



**Individual Application for  
Group Critical Illness Insurance**

**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"/> AIG Group CriticalCare <sup>SM</sup>	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	\$ _____	\$ _____	Other
---	----------------------------	----------------------------	----------------------------	----------	----------	-------

(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 #
<b>SP</b>						
<b>CH</b>						
<b>CH</b>						
<b>CH</b>						
<b>CH</b>						

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.

**AGREEMENT - 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 during the lifetime of all proposed insureds; (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. **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.

When an applicant consents to electronic delivery of the certificate, the Policyholder will accept the certificate in electronic format for delivery to the applicant covered under the group policy issued by the Company.

- I elect to receive an electronic copy of the certificate.

Email address: \_\_\_\_\_

**FRAUD NOTICE:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant's Spouse's Signature  
**(if Spouse coverage is elected)**

\_\_\_\_\_  
Date

**For Use in Florida Only**

\_\_\_\_\_  
Agent Name

\_\_\_\_\_  
FL License ID #

\_\_\_\_\_  
Agent Signature

Do you, the aforementioned agent, know whether this contract is intended to replace, discontinue or change an existing life insurance policy or annuity contract?

Yes  No