

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.

Please print or type all information requested.

Group Policy Number _____ Hire Date _____

Group Policyholder: _____

Applicant's Name: _____
(First, Middle, Last)

Applicant's Address: _____
(Number) (Street) (City) (State) (Zip) (Daytime Phone Number)

Social Security # / Employee ID No.: _____ Date of Birth: _____ Gender M/F ___ Height _____ Weight _____
(mm/dd/yy)

Benefits Requested

Employee Face Amount Spouse Face Amount

<input type="checkbox"/> AG Group CriticalCare	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	\$ _____	\$ _____	Other
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(Applicant Only) (Applicant & Spouse) (Applicant & Child(ren)) (Applicant & Family)

<input type="checkbox"/> AG Group CancerCare	\$ _____	Other
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(Applicant Only) (Applicant & Spouse) (Applicant & Child(ren)) (Applicant & Family)

(Write spouse's name below if you are applying for Applicant and Spouse or Applicant and Family coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

NAME	AGE	DATE OF BIRTH MM/DD/YY	SEX	HEIGHT	WEIGHT	SOCIAL SECURITY #
SP						
CH						
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1. Has any proposed insured used any form of tobacco or nicotine product, including a nicotine patch, in the last 12 months? Yes No

2. Has any proposed insured ever been diagnosed with or treated by a member of the medical profession for any of the following: Yes No

- stroke, transient ischemia attacks (TIA), Yes No
- kidney failure, polycystic kidneys, abnormal kidney function, Yes No
- glaucoma, macular degeneration, optic neuritis, Yes No
- familial adenomatous polyposis (Gardener's Syndrome); Yes No
- cancer, malignant tumor or growth, Yes No
- diabetes, heart disease, multiple sclerosis Yes No
- need an organ transplant? Yes No

3. Has any proposed insured tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS – related complex (ARC), or other immune disorders? Yes No
4. If any question answered “YES”, please give proposed insured person’s name and explain. Please specify condition, date occurred, duration, degree of recovery and name/address of doctor/hospital/clinic. Use a separate sheet if necessary:

Name of Person	Question Number	Date	Duration	Details	Name of Physician or Hospital

Beneficiary * (Please print full name and relationship):

First Name	Initial	Last Name	Relationship

* The applicant will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.

AUTHORIZATION: I authorize the premium for this insurance to be deducted from my salary and forwarded to the Company.

ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZE – UNDERSTAND

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter: agree to the following: (a) All statements and Answers in this application are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (1) during the lifetime of all proposed insureds; and (2) while there is no change in the insurability and health of such person from that stated in the application (c) No agent has authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. **AUTHORIZE:** (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, Medical Information Bureau(“MIB”), or any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for-insurance policy, and (3) the duration of a claim for benefits. **ACKNOWLEDGE** receipt of the following notices: (a) “Notice of Information Practices” required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; (c) Investigative Consumer Report; and (d) Outline of Coverage, if applicable. **UNDERSTAND** that” (a) I am applying for a critical illness policy and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

PRIMARY PROPOSED INSURED – If an investigative consumer report is prepared in connection with this Application:

- I elect to be interviewed. I elect NOT to be interviewed.

Applicant’s Signature

Date

FRAUD NOTICE: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For Administrative Use Only (if Agent is involved)	
Agent Name	License ID #
Agent Signature	