

SAMPLE SIGNATURE:

BRONZE

→  Personal  Worksite

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

A subsidiary of American International Group, Inc.

Home Office: 2727-A Allen Parkway, Houston, TX 77019

|  |  |  |   |
|--|--|--|---|
| 1. Employer (if worksite)  |  | 2. Employee Number/ID (if worksite)  |   |
| 3. Primary Proposed Insured (Please print full name)<br>Doe John M<br>Last First Middle  |  | 7. Age 35  | 8. Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F |
| 4. Address<br>123 Main St<br>Street<br>Anytown UT 84004<br>City State Zip Code<br>801 555-5555<br>Home Telephone Business Telephone<br>Preference <input checked="" type="checkbox"/> Home <input type="checkbox"/> Business<br>12345678 UT<br>Driver's License Number State of Issue  |  | 9. Marital Status <input checked="" type="checkbox"/> Single <input type="checkbox"/> Married  |   |
|  |  | 10. U.S. Citizen <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No<br>If no, date of entry _____ visa type _____   |   |
|  |  | 11. Modal Premium Total \$ 15.40<br>Payable<br><input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> O <input checked="" type="checkbox"/> Bank Draft <input type="checkbox"/> Other _____<br><input type="checkbox"/> Add to existing bank draft account, policy no. _____<br><input type="checkbox"/> (If worksite) Add to existing Salary Allotment account no. _____          |   |
| 5. Social Security No.<br>555 55 5555  |  | 6. Birth Date and Place<br>Month Day Year State Country<br>9 1 74 UT USA   |   |
| 12. Plan <input checked="" type="checkbox"/> 24 Hour Coverage<br><input type="checkbox"/> Non-Occupational Coverage only*<br>* For industries/occupations not qualifying for 24 hour coverage. Only applicable for Primary Proposed Insured.<br>Industry (Worksite) _____<br>Occupation (Individual) teacher<br>Units 1<br><input checked="" type="checkbox"/> Primary Insured <input type="checkbox"/> Family<br><input type="checkbox"/> Primary Insured & <input type="checkbox"/> Primary Insured &<br>Spouse Children |  | Riders:<br><input type="checkbox"/> Accident Only Disability Income Benefit Rider:<br>Type: <input type="checkbox"/> Non-Occupational Coverage only*<br><input type="checkbox"/> 24 hr coverage (only available with 24 hour base plan)<br>Units _____<br>Occupation _____<br>Occupation Class _____<br>Benefit Period <input type="checkbox"/> 6 mo <input type="checkbox"/> 12 mo<br>Annual Salary _____ |   |
|  |  | <input checked="" type="checkbox"/> Hospital Cash Benefit Rider:**<br>Units 5 units<br><input type="checkbox"/> Accidental Death and Dismemberment Rider:**<br>Units _____<br><input type="checkbox"/> Other Riders:** _____<br>** If base plan coverage is Non-Occupational Coverage only, all rider coverages will also be Non-Occupational Coverage only.   |   |
| 13. Owner (If other than Primary Proposed insured)   |  |  |   |
| Name _____<br>Last First Middle  |  | Social Security No. _____  |   |
| Relationship _____   |  | Date of Birth _____  |   |
| Address _____<br>Street City State Zip Code  |  |  |   |
| 14. Premium Payor (If other than Primary Proposed insured)   |  |  |   |
| Name _____<br>Last First Middle  |  | Social Security No. _____  |   |
| Relationship _____   |  | Date of Birth _____  |   |
| Address _____<br>Street City State Zip Code  |  |  |   |

→ 15. Primary Beneficiary The Estate of John Doe

Last First Middle

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Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

Contingent Beneficiary \_\_\_\_\_

Last First Middle

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Date of Birth \_\_\_\_\_ Relationship \_\_\_\_\_

16. Spouse (If coverage applied for)

Name \_\_\_\_\_

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Social Security No. \_\_\_\_\_ Birthplace \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Driver's License Number \_\_\_\_\_ State of Issue \_\_\_\_\_

17. List Dependent(s) Information:

| Full Name | Age | Relationship | Birth Date |     |     | Sex                      |                          |
|-----------|-----|--------------|------------|-----|-----|--------------------------|--------------------------|
|           |     |              | Mo.        | Day | Yr. | M                        | F                        |
| 1.        |     |              |            |     |     | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.        |     |              |            |     |     | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.        |     |              |            |     |     | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.        |     |              |            |     |     | <input type="checkbox"/> | <input type="checkbox"/> |

**FOR HOME OFFICE USE ONLY**

|   | INSURED                             |                                     | SPOUSE                   |                          | DEP #1                   |                          | DEP #2                   |                          | DEP #3                   |                          | DEP #4                   |                          |
|---|-------------------------------------|-------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
|   | YES                                 | NO                                  | YES                      | NO                       | YES                      | NO                       | YES                      | NO                       | YES                      | NO                       | YES                      | NO                       |
| → 18. Is the Primary Proposed Insured actively at work as of the date of this application?  | <input checked="" type="checkbox"/> | <input type="checkbox"/>            | NA                       |                          | NA                       |                          | NA                       |                          | NA                       |                          | NA                       |                          |
| X 19. Does the Primary Proposed Insured work at least 30 hours per week at the occupation listed in Section 12? (only answer if requesting the Accident Only Disability Income Benefit Rider)   | <input type="checkbox"/>            | <input type="checkbox"/>            | NA                       |                          | NA                       |                          | NA                       |                          | NA                       |                          | NA                       |                          |
| → 20. Has any Proposed Insured ever:  |                                     |                                     |                          |                          |                          |                          |                          |                          |                          |                          |                          |                          |
| a. Sought or received counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs?  | <input type="checkbox"/>            | <input checked="" 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"/> | <input type="checkbox"/> |
| b. Used cocaine, marijuana, heroin, controlled substance, or a drug requiring a prescription that was not legally prescribed by a physician?  | <input type="checkbox"/>            | <input checked="" 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"/> | <input type="checkbox"/> |
| → 21. Has any Proposed Insured participated within the last 3 years or have any intention of participating in flying in any type of aircraft as a student pilot or crew member, or in parachute jumping, auto, boat or motorcycle racing, hang gliding or scuba diving?                   | <input type="checkbox"/>            | <input checked="" 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"/> | <input type="checkbox"/> |
| → 22. Within the past 5 years, has any Proposed Insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's license revoked or suspended, or within the last 3 years had multiple moving violations in any vehicle(s) operated by the Proposed Insured? | <input type="checkbox"/>            | <input checked="" 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"/> | <input type="checkbox"/> |

23. Does any Proposed Insured have any existing or pending life, accident, health, cancer or critical illness contracts?  Yes  No  
 (If yes, complete Existing and Pending Insurance section.)

**Existing and Pending Insurance**

| Name of Proposed Insured | Policy Number | Company Name | Type* | Face Amount | Year Issued | Replace**<br>Yes No                               |
|--------------------------|---------------|--------------|-------|-------------|-------------|---|
|                          |               |              |       |             |             | <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"/> |
|                          |               |              |       |             |             | <input type="checkbox"/> <input type="checkbox"/> |

\* Type: I = individual or G = group AND L = life, AC = accident, H = health, C = cancer, CI = critical illness, or A = annuity (e.g., G/H)  
 \*\* Replace means that the accident illness insurance policy being applied for replaces any accident and sickness policy pending or presently in force, including health, cancer, accident, or critical illness insurance.

**Remarks/Special Instructions**

**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).**

*John Doe*  
 Signature of Primary Proposed Insured

9/1/09  
 Date

**AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING**

I, the Primary Proposed Insured, **AGREE** that: (a) **NO insurance** shall begin *unless* a policy is issued and the first premium has been paid in full within 31 days of the date of issue; and (b) **No conditional, temporary or interim insurance** of any kind will be in effect from the date of this application until the date a policy, if any, is issued, regardless of whether I paid any premium. Any such premium paid will be refunded if a policy is not issued, and American General Life Insurance Company ("Company") will have no further liability regarding this application; and (c) The policy I am applying for is **Not** a major medical insurance policy; and (d) All statements and answers in this application are complete and true to the best of my knowledge and belief; and (e) No agent has authority to waive any answer or otherwise modify this application, or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. I **AUTHORIZE** the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this Authorization, I agree that a photocopy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this Authorization and may revoke this Authorization at any time by written notification to the Company at its Home Office. I **ACKNOWLEDGE** receipt of: (a) NOTICES TO THE PROPOSED INSURED, page 5; and (b) Outline of Coverage. I **UNDERSTAND** that if I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

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

If an investigative consumer report is prepared in connection with this application, the Proposed Insured elects:  to be interviewed; or  not to be interviewed.

Signed at Salt Lake City, UT  
City State

9/1/09  
Date

X *John Doe*  
 Signature of Primary Proposed Insured (If Age 16 or Over)

X *[Signature]*  
 Signature of Licensed Agent

X \_\_\_\_\_  
 Signature of Spouse (Including as a Proposed Insured)

X \_\_\_\_\_  
 Signature of Owner (If other Than Primary Proposed Insured)

**AGENT'S REPORT**

- 1. How long have you known the Proposed Insured(s)?  
new client
- 2. Are you related to the Proposed Insured(s)?  
 Yes  No If "Yes", give details in remarks.
- 3. Do you have knowledge of any unfavorable information regarding the Proposed Insured(s) which has not been disclosed in the application?  
 Yes  No If "Yes", give details in remarks.
- 4. Have you given the insured a copy of the Outline of Coverage?  
 Yes  No
- 5. Do you have any information indicating that any proposed insured may replace any accident and sickness policies with any company, including health, cancer, accident or critical illness insurance, in connection with the insurance being applied for?  Yes  No  
If yes, please provide details in the Remarks section below.

**AGENT'S CERTIFICATION**

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.

9/1/10                      [Signature]  
Date                                      Signature of Licensed Agent

Zac Loringier  
Print Agent's Name

80670                                      \_\_\_\_\_  
Agent Number                                      Agency Code Number



**REMARKS**

[Empty space for remarks]

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 |
|---|---|---|---|---|---|---|---|---|

→ Account Number 

|   |   |   |   |   |   |   |   |   |   |   |   |   |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 0 | 1 | 2 | 4 | 5 | 6 | 7 | 8 | 7 | 8 | 7 | 8 | 7 |
|---|---|---|---|---|---|---|---|---|---|---|---|---|

 ||•


→ Type of Account:  Checking  Savings Credit Union:  yes  no

→ Name of Primary Proposed Insured John Doe Premium Amount \$ 15.40

→ 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!)