

SAMPLE PLATINUM

American General Life Insurance Company

A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

"Proposed Insured" refers to primary, spouse, and children proposed for coverage in this application.

<p>1. Primary Proposed Insured</p> <p><u>Doe</u> <u>John</u> <u>M</u> Last First Middle</p>		<p>8. Spouse (if coverage applied for) Sex <input type="checkbox"/> M <input type="checkbox"/> F</p> <p>Name _____ Last First Middle</p> <p>Month Day Year State Country _____ _____ _____ _____ _____</p> <p>Birth Date and Place Social Security No. Age</p>											
<p>2. Address</p> <p><u>123 Main St</u> Street</p> <p><u>Anytown</u> <u>UT</u> <u>84004</u> City State Zip Code</p>		<p>9. Primary Proposed Insured Height <u>6</u> Weight <u>2</u></p> <p>10. Spouse Height _____ Weight _____</p>											
<p>3. Social Security No.</p> <p><u>555-55-5555</u></p>	<p>4. Birth Date and Place</p> <table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td>Month</td> <td>Day</td> <td>Year</td> <td>State</td> <td>Country</td> </tr> <tr> <td style="text-align:center">09</td> <td style="text-align:center">01</td> <td style="text-align:center">74</td> <td style="text-align:center">UT</td> <td style="text-align:center">Utah</td> </tr> </table>	Month	Day	Year	State	Country	09	01	74	UT	Utah	<p>11. Beneficiary</p> <p>Name <u>The Estate of John Doe</u> Last First Middle</p> <p>Social Security No. Date of Birth Relationship</p>	
Month	Day	Year	State	Country									
09	01	74	UT	Utah									
<p>5. Age 35</p>	<p>6. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F</p>	<p>12. Primary Proposed Insured Driver's License</p> <p># <u>12233211243</u> State of Issue <u>UT</u></p>											
<p>7. U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If no, date of entry _____ visa type _____</p>													

13. List Dependent(s) Information:

	Full Name	Age	Relationship	Birth Date			Sex	
				Mo.	Day	Yr.	M	F
a.							<input type="checkbox"/>	<input type="checkbox"/>
b.							<input type="checkbox"/>	<input type="checkbox"/>
c.							<input type="checkbox"/>	<input type="checkbox"/>
d.							<input type="checkbox"/>	<input type="checkbox"/>
e.							<input type="checkbox"/>	<input type="checkbox"/>

Insurance Plan	
<p><input checked="" type="checkbox"/> Accident</p> <p>Coverage Level <input checked="" type="checkbox"/> Primary Proposed Insured <input type="checkbox"/> Primary Proposed Insured/Spouse <input type="checkbox"/> Family <input type="checkbox"/> Primary Proposed Insured/Children</p> <p>Deductible Amount: \$ <u>500</u></p> <p>Benefit Payable per Calender Year, per Insured: \$ <u>15000</u></p>	<p><input type="checkbox"/> Critical Illness Benefit Rider</p> <p>Coverage Level <input type="checkbox"/> Primary Proposed Insured <input type="checkbox"/> Primary Proposed Insured/Spouse</p> <p>Benefit Payable per Lifetime, per Insured:</p> <p>Primary Proposed Insured \$ _____ Spouse \$ _____</p>

Questions 14-17 are only applicable if applying for the Critical Illness Benefit Rider.

14. Additional Information – In the past 1 year, had any Proposed Insured used tobacco (cigarette, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? Yes No

For a "Yes" answer, please indicate Primary Proposed Insured and/or Spouse. Primary Proposed Insured Spouse

Health Questions		Yes	No
15.	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)?	<input type="checkbox"/>	<input type="checkbox"/>
16.	In the last 5 years, has any Proposed Insured been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's disease or non-Hodgkin's lymphoma?	<input type="checkbox"/>	<input type="checkbox"/>
17.	In the last 5 years, has any Proposed Insured been diagnosed as having or been treated for or consulted a licensed health care provider for:		
	a. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/>	<input type="checkbox"/>
	b. Diabetes?	<input type="checkbox"/>	<input type="checkbox"/>
	c. Disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>
	d. Kidney failure or abnormal kidney function?	<input type="checkbox"/>	<input type="checkbox"/>
	e. An organ transplant or been advised of the need of an organ transplant?	<input type="checkbox"/>	<input type="checkbox"/>

Health History—Details For Any "Yes" Answers

Question #	Name of Proposed Insured	Relationship			Description
		Primary Proposed Insured	Spouse	Child	

All Coverage—Existing or Pending Insurance Question

Does any Proposed Insured have any existing or pending accident or sickness insurance? **NO**
(If yes, complete section following)

Name of Proposed Insured	Company Name	Type*	Face Amount	Replace**	
				Yes	No
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

* Type A = accident, CI = critical illness, or O = other

** Replace means that the insurance policy being applied for replaces any accident and sickness policy pending or presently in force including health, accident, critical illness, disability or cancer insurance. If replacement may be involved, complete and submit any state-required replacement forms.

Modal Premiums

Frequency of modal premium: Annual Semi-annual Quarterly Monthly (Bank Draft only)

Method: Direct Billing Bank Draft (Complete Bank Draft Authorization.) List Bill: Number _____

Credit Card – Initial Premium Only (Complete Credit Card Authorization.)

Accident \$ 25.69	Critical Illness Benefit Rider \$ _____	Total Modal Premium \$ 25.69
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AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT – UNDERSTANDING

between Proposed Insured ("You or Your") and the Company and its affiliates ("We" or "Us")

Agreement.

Your insurance will not begin until: (a) We have issued Your policy and (b) received Your first premium in full. You must pay your first premium in full within 45 days of the date Your policy is issued. Even if You pay Your premium in advance, there will be no coverage until the day Your policy is issued. If Your policy is not issued for any reason, We will (a) refund Your premium, and (b) have no liability regarding this application.

The policy You are applying for is NOT major medical insurance. It is a limited benefit policy. This means that it pays benefits only as defined in the policy. Benefits payable are subject to the conditions, limits, reductions and exclusions in the policy.

All statements and answers are complete and true to the best of Your knowledge and belief. No agent can: (a) waive any answer, (b) modify this application, (c) bind Us or (d) make any promise or representation not contained in this application.

Authorization.

By signing the application, You authorize Us to release the information obtained in the application in these circumstances only: (a) to reinsurers or other persons or entities performing business or legal services in connection with this application or claims, (b) as may be lawfully required, or (c) as You may further authorize.

A photocopy is as valid as an original. This Authorization will be valid for 24 months of the date signed below, except that this Authorization will be valid for 180 days with regard to the results of a Human Immunodeficiency Virus (HIV) antibody test.

You or Your representative may request a copy. You also may revoke this Authorization at any time by written notification to Us at our Home Office.

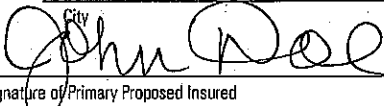
Acknowledgement.

By signing this application, you acknowledge receipt of the Outline of Coverage, Notice to the Primary Proposed Insured and the HIPAA Privacy Notice. If you are completing this application using voice signature, you acknowledge that you already have a copy of the Outline of Coverage and the HIPAA Privacy Notice, and that Notices to the Primary Proposed Insured have either been read to you or provided to you.

Understanding.

If You are receiving Medicaid payments, benefits under the policy may reduce those payments or any Medicaid benefits otherwise payable. Anyone who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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).

Signed at Salt Lake City UT 09/01/2009
City State Date
X  X _____
Signature of Primary Proposed Insured Signature of Owner (if other than Primary Proposed Insured)

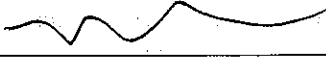
Information Sharing (Optional)

By signing below, You further authorize Us to use and/or share the demographic information in this application to provide You with information about other products and/or service offered by Us.

X _____
Signature of Primary Proposed Insured

Agent Section.

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge concerning any Proposed Insured. I also have provided the required Outlines of Coverage and the HIPAA Privacy Notice.

X  Zac Lovingier
Signature of Licensed Agent Printed Name of Agent
8DG70
Agent Number

SAMPLE

BANK DRAFT AUTHORIZATION

- **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 company checked above ("Company") will withdraw the premiums from the specified account. "You", "your", "I", and "me" refer to the bank account Owner whose name appears below.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Automatic Bank Draft Agreement

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason.

This must be dated and signed by the bank account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

→ Financial Institution Name AnyBank

→ Financial Institution Address 455 Center St City, State Anytown, UT ZIP 84004

→ Routing Number

1	2	3	4	5	6	7	8	9				
0	1	2	4	5	6	7	8	7	8	7	8	7

→ Account Number

0	1	2	4	5	6	7	8	7	8	7	8	7
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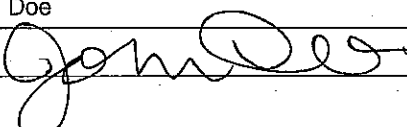
→ Type of Account: Checking Savings Credit Union: yes no

→ Name of Primary Proposed Insured John Doe Premium Amount \$ 25.69

→ Frequency: Annual Semi-annual Quarterly Monthly

→ Preferred Withdrawal Date (1st-28th) 5 Please debit my account for all outstanding premiums due.

→ Print Bank Account Owner(s) Name John Doe

→ Signature(s) of Bank Account Owner(s) X 

Please attach voided check or deposit slip.

(NOT NEEDED!)

SAMPLE

American General

Life Companies

Credit Card Authorization Form

Form to be used only for the collection of *initial* insurance premium

American General Life Insurance Company

Please read this authorization carefully and complete all requested items.

Type of Insurance/Contract Applied For: Accident Expense Plus

Policy Number: _____

Name of Proposed Insured: John Doe

Proposed Policy Owner: _____

Cardholder Name: (exactly as it appears on the card) John Doe

Cardholder Billing Address: 123 Main St, Anytown, UT 84004

Credit Card Number: 12345678910111213 Expiration Date: 8/12

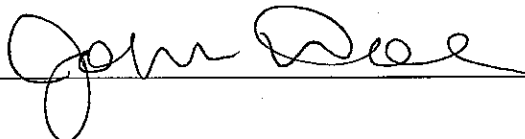
Card Type: American Express® MasterCard® Visa®

Quoted Initial Premium Amount: 25.69 Mode of ongoing premium payments: monthly EFT

By signing below, I, John Doe, authorize American General Life Insurance Company ("Company") or its representative to charge my credit card, listed above. I also understand and agree that:

- 1) If there are no changes to the policy/contract as applied for or the frequency of ongoing premium payments, the charge to my account for the Quoted Initial Premium Amount will be processed when the Company places my policy/contract in force.
- 2) In the event of changes to the policy/contract as applied for or the mode of ongoing premium payments, the new information will be communicated to me. If I accept the change(s), the charge to my account for the new amount will be processed when the Company places my policy/contract in force.

I understand and agree that this transaction is subject to the acceptance by, and the terms and conditions of, the credit card company indicated above. **I understand and agree that this Authorization Form is not a part of the application or policy/contract of insurance applied for and does not modify any terms or conditions contained therein.** I understand and agree that the Company shall incur no liability if the credit card company dishonors any amount charged under this Authorization and may terminate this Authorization immediately if any charges are not paid. I agree to hold the Company harmless against any liability pursuant to this authorization. I understand and agree that payment of the initial premium is one of the conditions required for coverage to be placed into effect. **If the charge is declined for any reason, I understand and agree that coverage will not be placed into effect.**

Cardholder's Signature: X  Date: 09/01/2009

For Internal Use Only

#: _____ Date: _____