	NO
Life	<input type="checkbox"/>	<input type="checkbox"/>	Employee Health	<input type="checkbox"/>	<input type="checkbox"/>
Disability	<input type="checkbox"/>	<input type="checkbox"/>	Dependent Health	<input type="checkbox"/>	<input type="checkbox"/>

\*Amount of hours may vary by state law or employee's administrative practice.

**EMPLOYER'S DECLARATION**

1. To the best of my knowledge and belief, all the statements and answers in this application are true.
2. I understand that if AG Life Insurance Co. of DE accepts this application, the group's insurance will be reinstated on the date in writing by AG Life Insurance Co. of DE.
3. I understand that reinstatement, if approved, applies **only** to coverages that are insured and administered by AG Life Insurance Co. of DE. Requests to reinstate coverages that are insured and administered by another insurance company, if applicable, should be directed to that carrier.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Print Name of Officer, Partner or Proprietor

\_\_\_\_\_  
Witness

\_\_\_\_\_  
Signature of Officer, Partner or Proprietor