



## Tips for Submitting a Complete and Compliant Replacement

If the application being submitted includes existing coverage, the following tips will assist in completing the replacement form and application.

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### Part A Application

#### **Existing Coverage Question**

- Answer 'yes' or 'no' to the Existing Coverage question. If answer is 'yes':
  - Enter the Existing Policy Number, or write 'Unknown' in the space provided
  - Enter the Name of the Existing Carrier
  - Enter the Face Amount of the existing coverage

#### **Replacement Question**

- Answer 'yes' or 'no' to the Replacement question.
  - If the existing coverage is 'Pending', the Replacement question should be answered 'no', unless the pending policy is under a binding or conditional receipt or is within an unconditional receipt refund period, even if the pending policy will not be put in force.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. **However, in states that require notice form AGLC0188, the form should be completed if the Existing Coverage question is answered 'yes', even if not replacing.**

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### Agent's Report

- Answer 'yes' or 'no' to the Existing Coverage question.
- Answer 'yes' or 'no' to the Replacement question
- Both of these questions on the Agent's Report should match what the applicant indicated on the Part A.
- Complete all fields, including license number, agent address, agent phone number, etc.

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### Replacement Notice

- Verify that you have the correct Replacement Notice for the state in which the application is signed.
- Answer all replacement and financing questions; do not leave any fields blank.
- If the existing policy number is not known, applicant should write 'Unknown' in the space provided.
- Answer the **Reason for Replacement** section, if applicable.
- If the Notice has a Sales Material section, (1) complete it and (2) submit any individualized sales materials, including illustrations. If no sales materials were used, write 'None' in the space provided.
- Be sure the applicant signs and dates the form. **The Replacement Notice must be dated on or before the date of the Part A.**
- Agent signature and date are required.

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### **Reminders:**

- Group coverage being replaced does not require a Replacement Notice; however, the Existing Coverage Question and Replacement Question are all required to be completed on the Part A.
- If an existing internal cash value policy (WL, UL, VUL or ROP Term) has lapsed or was cancelled within the last 4 months, the application is processed as a replacement and all replacement requirements apply.

Note: DO NOT submit this instruction sheet with the application packet.

# American General

Life Companies

## Term Insurance Application

### Part A

Washington Version

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- American General Life Insurance Company of Delaware, Wilmington, DE

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

### 1. Primary Proposed Insured

First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Sex  M  F Birthplace\* (state, country) \_\_\_\_\_ Date of Birth \_\_\_\_\_ Current Age \_\_\_\_\_

**Tobacco Use** Have you ever used any form of tobacco or nicotine products?  yes  no Type and quantity used \_\_\_\_\_

If yes, are you a current user?  yes  no If no, date of last use \_\_\_\_\_

Driver's License  yes  no License State \_\_\_\_\_ Number \_\_\_\_\_

U.S. Citizen or Permanent Resident (Green Card holder)  yes  no

If no, Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ (Copy of Visa Required)

Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Alternate Phone ( ) \_\_\_\_\_ Email \_\_\_\_\_

Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Length of Employment \_\_\_\_\_

Employer Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Duties \_\_\_\_\_

Personal Earned Income \$ \_\_\_\_\_ Household Income \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_

Personal Earned Income means salary, wages, commissions, fees, or other earned income received during the last 12 months, reduced by regular business expenses, but before all other deductions.

If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force on any of the following: Spouse \$ \_\_\_\_\_ Father \$ \_\_\_\_\_ Mother \$ \_\_\_\_\_ Siblings \$ \_\_\_\_\_

### 2. Owner

#### A. Complete if the Primary Proposed Insured is not the Owner (If contingent Owner is required, use Remarks section)

First Name \_\_\_\_\_ MI \_\_\_ Last Name \_\_\_\_\_ Sex  M  F

Social Security or Tax ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_

U.S. Citizen  yes  no If no, Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone ( ) \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_

Email \_\_\_\_\_

#### B. Complete if Owner is a trust (If trustee is premium payor also complete section 8 D)

Exact Name of Trust \_\_\_\_\_ Trust Tax ID # \_\_\_\_\_

Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Email \_\_\_\_\_

Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

### 3. Plan of Insurance

Product Name \_\_\_\_\_ Term Duration \_\_\_\_\_ Amount Applied For \$ \_\_\_\_\_

Premium Class Quoted \_\_\_\_\_ Reason for Insurance \_\_\_\_\_

#### Riders/Benefits

Child Rider Amount \$ \_\_\_\_\_ (Complete Child Rider Attachment) or  No current children

Waiver of Premium  Accidental Death Benefit Amount \$ \_\_\_\_\_  Terminal Illness Rider

Select Income Rider (Complete the following if SI Rider selected) Benefit Duration \_\_\_\_\_ Monthly Benefit Amt \$ \_\_\_\_\_

Disability Income Rider (Complete the following if DI Rider selected)

Number of Units (1 unit = \$100): \_\_\_\_\_ Occupational Class (Please check):  1  2

Other Riders/Benefits #1 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_

Other Riders/Benefits #2 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_

\*for identification purposes only

**4. Primary Beneficiary**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_% DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_% DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_% DOB \_\_\_\_\_ SSN \_\_\_\_\_

**5. Contingent Beneficiary**

Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_% DOB \_\_\_\_\_ SSN \_\_\_\_\_  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_% DOB \_\_\_\_\_ SSN \_\_\_\_\_

**6. Trust Information (if Beneficiary)** Exact Name of Trust \_\_\_\_\_  
 Trust Tax ID # \_\_\_\_\_ Current Trustee(s) \_\_\_\_\_ Date of Trust \_\_\_\_\_

**7. Business Insurance Details** *(Complete only if applying for business coverage)*

Does the Primary Proposed Insured have an ownership interest in the business?  yes  no  
 If yes, what is the percentage of ownership for the Primary Proposed Insured? \_\_\_\_\_%  
 Net Profit of Business \$ \_\_\_\_\_ Fair Market Value of Business \$ \_\_\_\_\_  
 If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered?  yes  no  
 If no, provide the reason why all partners are not covered \_\_\_\_\_  
 Describe any special circumstances \_\_\_\_\_

**8. Premium Payment**  Modal \$ \_\_\_\_\_

**A. Frequency of modal premium:**  Annual  Semi-annual  Quarterly  Monthly *(Bank Draft only)*  
**B. Method:**  Direct Billing  Bank Draft *(Complete Bank Draft Authorization)*  List Bill: Number \_\_\_\_\_  
 Credit Card - Initial Premium Only *(Complete Credit Card Authorization)*  
 Other *(Please explain)* \_\_\_\_\_  
**C. Amount submitted with application \$** \_\_\_\_\_  
**D. Premium Payor** *(Complete if other than Owner or if Owner is Trustee)*  
 First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Sex  M  F  
 Social Security or Tax ID # \_\_\_\_\_ Date of Birth \_\_\_\_\_  
 Relationship to Primary Proposed Insured \_\_\_\_\_  
 U.S. Citizen  yes  no If no, Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

**9. Existing Coverage and Replacements**

**A. Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies?\***  yes  no  
**B. If question 9A is answered "yes", please provide the following information:**

Type (see below)	Year of Issue	Face Amount	Insurance Company	Contract or Policy #	Is Coverage being Replaced?***
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

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

\*If 9A is answered "yes", certain states require completion of replacement-related forms even when existing or pending life insurance or annuities are not being replaced by the life insurance policy being applied for.

\*\*\*"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

**C. Disability Coverage** *(Complete only if Disability Income Rider coverage requested)*

**Does the Primary Proposed Insured have any existing or pending Disability insurance policies?**  yes  no  
*(If yes, complete the following regarding existing or pending disability insurance)*

Insurance Company	Benefit Amount	Benefit Period	Elimination Period	Year Issued
_____	_____	_____	_____	_____

**10. Background Information** (Complete questions A through J. If yes answer applies to the Primary Proposed Insured, provide details specified after each question)

**A.** Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years?  yes  no  
(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire) \_\_\_\_\_

**B.** In the past five years, has the Primary Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities?  yes  no  
(If yes, complete the Aviation and/or Avocation Questionnaire)

**C.** Has the Primary Proposed Insured:  
1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application?  yes  no  
(If yes, list company name, amount applied for, purpose of insurance, and if application will be placed) \_\_\_\_\_

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal?  yes  no  
(If yes, list date and reason) \_\_\_\_\_

**D.** Has the Primary Proposed Insured ever filed for bankruptcy?  yes  no  
(If yes, list chapter filed, date, reason, and discharge date) \_\_\_\_\_

**E.** In the past five years, has the Proposed Insured been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs?  yes  no  
(If yes, list date, state, license #, and specific violation) \_\_\_\_\_

**F.** Has the Primary Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending?  yes  no  
(If yes, list date, county, state, charge, and current status) \_\_\_\_\_

**G.** Is the Proposed Insured an active duty service member of the US Armed Forces, a member of the National Guard or an active reservist of the US Armed Forces, or a dependent of an active duty service member of the US Armed Forces?  yes  no  
(If yes, provide Pay Grade, Rank and any known foreign assignments. Complete the applicable Military Disclosure) \_\_\_\_\_

**H.** Is there an intention that any party, other than the Owner, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application?  yes  no

**I.** Does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement?  yes  no

**J.** Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, etc) as an incentive to enter into this transaction?  yes  no  
(If yes, describe the incentive) \_\_\_\_\_

**Remarks**

**11. Details and Explanations**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

**Agreement, Authorization to Obtain and Disclose Information and Signatures**

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments 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 attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, 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 issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Limited Temporary Life Insurance Agreement ("LTLIA") – If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy and only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the questions regarding the Primary Proposed Insured's health and age in section 3 of the LTLIA; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me, my spouse 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; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; 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: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: 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. I understand this consent may be revoked at any time by sending a written request to the Company, 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 AGLC or affiliated insurers 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.

**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; and (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 signed at** (city, state) \_\_\_\_\_ **On** (date) \_\_\_\_\_

**Owner Signature X** \_\_\_\_\_ **Title** \_\_\_\_\_  
*(If Corporate Officer or Trustee)*

**Primary Proposed Insured Signature** (if other than Owner) **X** \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

**Insurance Producer Signature**

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

**Writing Insurance Producer Name** *(please print)* \_\_\_\_\_ **Writing Insurance Producer #** \_\_\_\_\_

**Writing Insurance Producer Signature X** \_\_\_\_\_ **Countersigned** \_\_\_\_\_  
*(Licensed resident insurance producer if state required)*

**Insurance Producer's Report**

**1. Statements**

- A. Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies?  yes  no  
*(If yes, 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 - please attach such forms)*
- B. If yes to question 1A., do you have any information that the Primary Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for?  yes  no  
*(If yes, please provide details in the Remarks section below and attach replacement-related forms)*
- C. Number of years you have known the Primary Proposed Insured: \_\_\_\_\_
- D. Are you aware of any other information that would adversely affect the Primary Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance)*  yes  no
- E. Did you provide the Owner with a Limited Temporary Life Insurance Agreement?  yes  no

**2. Remarks, Details and Explanations** *(Please include information on any collateral assignment, etc)*

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**3. Commission, Insurance Producer/Agency Information** *(Please list servicing insurance producer first)*

Insurance Producer(s) to Receive Commission	Agency Number	Insurance Producer Number	Percent of Split
_____	_____	_____	%
_____	_____	_____	%
_____	_____	_____	%
_____	_____	_____	%

**4. Insurance Producer Agreement and Signature**

I understand and agree that if I am made aware of any changes to any of the answers contained in any of the forms I will notify the company of the changes.

Writing Insurance Producer Name *(Please print)* \_\_\_\_\_ Date \_\_\_\_\_

Writing Insurance Producer Signature **X** \_\_\_\_\_

State License # \_\_\_\_\_ Phone # \_\_\_\_\_

Email \_\_\_\_\_ Fax # \_\_\_\_\_

**For Home Office use**

Processing Center \_\_\_\_\_ Contact Person \_\_\_\_\_ Phone # \_\_\_\_\_

Servicing Insurance Producer (if other than Writing Insurance Producer) send policy/delivery requirements to \_\_\_\_\_

\_\_\_\_\_

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")  
Authorization to Obtain and Disclose Information**

\_\_\_\_\_  
**Name of Patient/Proposed Insured (Please Print)**

\_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
**Date of Birth**

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company of Delaware, American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and any affiliated services company, (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life Companies company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

\_\_\_\_\_  
Signature of Proposed Insured or  
Proposed Insured's Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Description of Authority of Personal Representative  
(if applicable)



**LEAVE THIS FORM WITH THE PROPOSED INSURED(S)  
NOTICES TO THE PROPOSED INSURED(S)**

**American General Life  
Insurance Company,  
Houston, TX**

**The United States Life Insurance Company  
in the City of New York,  
New York, NY**

**American General Life  
Insurance Company  
of Delaware, Wilmington, DE**

You have applied for life insurance with one of the insurance companies identified above. "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 (AGLC), a company providing services to affiliated life insurance companies.

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**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 or health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

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.

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**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, Inc., formerly known as Medical Information Bureau, 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 about you 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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**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

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**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.

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**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.

**LEAVE COMPLETED AND SIGNED FORM WITH THE OWNER**

Limited Temporary Life Insurance Agreement (Agreement)
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**THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.**

**1. Check appropriate Company:**

- American General Life Insurance Company, Houston, TX     
  The United States Life Insurance Company in the City of New York, New York, NY     
  American General Life Insurance Company of Delaware, Wilmington, DE

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

**2. Complete the following: (please print)**

Primary Proposed Insured _____
Other Proposed Insured _____ <i>(applicable only for a joint life or survivorship policy)</i>
Owner (if other than Primary Proposed Insured) _____
Modal Premium Amount Received _____
Date of Policy Application _____

**3. Answer the following questions:**

	Yes	No
a. Has any 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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is any Proposed Insured age 71 or above?	<input type="checkbox"/>	<input type="checkbox"/>

<p><b>STOP</b> If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.</p>
-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------

**TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT**

**A. Eligibility for Coverage:** If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

**B. When Coverage Will Begin:**

COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

**Coverage under this Agreement will not exist until all of the conditions listed above have been met.**

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Automatic Bank Draft Agreement; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

**C. When Coverage Will End:**

COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that the application will not be considered on a prepaid basis;
- The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
- 60 calendar days from the date coverage begins under this Agreement.

**D. The Company will pay the death benefit amount described below to the beneficiary named in the application if:**

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- \$500,000 plus the amount of any premium paid for coverage in excess of \$500,000; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**4. Complete and sign this section:**

Any misrepresentation contained in this Agreement or the Receipt and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement or the Receipt.

*I, the Owner, have received and read this Agreement and the Receipt or they were read to me and agree to be bound by the terms and conditions stated herein.*

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

Signature of Primary Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Signature of Other Proposed Insured *(if applicable)* \_\_\_\_\_ Date \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Writing Insurance Producer Name *(please print)* \_\_\_\_\_ Writing Insurance Producer # \_\_\_\_\_

**SUBMIT COMPLETED FORM WITH SIGNED APPLICATION**

Limited Temporary Life Insurance Agreement Receipt

**1. Check appropriate Company:**

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- American General Life Insurance Company of Delaware, Wilmington, DE

In this Receipt, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable. The "Agreement" refers to the Limited Temporary Life Insurance Agreement.

**2. Complete the following: (please print)**

Primary Proposed Insured \_\_\_\_\_

Other Proposed Insured \_\_\_\_\_  
*(applicable only for a joint life or survivorship policy)*

Owner (if other than Primary Proposed Insured) \_\_\_\_\_

Modal Premium Amount Received \_\_\_\_\_

**3. Answer the following questions:**

Yes      No

a. Has any 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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Is any Proposed Insured age 71 or above?	<input type="checkbox"/>	<input type="checkbox"/>

**STOP** If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under the Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under the Agreement.

The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under the Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under the Agreement have been met.

The total death benefit amount pursuant to the Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- \$500,000 plus the amount of any premium paid for coverage in excess of \$500,000.

If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**4. Complete and sign this section:**

Any misrepresentation contained in the Agreement or this Receipt and relied on by the Company may be used to deny a claim or to void the Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of the Agreement or this Receipt.

*I, the Owner, have received and read the Agreement and this Receipt or they were read to me and agree to be bound by the terms and conditions stated therein.*

Signature of Owner \_\_\_\_\_ Date \_\_\_\_\_

Signature of Primary Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Signature of Other Proposed Insured (if applicable) \_\_\_\_\_ Date \_\_\_\_\_  
*(If under age 15, signature of parent or guardian)*

Writing Insurance Producer Name (please print) \_\_\_\_\_ Writing Insurance Producer # \_\_\_\_\_



## **Terminal Illness Rider Instruction Sheet** (For use with the Accelerated Death Benefit Form)

If the Terminal Illness Rider is not desired, please disregard this instruction sheet and attached form.

Eligibility for the Terminal Illness Rider varies by state.

The attached form is not required in any state not listed below.

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### **Please use the following information for the following states:**

**AL, AR, DC, LA, MA, MN, MS, NC, OH, OK, and TX.**

- If the applicant is requesting the Terminal Illness Rider on any product that has this rider available, the attached form (AGLC102084 or AGLC101954-MA) must be completed and submitted with the application packet.
- Directions for completing the Part A:
  - If the Common App (AGLC100565) was completed, place a checkmark in the Terminal Illness Rider checkbox in Section 8.
  - If the Term App (AGLC100240) was completed, add the Terminal Illness Rider as an Other Riders / Benefits in Section 3 and place N/A in the Amount/Unit(s) line.

Note: DO NOT submit this instruction sheet with the application packet.

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### **Please use the following information for the following states:**

**CT, IN, KS, MI, OR, VA and WA.**

For AG Select-A-Term<sup>SM\*\*</sup> or Ultra Series applications, the Terminal Illness Rider is not available due to state regulations.

- Do not complete this form.
- Do not request the Terminal Illness Rider on the Part A.

\*\*Note: AG ROP Select-A-Term<sup>SM</sup> is eligible to receive the Terminal Illness Rider.

For products other than AG Select-A-Term<sup>SM</sup> or Ultra Series, the Terminal Illness Rider is available on products that have been filed with this rider.

- Complete the attached form AGLC102084.
- Complete the additional rider information on the Part A:
  - If the Common App (AGLC100565) was completed, place a checkmark in the Terminal Illness Rider checkbox in Section 8.
  - If the Term App (AGLC100240) was completed, add the Terminal Illness Rider as an Other Riders / Benefits in Section 3 and place N/A in the Amount/Unit(s) line.

Note: DO NOT submit this instruction sheet with the application packet.

**American General Life Insurance Company**

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**Disclosure Statement For Accelerated Death Benefits  
Required At Time Of Application For Policy**

**Limitations of the Accelerated Benefit:**

You may use the money you receive from the Terminal Illness Accelerated Benefit Rider for any purpose. Unlike conventional life insurance proceeds, accelerated benefits payable under this rider **COULD BE TAXABLE IN SOME CIRCUMSTANCES**. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from this accelerated benefit product.

**A. Consequences of This Benefit:**

Receipt of accelerated benefits **MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI")**, or other government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

**Effects of the benefit payment:**

1. We will defer premiums on the policy and any attached riders;
2. A lien against future policy benefits will be established;
3. Any unpaid policy loan will be added to the lien;
4. The amount of the lien and any policy loan will be deducted from the Death Benefit;
5. Interest will accrue daily on paid out benefits and any deferred premiums.

**B. Medical Condition(s) Enabling Accelerating of Life Benefit:**

Terminal Illness means a condition that a physician certifies will reasonably be expected to result in death in 12 months or less as specified in the Terminal Illness Accelerated Benefit Rider.

**C. Option:**

The Terminal Illness Benefit is a one time acceleration of up to 50% of the death benefit proceeds payable under the base policy, but not to exceed \$250,000.

**D. Premium for Accelerated Benefit:**

NONE, there is no additional charge for the Terminal Illness Accelerated Benefit Rider.

**E. Administrative Expense Charge:**

On the date the accelerated benefit is paid under this rider, an administrative fee not to exceed \$250.00 will be established as a lien against future policy benefits.

\_\_\_\_\_  
Signature of Applicant

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

\_\_\_\_\_  
Date

\_\_\_\_\_  
Date

Agent Instructions: Please provide a copy of this form to the applicant and retain a copy for yourself.

- American General Life Insurance Company, Houston, TX**
- The United States Life Insurance Company in the City of New York, New York, NY**
- American General Life Insurance Company of Delaware, Wilmington, DE**

In this form, the "Company" refers to the insurance company whose name is checked above.

The insurance company checked above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments.

**Information and Consent Form for Human Immunodeficiency Virus (HIV) Related Tests**

**AIDS**

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system, caused by a virus, HIV. The virus is transmitted by sexual contact with an infected person, from an infected mother to her newborn infant, or by exposure to infected blood (as in needle sharing during IV drug use). Persons at high risk of contracting AIDS include males who have had sexual contact with another man, intravenous drug users, hemophiliacs, and sexual contacts of any of these persons.

**The Tests**

To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) for testing and analysis. By signing and dating this form you agree that this test may be performed and that underwriting decisions will be based on the test results. One of the tests to be performed on this sample may be a test to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests consisting of two ELISA (enzyme-linked immunosorbent assay) tests and one Western Blot test done by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

**Risks From Having the Tests**

A positive test result may cause you significant anxiety. A positive test result will adversely affect your insurance application, and may result in uninsurability for life, health, or disability insurance policies you may apply for in the future. A negative result may create a false sense of security.

**Pre-Testing Considerations**

Many public health organizations have recommended that before taking an AIDS-related bodily fluids test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested. A list of public health care facilities providing such counseling is attached.

**Confidentiality of Test Results**

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to affiliates, medical personnel, or employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer, or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS. No other disclosures will be made except as authorized by you.

**Notification of Test Results**

If your test results are negative, no routine notification will be sent to you. If your test results are reported by the laboratory to the Insurer as being positive or indeterminate, you are entitled to post-test counseling. Because a trained person should deliver that information so that you can understand clearly what the test result means, you may designate either your private physician, a health care provider or a health care agency to whom the insurer will provide positive or indeterminate test results for interpretation and post-test counseling. If you do not designate a physician, health care provider or health care agency, positive test results will be disclosed to your local health department for interpretation and post-test counseling.

Positive or indeterminate test results will not be sent directly to you.

Name of physician, health care provider or health care agency for reporting a positive or indeterminate test result:

Address: \_\_\_\_\_

**Consent**

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A certified true photocopy of this form will be as valid as the original.

\_\_\_\_\_  
Name of Proposed Insured (Please Print)

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
Address

**Submit this page with the application**

**WASHINGTON STATE HIV ANTIBODY TESTING/COUNSELING SERVICES**

ADAMS CTY HEALTH DEPT.  
103 West Main  
Ritzville, WA 99169  
(509) 659-0090, Ext. 206

ASOTIN CTY HEALTH DIST.  
C/O NORTH CENTRAL HEALTH DIST.  
1221 "F" Street  
Lewiston, ID 83501  
(208) 799-1300

BELLINGHAM-WHATCOM CTY HEALTH DIST.  
509 Girard Street  
Bellingham, WA 98227  
(206) 676-6720

BENTON-FRANKLIN HEALTH DIST.  
506 McKenzie  
Richland, WA 99352  
(509) 943-2614

BREMERTON-KITSAP CTY HEALTH DEPT  
109 Austin Drive  
Bremerton, WA 98412  
(206) 478-5235; 1-800-874-2437

CHELAN-DOUGLAS CTY HEALTH DIST.  
316 Washington Street  
Wenatchee, WA 98801  
(509) 664-5306

CLALLAM CTY HEALTH DEPT.  
223 East Fourth Street  
Port Angeles, WA 98362  
(206) 452-7831

COWLITZ-WAHIAKUM HEALTH DIST.  
1516 Hudson  
Longview, WA 98632  
(206) 425-7400

GARFIELD CTY HEALTH DIST.  
P.O. Box 130 (10th & Columbia)  
Pomeroy, WA 99347  
(509) 843-3412

GRANT CTY HEALTH DIST: CTY COURT-HOUSE  
P.O. Box 37  
Ephrata, WA 98823  
(509) 754-2011, Ext. .372

GRAYS HARBOR CTY HEALTH DEPT.  
3109 Sumner Avenue  
Aberdeen, WA 98520  
(206) 532-8631

ISLAND CTY HEALTH DEPT.  
Courthouse Annex  
P.O. Box 840  
Coupeville, WA 98239  
(206) 679-7350

JEFFERSON CTY HEALTH DEPT.  
Multi-Services Building, 2nd Floor  
802 Sheridan  
Port Townsend, WA 98368  
(206) 385-0722

KITTITAS CTY HEALTH DEPT.  
507 Nanum  
Eielsburg, WA 98926  
(509) 962-6811, Ext. 109

LEWIS CTY HEALTH DIST.  
Health Services Building 360 N.W.  
North Street  
P.O. Box 706  
Chehalis, WA 98532  
(206) 748-9121, Ext. 2233

LINCOLN CTY HEALTH DEPT.  
Nursing Office: Drane A. Martin,  
R.N., Director  
507 7th Street - P.O. Box 215  
Davenport, WA 99122  
(509) 725-1001

MASON CTY HEALTH DEPT.  
411 North 5th (Nursing Division)  
Shelton, WA 98584  
(206) 427-9670, Ext. 400

NORTHEAST TRI-CITY HEALTH DIST.  
East 347 Astor  
P.O. Box 270  
Colville WA 99114  
(509) 684-5048

OKANOGAN CTY HEALTH DIST.  
Administration Building  
P.O. Box 231  
Okanogan, WA 98840  
(509) 422-3867

PACIFIC CTY HEALTH DEPT.  
Box 26  
South Bend, WA 98586  
(206) 875-6541, Ext. 365

SAN JUAN CTY HEALTH DEPT.  
P.O. Box 607, 145 Rhone  
Friday Harbor, WA 98250-0607  
(206) 378-4474

SEATTLE-KING CTY HEALTH DEPT.  
AIDS Prevention Project  
(Gay/Bisexual Men Preferred)  
1116 Summit Avenue, Suite 200  
Seattle, WA 98101  
(206) 296-4999, TDD (206) 340-2033

SEXUALLY TRANSMITTED DISEASE CLINIC  
325 9th Avenue, 3rd Floor, South Wing  
Seattle, WA  
(206) 223-3590

SEATTLE GAY CLINIC  
500 19th Avenue East  
Seattle, WA 98102  
(Will see anyone: Tuesday Evening 6:30 - 9:00 p.m.; Saturday, Noon - 3:00 p.m.)  
(206) 461-4540

LOW RISK TESTING SITES  
(SEATTLE-KING CO.)

A. NORTH SEATTLE PUBLIC HEALTH CTR  
10501 Meridan Avenue North  
Seattle, WA  
(206) 367-6900

B. SOUTHEAST PUBLIC HEALTH CTR AT RENTON  
3001 N.E. 4th Street  
Renton, WA  
(206) 344-6700

C. SOUTHWEST PUBLIC HEALTH CTR  
10821 8th Avenue S.W.  
Seattle, WA  
(206) 344-7474

D. EAST PUBLIC HEALTH CTR  
2424 156th Avenue N.E.  
Bellevue, WA  
(206) 344-6882

E. SOUTHEAST PUBLIC HEALTH CTR AT AUBURN  
20 Auburn Avenue  
Auburn, WA  
(206) 852-8400

SKAGIT COUNTY HEALTH DEPT.  
Courthouse Administration Building  
Mount Vernon, WA 98273  
(206) 336-9386

SHOHOMISH HEALTH DIST.  
2722 Colby Street, Suite 333  
Everett, WA 98201  
(206) 259-2330 or 1-800-344-2437

SOUTHWEST WASHINGTON HEALTH DIST.  
Vancouver-Clark City Health Center  
2000 Fort Vancouver Way - P.O. Box 1870  
Vancouver, WA 98663  
(206)695-9215

SPOKANE CTY HEALTH DIST.  
West 1101 College Avenue  
Spokane, WA 99201  
(509) 456-3630

TACOMA-PIERCE CTY HEALTH DEPT.  
3629 South "D" Street  
Tacoma, WA 98408  
(206) 591-6060

THURSTON CTY HEALTH DEPT.  
529 Southwest Fourth  
Olympia, WA 98501  
(206) 786-5581

WALLA-WALLA CTY- CITY HEALTH DEPT.  
310 West Poplar - P.O. Box 1753  
Walla Walla, WA 99362  
(509) 527-3290

WHITMAN CTY HEALTH DEPT.  
Public Service Building  
North 310 Main Street  
Colfax, WA 99111  
(509) 397-3471

YAKIMA CTY HEALTH DIST.  
104 North First Street  
Yakima, WA 98901  
(509) 575-4040

**American General Life Insurance Company**

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**(Save this notice! It may be important to you in the future.)**

The decision to buy a new life insurance policy or annuity and discontinue or change an existing one is very important. Your decision could be a good one—or a mistake. It should be carefully considered. The Washington State Insurance Commissioner requires us to give you this notice to help you make a wise decision.

**STATEMENT TO APPLICANT BY AGENT OR BROKER:**

(Use additional pages if necessary.)

I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following factors, which I call to your attention.

1. Can there be reduced benefits or increased premiums in later years?  
 No  Yes If "yes," explain: \_\_\_\_\_  
 \_\_\_\_\_
2. Are there penalties or setup or surrender charges for the new policy?  
 No  Yes If "yes," explain, emphasizing any extra cost for early withdrawal: \_\_\_\_\_  
 \_\_\_\_\_
3. Will there be penalties or surrender charges under the existing insurance as a result of the proposed transaction?  
 No  Yes If "yes," explain: \_\_\_\_\_  
 \_\_\_\_\_
4. Are there adverse tax consequences from the replacement under current tax law?  
 No  Yes If "yes," explain: \_\_\_\_\_  
 \_\_\_\_\_
5. (a) Are interest earnings a consideration in this replacement?  No  Yes  
 (b) If "yes," explain what portions of premiums or contributions will produce limited or no earnings. As pertinent, include in your explanation the need for minimum deposits to enhance earnings and the reduction of earnings that may result from setup charges, policy fees, and other factors: \_\_\_\_\_  
 \_\_\_\_\_
6. Are minimum amounts required to be on deposit before excess interest will be paid?  
 No  Yes If "yes," explain: \_\_\_\_\_  
 \_\_\_\_\_
7. If the new program is based on a variable or universal life insurance policy or a single-premium policy or annuity...  
 (a) Are the interest rates quoted before or after fees and mortality charges have been deducted? \_\_\_\_\_  
 (b) Interest rates are guaranteed for how long? \_\_\_\_\_  
 (c) The minimum interest rate to be paid is how much? \_\_\_\_\_  
 (d) If applicable, the rate you pay to borrow is \_\_\_\_\_, and the limit on the amount which can be borrowed is \_\_\_\_\_.  
 (e) The surrender charges are \_\_\_\_\_.  
 (f) The death benefit is \_\_\_\_\_.
8. Are there other short- or long-term effects from the replacement that might be materially adverse?  
 No  Yes If "yes," explain: \_\_\_\_\_  
 \_\_\_\_\_

**X** \_\_\_\_\_  
SIGNATURE OF AGENT OR BROKER DATE

NAME AND ADDRESS AGENT OR BROKER (PLEASE PRINT OR TYPE.)

**LIST OF POLICIES OR CONTRACTS TO BE REPLACED:**

Insured's Name	Company	Contract Number

**CAUTION!** The Insurance Commissioner suggests you consider these points:

- **USUALLY, CONTESTABLE AND SUICIDE PERIODS START AGAIN UNDER A NEW POLICY. BENEFITS MIGHT BE EXCLUDED UNDER A NEW POLICY THAT WOULD BE PAID UNDER EXISTING INSURANCE.**
- **TERMINATING OR ALTERING EXISTING COVERAGE BEFORE NEW INSURANCE HAS BEEN ISSUED MIGHT LEAVE LEAVE YOU UNABLE TO PURCHASE OTHER LIFE INSURANCE OR ABLE TO BUY IT ONLY AT SUBSTANTIALLY HIGHER RATES.**
- **YOU ARE ENTITLED TO ADVICE FROM THE EXISTING AGENT OR COMPANY. SUCH ADVICE MIGHT BE HELPFUL.**
- **STUDY THE COMMENTS MADE ON THIS FORM BY THE AGENT OR BROKER. THEY APPLY TO YOU AND THIS PROPOSAL. THEY ARE IMPORTANT TO YOU AND YOUR FUTURE.**

A completed copy of this form was received on \_\_\_\_\_  
DATE

**X** \_\_\_\_\_  
SIGNATURE OF APPLICANT

**THIS COMPLETED FORM SHOULD BE FILED PERMANENTLY WITH YOUR NEW INSURANCE POLICY.**

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- American General Life Insurance Company of Delaware, Wilmington, DE

In this questionnaire, the "Company" refers to the insurance company whose name is checked above.

The insurance company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

### Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #
1. Your income (before Income Tax):		Current fiscal year (Date / / thru / / )	Previous fiscal year	
Salary or wages				
Bonuses and/or commissions				
Net business or professional income (i.e., Gross income less business expenses, but not before personal income)				
Other earned income (give details in "Remarks" below)				
Unearned income (interest and dividends, net real estate income, etc.) give details in "Remarks" below				
<b>TOTAL</b>				
2. What is your approximate net worth, i.e., assets minus liabilities? (if necessary, give details in "Remarks" below)		Current fiscal year (Date / / thru / / )	Previous fiscal year	
Personal Assets				
Business Assets				
Liabilities				
Net worth				
3. Estimated tax liabilities at death (include potential estate taxes, inheritance taxes and capital gains taxes, both federal and state)				
4. How was the need for this new amount of coverage determined?				
Remarks (questions 1-4)				

If applying for personal insurance, please complete the Signature and Agreement section on the following page. If applying for business insurance, please complete questions 5-11 and the Signature and Agreement section on the following page.

If applying for personal insurance, please skip questions 5 - 11 and complete the Signature and Agreement section at the bottom of this page.  
If applying for business insurance, please complete questions 5 -11 and the Signature and Agreement section on this page.

5. Purpose of business insurance

- Key Person       Deferred Compensation       Buy-Sell Agreement/Stock Repurchase       Other

Other purpose — explain: \_\_\_\_\_  
\_\_\_\_\_

6. Is there a written buy/sell agreement in effect? (if yes, attach copy)       yes       no

Is there a buy/sell agreement contemplated?       yes       no

7. Creditor: Name of lender \_\_\_\_\_

Is insurance requested by lender?       yes       no

Coverage amount required by creditor: \_\_\_\_\_

Purpose of loan: \_\_\_\_\_  
\_\_\_\_\_

(Use "Remarks" below for further details.)

8. Are other corporate officers or partners being insured?       yes       no

If yes, provide amount of inforce and/or applied for coverage with us or another insurance company. If no, explain: \_\_\_\_\_  
\_\_\_\_\_

9. What percentage of the business do you own? \_\_\_\_\_%

10. Estimated fair market value of business: \_\_\_\_\_

(In "Remarks" state how this value was determined)

11. Financial details of business:      Current fiscal year      Previous fiscal year  
(Date / / thru / / )

A. Total assets \_\_\_\_\_

B. Total liabilities \_\_\_\_\_

C. Gross sales or revenue \_\_\_\_\_

D. Net income (before taxes) \_\_\_\_\_

Please submit a copy of the most recent balance sheet and income statement (year or quarter).

Remarks (questions 5 - 11) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Signature and Agreement:**

All of the above answers are full, complete and true to the best of my knowledge and belief, and are a continuation of, and form a part of, the application for insurance.

Owner Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

Signed at (city, state) \_\_\_\_\_

Proposed Insured Signature **X** \_\_\_\_\_ Date \_\_\_\_\_

(If under age 15, signature of parent or guardian)