

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
Accident and Sickness**

AG Group HospitalCare A B C D E Other

- (Applicant Only) (Applicant & Spouse)
 (Applicant & Child(ren)) (Applicant & Family)

Accident Only*

AG Group EmergencyCare A B C Other

*Questions 1-3 do not need to be completed.

- (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						
CH						
CH						
CH						

1. To the best of your knowledge and belief, has any proposed insured ever been diagnosed with or treated for any of the following: (If YES, please check (√) the appropriate box)

	Applicant	
	Yes	No
disease or disorder of the heart; lung; kidney; liver	<input type="checkbox"/>	<input type="checkbox"/>
tumors; cancer; diabetes;	<input type="checkbox"/>	<input type="checkbox"/>
high blood pressure;	<input type="checkbox"/>	<input type="checkbox"/>
brain or nervous system disease;	<input type="checkbox"/>	<input type="checkbox"/>
mental or nervous disorders;	<input type="checkbox"/>	<input type="checkbox"/>
alcohol or drug dependency;	<input type="checkbox"/>	<input type="checkbox"/>
arthritis or other musculoskeletal disease or disorder;	<input type="checkbox"/>	<input type="checkbox"/>
any other serious disorder?	<input type="checkbox"/>	<input type="checkbox"/>

2. Have you or 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
3. Within the last 12 months, have you or any proposed insured missed more than 5 consecutive days of work due to illness or injury? Yes No

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.

I/We hereby represent that the above is true and correct to the best of my/our knowledge and belief. I understand my/our answers to the above questions determine my/our eligibility for coverage and that coverage will not become effective unless and until this application is approved and accepted. I/We understand that if coverage does become effective, the coverage effective date will be indicated in the Certificate of Insurance I will receive.

Applicant's Signature

Date

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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