

American General
Life Companies

Application for Life Insurance

American General Life Insurance Company
Houston, Texas

This application is for:

New Coverage Increase in Coverage (UL only)

Administrative Office: Mail Stop 6-G2, P.O. Box 4373, Houston, TX 77210-9739
Phone: 866-242-2737 Fax: 713-831-3249

Universal Life

Employee Policy # _____ Spouse/Domestic Partner Policy # _____

Child #1 Policy # _____ Child #2 Policy # _____ Child #3 Policy # _____

Level Term

Employee Policy # _____ Spouse/Domestic Partner Policy # _____

Employee/Member Information (Employee/Member will be the owner of all coverage applied for.)

1. Employee/Member/Proposed Insured Name			7. Age Nearest Birthday _____	8. Gender <input type="checkbox"/> M <input type="checkbox"/> F
Last _____	First _____	Middle _____	9. Annual Salary \$ _____	
2. Address			10. Is the Employee/Member a U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Street _____			If no, date of entry _____ visa type _____	
City _____ State _____ Zip Code _____			11. Payroll Deduction Frequency	
E-mail Address _____			<input type="checkbox"/> 52 Pay (weekly) <input type="checkbox"/> 26 Pay (Bi-weekly) <input type="checkbox"/> 24 Pay (Semi-Monthly)	
Day Phone Number _____			<input type="checkbox"/> Other _____	
3. Employer/Group		12. Hire Date: _____		
4. Employee No./ID		Month	Day	Year
5. Social Security No.		13. Is the Employee/Member actively at work today, the usual number of hours without limitation? <input type="checkbox"/> Yes <input type="checkbox"/> No		
6. Birth Date		14. Number of work hours per week? _____		
Month	Day	Year		

Other Proposed Insured Information

15. Spouse/Domestic Partner Name _____			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date _____
Last _____	First _____	Middle _____	Age Nearest Birthday _____	Month Day Year
16. Child #1 Name _____			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date _____
Last _____	First _____	Middle _____	Age Nearest Birthday _____	Month Day Year
Relationship _____ Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No				
17. Child #2 Name _____			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date _____
Last _____	First _____	Middle _____	Age Nearest Birthday _____	Month Day Year
Relationship _____ Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No				
18. Child #3 Name _____			Gender <input type="checkbox"/> M <input type="checkbox"/> F	Birth Date _____
Last _____	First _____	Middle _____	Age Nearest Birthday _____	Month Day Year
Relationship _____ Full Time Student <input type="checkbox"/> Yes <input type="checkbox"/> No				

Tobacco Usage Question (Only applies to any Proposed Insured age 18 or over.)

	Employee		Spouse/DP*		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
19. Has any Proposed Insured used tobacco and/or other products that contain nicotine in the past 24 months?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Insured Plans

Universal Life

	Employee	Spouse/DP*	Child #1	Child #2	Child #3
<i>Amount of Insurance/Increase By:</i> Death Benefit Option (Level-1, Increasing-2)	\$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2	\$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2	\$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2	\$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2	\$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2
<i>Additional Benefits:</i> Accidental Death Benefit (ADB) Waiver of Monthly Deduction (WMD) Future Guaranteed Insurability Rider (FGIR) Children's Insurance Benefit (CIB) Terminal Illness Benefit (TIB) Other Rider _____ Other Rider _____ Other Rider _____	<input type="checkbox"/> ADB <input type="checkbox"/> WMD <input type="checkbox"/> FGIR CIB _____ units <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> ADB <input type="checkbox"/> WMD <input type="checkbox"/> FGIR CIB _____ units <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> ADB <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> ADB <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> ADB <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<i>Payroll Deduction Amount:</i>	\$ _____	\$ _____	\$ _____	\$ _____	\$ _____

Universal Life Beneficiary (Payment will be made in equal shares unless otherwise designated.)

20. Employee/Member Primary Beneficiary
 1. Name _____ Relationship _____ % _____
 2. Name _____ Relationship _____ % _____
 Employee/Member Contingent Beneficiary
 1. Name _____ Relationship _____ % _____
 2. Name _____ Relationship _____ % _____
 The beneficiary for the spouse/domestic partner/child coverage applied for will be the Employee/Member.

Term Life

	Employee	Spouse/DP*	<i>Additional Benefits:</i>	Employee	Spouse/DP*
Level Term Life Insurance	<input type="checkbox"/> 10 Year Level <input type="checkbox"/> 15 Year Level <input type="checkbox"/> 20 Year Level	<input type="checkbox"/> 10 Year Level <input type="checkbox"/> 15 Year Level <input type="checkbox"/> 20 Year Level	Accidental Death Benefit (ADB) Waiver of Premium (WP) Children's Insurance Benefit (CIB) Terminal Illness Benefit (TIB) Other Rider _____ Other Rider _____ Other Rider _____	<input type="checkbox"/> ADB <input type="checkbox"/> WP CIB _____ units <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> ADB <input type="checkbox"/> WP CIB _____ units <input type="checkbox"/> TIB <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
<i>Amount of Insurance:</i>	\$ _____	\$ _____			
			<i>Payroll Deduction Amount:</i>	\$ _____	\$ _____

Term Life Beneficiary (Payment will be made in equal shares unless otherwise designated.)

21. Employee/Member Primary Beneficiary
 1. Name _____ Relationship _____ % _____
 2. Name _____ Relationship _____ % _____
 Employee/Member Contingent Beneficiary
 1. Name _____ Relationship _____ % _____
 2. Name _____ Relationship _____ % _____
 The beneficiary for the spouse/domestic partner coverage applied for will be the Employee/Member.

Health Questions

Part A (Complete for Simplified Issue or Contingent Guaranteed Issue only)

	Employee		Spouse/DP*		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
22. 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), AIDS Related Complex (ARC), or any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
23. In the 180 days prior to the date of this application, has any Proposed Insured consulted with a physician, or received treatment for, cancer, disease or disorder of the heart, heart attack, stroke, or drug or alcohol dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
24. In the 90 days prior to the date of this application, has any Proposed Insured missed more than 3 consecutive days of work due to injury or illness other than cold, flu or maternity?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						

Part B (Complete for Simplified Issue only)

	Employee		Spouse/DP*		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
25. Has any Proposed Insured participated within the last 3 years 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?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
26. Has any Proposed Insured within the last 5 years been diagnosed as having, been treated for, or consulted a licensed health care provider for:										
a. mental or nervous disorder, epilepsy, convulsions, paralysis, stroke or transient ischemic attack?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. disease or disorder of the lungs, emphysema or tuberculosis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. disease or disorder of the kidney, bladder or prostate?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. disease or disorder of the stomach, intestines, rectum or liver?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. sugar, albumin, or blood in urine?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. cancer (other than basal cell skin cancer), tumor, syphilis, diabetes, gland or blood disorder?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. disease or disorder of breast or reproductive organs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. multiple sclerosis, Crohn's disease or ulcerative colitis?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
27. Has any Proposed Insured in the last 3 years had fainting spells, pain or discomfort in chest, or shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
28. Has any Proposed Insured within the last 10 years:										
a. sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs including the use of prescription drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. used cocaine, marijuana, heroin, controlled substance, or any other drug except as legally prescribed by a physician?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
29. Height	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.	____ft. ____in.
30. Weight	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.	____lbs.

*Domestic Partner

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*
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> Yes <input type="checkbox"/> No

* **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.**

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? Yes No

If "yes," submit complete requirements of state where the application was signed.

The undersigned agent hereby confirms that:

- 1) no illustration was used in connection with soliciting the application for Life Insurance, and,
- 2) all of the applicant's answers to the questions in the application, if applicable, were accurately and truthfully recorded by the Writing Agent.

Writing Agent Signature

Writing Agent Number

Date

Authorization and Temporary Insurance

Agreement and Authorization to Obtain and Disclose Information and Declaration

I, the Employee/Member 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 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.

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 understand any 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; other persons or organizations performing business or legal services in connection with my application or claim; 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.

Premium Payment Authorization

I authorize my employer to deduct the required premium from my pay for the coverage applied for in this enrollment and forward same to the Company. Premium for this coverage is considered paid if the first full modal premium (including signed Payroll Deduction Authorization or Automatic Bank Check) is submitted with this application. If the form of payment is Automatic Bank Check, payment must be honored upon its first presentation.

TEMPORARY INSURANCE AGREEMENT (TIA)

Subject to the terms of the policy applied for and this TIA, the Company agrees to pay the lesser of the Amount of Insurance applied for or \$100,000, upon receipt of due proof that the Proposed Insured died while Temporary Insurance was in effect. Temporary Insurance will begin on the date the Proposed Insured signed this application (Signature Date). I understand and agree that Temporary Insurance will only begin for any Proposed Insured if: (1) I am actively at work on the Signature Date, the usual number of hours, without limitation; and (2) I have answered "No" to all applicable health questions in the application.

Temporary Insurance automatically ends on the earliest of the following: (1) the date this application is approved; (2) the date the Company sends notice to the Proposed Insured at the address shown in the application that the Company has declined to issue insurance; or (3) 60 days after the Signature Date.

If this application is approved as applied for, the policy will be effective on the date this application is approved by the Company. Otherwise, any insurance issued other than applied for will be effective upon delivery and acceptance of the policy.

Fraud

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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).

Employee/Member Signature

Signed at _____ On _____
(City, State) (Date)

X _____
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.

TEMPORARY INSURANCE AGREEMENT (TIA)

Subject to the terms of the policy applied for and this TIA, the Company agrees to pay the lesser of the Amount of Insurance applied for or \$100,000, upon receipt of due proof that the Proposed Insured died while Temporary Insurance was in effect. Temporary Insurance will begin on the date the Proposed Insured signed this application (Signature Date). It is understood and agreed that Temporary Insurance will only begin for any Proposed Insured if the Proposed Insured is actively at work on the Signature Date, the usual number of hours, without limitation; and all applicable health questions in the application have been answered "No."

Temporary Insurance automatically ends on the earliest of the following: (1) the date this application is approved; (2) the date the Company sends notice to the Proposed Insured at the address shown in the application that the Company has declined to issue insurance; or (3) 60 days after the Signature Date.

If this application is approved as applied for, the policy will be effective on the date this application is approved by the Company. Otherwise, any insurance issued other than applied for will be effective upon delivery and acceptance of the policy.

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.