AIG AMERICAN GENERAL

Application for Life Insurance West Virginia

American General Life Insurance Company
Houston, Texas

Administrative Office: P.O. Box 30081, Tampa, FL 33630-3081
Phone: 877-672-1647 Fax: 877-672-1649

Universal Life
Empl Pol # ____________________
Spouse Pol # ____________________
Child #1 Pol # ____________________
Child #2 Pol # ____________________
Child #3 Pol # ____________________

Level Term
Empl Pol # ____________________
Spouse Pol # ____________________

ROP Term
Empl Pol # ____________________
Spouse Pol # ____________________

Payor Information (The owner of all coverage applied for shall be the Employee/Member)

1. Primary Proposed Insured-Employee/Member Name
   Last ______ First ______ Middle ______
2. Address
   Street ____________________
   City ______ State ______ Zip Code ______
   E-mail Address ____________________
3. Employer
4. Employee No./ID
5. Social Security No.
6. Birth Date and Place — Month | Day | Year | State | Country
7. Age Nearest Birthday
8. Sex ❑ M ❑ F
9. Annual Salary $
10. U.S. Citizen ❑ Yes ❑ No
    If no, date of entry ______________ visa type ________
11. Number of work hours per week? ____________________
12. Payroll Deduction Frequency ____________________
13. Hire Date: ____________________
14. Employee's Driver's License
    #____________________ State of Issue ________

Other Proposed Insured Information

15. Spouse Name ______________________________ (Last, First, Middle) Sex ❑ M ❑ F Birth Date and Place (Month | Day | Year | State | Country)
    Drivers Lic # ____________________ State of Issue ________ Age Nearest Birthday ______

16. Child #1 Name ______________________________ (Last, First, Middle) Sex ❑ M ❑ F Birth Date and Place (Month | Day | Year | State | Country)
    Drivers Lic # ____________________ State of Issue ______ Relationship ____________ ❑ UL Policy Age Nearest Birthday ____

17. Child #2 Name ______________________________ (Last, First, Middle) Sex ❑ M ❑ F Birth Date and Place (Month | Day | Year | State | Country)
    Drivers Lic # ____________________ State of Issue ______ Relationship ____________ ❑ UL Policy Age Nearest Birthday ____

18. Child #3 Name ______________________________ (Last, First, Middle) Sex ❑ M ❑ F Birth Date and Place (Month | Day | Year | State | Country)
    Drivers Lic # ____________________ State of Issue ______ Relationship ____________ ❑ UL Policy Age Nearest Birthday ____

19. Beneficiary ______________________________ Relationship ____________________
    The beneficiary for the spouse/dependent coverage applied for will be the Employee/Member
    Foundation Rider Beneficiary ______________________________
    The Company does not believe a tax deduction results from naming a charitable organization as the Beneficiary. Consult your own tax advisor.

Insured Plans

☐ **Universal Life** Insurance based on: ❑ Defined Benefit ❑ Money Purchase

	Employee	Spouse	Child #1	Child #2	Child #3
Amount of Insurance:	$________	$________	$________	$________	$________
Death Benefit Option (Level-1, Increasing-2)	❑ 1 ❑ 2	❑ 1 ❑ 2	❑ 1 ❑ 2	❑ 1 ❑ 2	❑ 1 ❑ 2
Additional Benefits:					
Accidental Death Benefit (ADB)	❑ ADB	❑ ADB	❑ ADB	❑ ADB	❑ ADB
Waiver of Monthly Deduction (WMD)	❑ WMD	❑ WMD			
Future Guaranteed Insurability Rider (FGIR)	❑ FGIR	❑ FGIR			
Children's Insurance Benefit (CIB)	CIB ____ units	CIB ____ units			
Critical Illness Accelerated Benefit Rider (CIABR)	❑ CIABR	❑ CIABR	❑ CIABR	❑ CIABR	❑ CIABR
Level Term to 70 Rider (LTR)	❑ AMT $____	❑ AMT $____			
Living Benefits Rider (LBR)	LBR _____ %	LBR _____ %			
Foundation Rider (FR)	❑ AMT $____	❑ AMT $____			
Other Rider(s): ______________________	❑	❑	❑	❑	❑
Payroll Deduction Amount:	$________	$________	$________	$________	$________

☐ **Term Life**

		Employee	Spouse
❑ Level Term Life Insurance	*Amount of Insurance:*	$________	$________
❑ 10 Year Level	*Additional Benefits:*		
❑ 15 Year Level	Accidental Death Benefit (ADB)	❑ ADB	❑ ADB
❑ 20 Year Level	Waiver of Premium (WP)	❑ WP	❑ WP
❑ Return of Premium (ROP Term)	Children's Insurance Benefit (CIB)	CIB ____ units	CIB ____ units
❑ 20 Year Level Term	Critical Illness Accelerated Benefit Rider* (CIABR)	CIABR ____ %	CIABR ____ %
❑ Other: ______________________	Other Rider(s): ______________________	❑	❑
** Not available on ROP Term*	*Payroll Deduction Amount:*	$________	$________

Limited Temporary Life Insurance Eligibility

20. **Health and Age Questions** (If the correct answer is yes to either question below, temporary insurance is not available, the agreement will be void and any payment submitted will be refunded.)
    a. Has the Primary Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? ❑ Yes ❑ No
    b. Is the Primary Proposed Insured age 71 or above? ❑ Yes ❑ No

Health Questions	Employee	Spouse	Child #1	Child #2	Child #3
	YES NO	YES NO	YES NO	YES NO	YES NO
21. Has any Proposed Insured used tobacco in any form in the past 24 months?	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
Part A	Employee	Spouse	Child #1	Child #2	Child #3
	YES NO	YES NO	YES NO	YES NO	YES NO
22. Has the Employee missed more than three consecutive workdays during the 90 days preceding the date of this application due to his/her own accident or sickness other than flu, cold or sore throat?	❑ ❑				
23. Has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
24. Has any Proposed Insured been treated at a medical facility (hospital, medical center, mental health facility or drug or alcohol treatment center) on an inpatient or outpatient basis within the 90 days prior to the date of this application?	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑

Health Questions										
Part B	Employee		Spouse		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
25. In the last 5 years, has any Proposed Insured been diagnosed as having or been treated for, or consulted a licensed heath care provider for any of the following: stroke or transient ischemic attack, heart attack, coronary artery disease, vascular insufficiency, cancer (other than basal cell skin cancer), liver disease, rheumatoid arthritis, disease or disorder of the back or neck, multiple sclerosis, kidney failure or end stage renal disease, organ transplant, emphysema, carpal tunnel syndrome, chronic bronchitis or other restrictive lung disease, Crohn's disease or ulcerative colitis?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
26. Has any Proposed Insured participated within the last 3 years or have any intention in participating in: flying in any type of aircraft as a student pilot or crew member; parachute jumping; auto, boat or motorcycle racing; hang gliding or scuba diving?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
27. Has any Proposed Insured ever applied for Life or Health Insurance or for reinstatement which was declined, postponed, cancelled, withdrawn or modified in any way?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
28. Has any Proposed Insured ever been diagnosed as having, or been treated for, or consulted a licensed health care provider for:										
a. mental or nervous disorder, epilepsy, convulsions, paralysis or stroke?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b. disease or disorder of the heart or blood vessels; heart attack or high blood pressure?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c. disease or disorder of lungs; emphysema or tuberculosis?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d. disease or disorder of the kidney, bladder or prostate?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e. disease or disorder of the stomach, intestines, rectum, liver or ulcer?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f. sugar, albumin, or blood in urine?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g. cancer, tumor, syphilis, diabetes, gland, or blood disorder?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
h. disease or disorder of breast or reproductive organs?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
29. Has any Proposed Insured in the last 3 years had fainting spells, pain or discomfort in chest, or shortness or breath?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
30. Has any Proposed Insured:										
a. ever sought or received advice, counseling, treatment by a medical professional for the use of alcohol or drugs including the use of prescription drugs?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b. within the last 10 years used cocaine, marijuana, heroin, controlled substance, or any other drug except as legally prescribed by a physician?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
31. Height										
32. Weight										

Health History—Details For Any "Yes" Answers (Use additional sheets as necessary.)

Question #	Name of Proposed Insured	Relationship Empl	Spouse	Child	Description

Remarks

Details and Explanations ______________________________

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Other Life Insurance or Annuities *(Indicate life insurance policies or annuities in force or pending for the proposed insured(s).)*

Does any proposed insured have any existing or pending annuity or life insurance contracts? ❑ Yes ❑ No

(If yes, indicate life insurance policies or annuities in force or pending for the proposed insured(s).)

Type: i = individual, b = business, g = group, p = pending life insurance or annuity

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) (see above)	Year of Issue	Face Amount	Replace*
						❑ Yes
						❑ Yes

* **Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: certain states require completion of replacement related forms even when other life insurance or annuities are not being replaced by the policy being applied for.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Owner ______________________ Date ______________

Agent Information

To the best of your knowledge, will the insurance herein applied for replace or change existing insurance in this or any other company? If "yes," submit complete requirements of state where the application was signed. ❑ Yes ❑ No

The undersigned agent hereby confirms that no illustration was used in connection with soliciting the application for Life Insurance.

Writing Agent Signature ______________________ Writing Agent Number ______________ Date ______________

Agreement Authorization and Signature

Agreement and Authorization to Obtain and Disclose Information and Declaration

I, the Primary Proposed Insured signing below, agree that I have read the above statements or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: 1) will consist of Part A, Part B, and if applicable, related forms; and 2) shall be the basis for any policy issued. I understand that any misrepresentation made in this application and relied on by the insurer issuing the policy may be used to reduce or deny a claim or void the policy, if: 1) it is within its contestable period; and 2) such misrepresentation materially affects the acceptance of the risk.

Except as may be stated in any Limited Temporary Life Insurance Agreement (LTLIA) for which all requirements are met, I understand and agree that no insurance will be in effect under this application, or any new policy issued by the insurer, unless or until all three of the following conditions are met: 1) the policy has been delivered and accepted; and 2) the full first modal premium for the policy has been paid; and 3) there has been no change in the health of the proposed insured that would change any answers to any questions in the application before 1) and 2) above have occurred.

Limited Temporary Life Insurance Agreement– If eligible, I have received and accepted the LTLIA. This insurance is available on my life only if: 1) the full first modal premium is submitted with this application; and 2) only "no" answers have been truthfully given to the Health and Age questions in section 20.

I understand and agree that no agent may: accept risks or pass upon insurability; make or modify contracts; or waive any of the insurers rights or requirements. I acknowledge that: 1) no illustration conforming to the term life or universal life policy was provided; and 2) an illustration conforming to the universal life policy as issued, if any, will be provided by the time the policy is delivered.

I have received a copy of the Notices to the Proposed Insured.

I give my consent to any of the entities listed below to give the Company, its legal representative, or American General Life Companies, LLC (an affiliated service company), all information they have pertaining to: medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; or any other information for me or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles or court records; foreign travel; etc. The list of entities for which I give my consent to provide the information above is as follows: any physician or medical practitioner; any hospital, clinic or other health care facility; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. The Company may disclose any information gathered during its evaluation of my application to: its reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent from American General Life Companies, LLC. I understand this consent may be revoked at any time by sending a written request to American General Life Companies, LCC., ATTN: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. ☐ Check if you wish to be interviewed.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Proposed Insured/Owner Signature(s)

Signed at (*City, State)* ______________________ On (*Date*)______________________

X ____

Primary Proposed Insured-Employee/Member

Detach this page and leave it with the proposed insured

NOTICES TO THE PROPOSED INSURED

American General Life Insurance Company, Houston, TX

"Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies LLC, an affiliated service company.

FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living. No information collected concerning the sexual orientation of the Proposed Insured will be used to determine his or her eligibility for insurance.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station Boston, Massachusetts 02112.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or heath insurance, or to whom a claim for benefits may be submitted.

INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: American General Life Companies LLC, P.O. Box 1931, Houston, TX 77251-1931

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.