



## 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 to AIG American General with the application packet.



- Insurance company selection options: American General Life Insurance Company, Houston, TX; The United States Life Insurance Company in the City of New York, New York, NY; AIG Life Insurance Company, Wilmington, DE

Member companies of American International Group, Inc.

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.

Personal Information

1. Primary Proposed Insured

Form for Primary Proposed Insured including fields for Name, Social Security #, Sex, Birthplace, Date of Birth, Current Age, Tobacco Use, Driver's License, U.S. Citizen, Visa Type, Exp. Date, Address, City, State, ZIP, Home Phone, Work Phone, Email, Employer, Occupation, Length of Employment, Employer Address, City, State, ZIP, Duties, Personal Earned Income, Household Income, Net Worth, and insurance in force on other family members.

2. Other Proposed Insured

Form for Other Proposed Insured including fields for Name, Social Security #, Sex, Birthplace, Date of Birth, Current Age, Relationship to Primary Proposed Insured, Tobacco Use, Driver's License, U.S. Citizen, Visa Type, Exp. Date, Address, City, State, ZIP, Home Phone, Work Phone, Email, Employer, Occupation, Length of Employment, Employer Address, City, State, ZIP, Duties, Personal Earned Income, Household Income, Net Worth.

Ownership

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

Form for contingent owner including fields for Name, Social Security or Tax ID #, Date of Birth, 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 14 D.)

Form for trust owner including fields for Exact Name of Trust, Trust Tax ID #, Address, City, State, ZIP, Email, Current Trustee(s), Date of Trust.

\*for identification purposes only

**Product Information**

4. **Product Name** (Complete appropriate supplemental application if applicable.) \_\_\_\_\_  
Amount Applied For: Base Coverage \$ \_\_\_\_\_ Supplemental Coverage (If applicable) \$ \_\_\_\_\_  
Death Benefit Compliance Test Used (If applicable):  Guideline Premium  Cash Value Accumulation  
Automatic Premium Loan (If applicable):  Yes  No Premium Class Quoted \_\_\_\_\_  
Reason for Insurance \_\_\_\_\_

5. **Dividend Options** (For participating policy only.)  
 Cash  Premium Reduction  Paid-up Additions  Deposit Earning Interest  Other (Explain) \_\_\_\_\_

6. **Premium Allocation** (For Indexed UL only if applicable.)  
Indicate how each premium received is to be allocated. **Total allocations must equal 100%. Use whole percentage only.**  
Indexed Interest Account \_\_\_\_\_% Excess Interest Account \_\_\_\_\_% Total 100%

7. **Death Benefit Options** (For UL & VUL only.)  Option 1 - Level  Option 2 - Increasing  Option 3 – Level Plus Return of Premium

8. **Riders/Benefits**  
 Child Rider Amount \$ \_\_\_\_\_ (**Complete Child Rider Attachment**) or  No current children  
 Waiver of Premium  Waiver of Monthly Deduction  Waiver of Monthly Guarantee Premium  
 Maturity Extension Rider – Accumulation Value  Maturity Extension Rider – Death Benefit  Terminal Illness Rider  
 Accidental Death Benefit Amount \$ \_\_\_\_\_  Other Insured/Spouse Rider Amount \$ \_\_\_\_\_  
 Disability Income Rider (Complete the following if DI Rider is requested)  
Number of Units (1 unit = \$100): \_\_\_\_\_ Occupational Class (Please check):  1  2  
 Adjustable Return of Premium Rider – (Provide % of Premium) \_\_\_\_\_  
 Scheduled Increase Rider  
 Other Riders/Benefits #1 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_  
 Other Riders/Benefits #2 \_\_\_\_\_ Amount/Unit(s) \_\_\_\_\_

**Beneficiary**

9. **Primary** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
10. **Contingent** Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%  
Name \_\_\_\_\_ Relationship \_\_\_\_\_ Share \_\_\_\_\_%

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

12. **Rider Beneficiaries** (Complete if other than Primary Proposed Insured.)  
Other Insured/Spouse Rider \_\_\_\_\_ Relationship \_\_\_\_\_  
Child Rider \_\_\_\_\_ Relationship \_\_\_\_\_

**Business Coverage**

13. **Business Insurance Details** (Complete only if applying for business coverage.)  
Does any Proposed Insured have an ownership interest in the business?  yes  no  
If yes, what is the percentage of ownership for the: Primary Proposed Insured \_\_\_\_\_% Other 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  
Describe any special circumstances. \_\_\_\_\_

**Premium**

- 14. Premium Payment**    Modal \$ \_\_\_\_\_    Single \$ \_\_\_\_\_    Additional Initial \$ \_\_\_\_\_
- 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.)*  
Name \_\_\_\_\_ Social Security or Tax ID # \_\_\_\_\_  
Relationship to Primary Proposed Insured \_\_\_\_\_  
Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

**Limited Temporary Life Insurance Eligibility**

- 15. Health and Age Questions** *(Regarding the Primary Proposed Insured and the Other Proposed Insured under a joint life or survivorship policy, if the correct answer to either question below is "yes" or any question is answered falsely or left blank, coverage is not available under the Limited Temporary Life Insurance Agreement ("LTLIA") and it is void, and any payment submitted will be refunded. Read the LTLIA for additional terms and conditions of coverage.)*
- 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?    yes    no
- B.** Is any Proposed Insured age 71 or above?    yes    no

**Existing Coverage**

**16. Existing Coverage**

**A. Life and Annuity Coverage**

**Does any Proposed Insured have any existing or pending annuities or life insurance policies?**    yes    no

*(If yes, complete the following regarding such annuities or life insurance policies.)*

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

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) <i>(see above)</i>	Year of Issue	Face Amount	Replace*	1035 Ex
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes

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

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

**Does any Proposed Insured have any existing or pending Disability insurance policies?**    yes    no

*(If yes, complete the following regarding existing and pending disability insurance)*

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

**Nonmedical Questions**

**17. Background Information** *(Complete questions A through F. If yes answer applies to any Proposed Insured, provide details specified after each question.)*

**A.** Does any 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, date, length of stay and purpose.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**B.** In the past five years, has any 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, circle or list the applicable activities and complete the Aviation and/or Avocation Questionnaire.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**C.** Has any Proposed Insured 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.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**D.** Has any 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 any Proposed Insured been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations?  yes  no

*(If yes, list date, state, license no. and specific violation.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**F.** Has any 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, state and charge.)* \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Remarks**

**18. 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 any 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 the Other Proposed Insured under a joint and survivorship life policy, if applicable) 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 Health and Age Questions in section 15; 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).

**Proposed Insured(s)/Owner Signature**

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

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

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

Owner *(If other than Primary Proposed Insured)*  \_\_\_\_\_

**Agent(s) Signature(s)**

I certify that the information supplied by the Primary Proposed Insured(s)/Owner has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* \_\_\_\_\_ Writing Agent # \_\_\_\_\_

Writing Agent Signature  \_\_\_\_\_ Countersigned \_\_\_\_\_  
*(Licensed resident agent if state required)*

**Agent's Report**

**1. Statements**

A. Number of years you have known Primary Proposed Insured: \_\_\_\_\_  
Other Proposed Insured: \_\_\_\_\_

B. Does any Proposed Insured have any existing or pending annuities or life insurance policies?  yes  no  
If yes, do you have any information that indicates that any Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance?  yes  no

*(If yes, please provide details in the Remarks section below and attach all replacement-related forms. 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.)*

C. Are you aware of any other information that would adversely affect any 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

D. 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, Agent/Agency Information** *(Please list servicing agent first.)*

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

Writing Agent Name *(Please print)* \_\_\_\_\_ Date \_\_\_\_\_

Writing Agent Signature **X** \_\_\_\_\_

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

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

**For Home Office use**

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

Servicing Agent (if other than writing agent) 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 AIG Life Insurance Company, American General Life Insurance Company, American Home Assurance Company, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service 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.

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 AIG American General 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 AIG American General 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: AIG American General 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)



**Detach this page and leave it 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**

**AIG Life Insurance  
Company,  
Wilmington, DE**

The life insurance company checked on page 1 of your application ("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. This notice is provided on behalf of the Company and American General Life Companies LLC, an affiliated service company.

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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, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

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

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

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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.

This form must be completed, signed and **left with the applicant.**

Limited Temporary Life Insurance Agreement (Agreement)

**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
 AIG Life Insurance Company, 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 \_\_\_\_\_
(applicable only for a joint life or survivorship policy)
Owner (if other than Primary Proposed Insured) \_\_\_\_\_
Modal Premium Amount Received \_\_\_\_\_
Date of Policy Application \_\_\_\_\_

**3. Answer the following questions:**

Table with 3 columns: Question, Yes, No. Row 1: a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system... Row 2: b. Is any Proposed Insured age 71 or above?

**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 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.

**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 and the Company can show that suicide was intended when the policy was applied for, 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 \_\_\_\_\_

Signature of Other Proposed Insured (if applicable) \_\_\_\_\_ Date \_\_\_\_\_

Writing Agent Name (please print) \_\_\_\_\_ Writing Agent # \_\_\_\_\_

This form to be completed, detached and **submitted with the 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
AIG Life Insurance Company, 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

Table with 3 columns: Question, Yes, No. Row 1: Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system... Row 2: Is any Proposed Insured age 71 or above?

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 and the Company can show that suicide was intended when the policy was applied for, 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
Signature of Other Proposed Insured (if applicable) Date
Writing Agent Name (please print) Writing Agent #

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

Member companies of American International Group, Inc.

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.

**Notice and Consent for Testing of Biological Specimens to Include HIV (AIDS Virus) Testing**

Examiner: \_\_\_\_\_

To determine your insurability, the Insurer named above has requested that you provide a biological specimen for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV, the (AIDS virus), its component parts, or its antibodies. These tests are extremely reliable. Other tests which may be performed include determinations of blood cholesterol and related lipids (fats) cotinine, cocaine, and screening for liver or kidney disorders, diabetes and immune disorders.

All test results will be treated confidentially. They will be reported by the laboratory to the Insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors. If a biological specimen other than blood is tested to determine the presence of HIV virus, its component parts, or its antibodies, the Insurer may at a later time request a specimen of your blood for further HIV testing. If you choose to decline that request, the results of all testing which has been performed will be provided to the physician which you have designated to receive such results. In addition, if the insurer is a member of the Medical Information Bureau (MIB, Inc.) and you choose to decline the request that you submit a blood specimen for further HIV testing, the Insurer will report to the MIB, Inc. a generic code which specifies only a non-specific blood test has been ordered and not received. Regardless of the number of tests requested, if the final HIV testing results (including the results of any confirmatory tests dictated by standard medical practice) are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific test abnormality. If your final HIV testing results are normal, no report will be made about it to the MIB, Inc. Other test results may be reported to the MIB, Inc. in a more specific manner. The organizations described in this paragraph may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV tests are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may also contact you if there are other abnormal test results which, in the Insurer's opinion, are significant. The Insurer may ask you to confirm the name of a physician to whom you authorize disclosure and with whom you may wish to discuss the results. If you are a resident of Missouri and your HIV test(s) indicates confirmed infection with HIV and you have not provided the Insurer with the name of a physician to whom you authorize disclosure of test results, the Insurer will disclose test results to the Missouri Department of Health as required by law.

Positive HIV test results or other significant abnormalities detected by additional tests of biological specimens will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged or that other policy changes may be necessary.

Physician \_\_\_\_\_ Address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

I have read and I understand this Notice of Consent for Testing of biological specimens, which includes HIV testing. I voluntarily consent to provide biological specimen(s) for testing, to the testing of such specimen(s) and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this information. A photocopy of this form will be as valid as the original.

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

\_\_\_\_\_  
Signature of Proposed Insured or Parent/Guardian Date State of Residence

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

*Member companies of American International Group, Inc.*

In this application, 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.

Insured's Social Security Number \_\_\_\_\_ Policy Number \_\_\_\_\_

This Form must be completed prior to taking any application for permanent life insurance seeking a death benefit of \$500,000.00 or more and the insured is age 70 or older. AIG American General may also request agents to complete this Form in other situations where it is deemed appropriate. Carefully review these statements and the Company Field Bulletins regarding Investor Owned Life Insurance and Stranger Owned Life Insurance before submitting this Form.

- **Are all or part of the premiums paid towards this policy being financed?** (This does not include financing through a split dollar agreement with your employer or a family's private split dollar agreement.)
- **If the answer is "no" please check the appropriate box and sign below.**
- **If the answer is "yes" please check the appropriate box, review and sign the certification below.** If the answer is "yes" and you cannot sign the certification you should not take the application.

- 1) I have reviewed and am familiar with all aspects of the premium financing proposal.
- 2) Based upon my review of the financing proposal I believe that the costs associated with this premium financing proposal are such that assuming no change in the insured's health it is more likely than not that the insured will maintain the policy in force for the benefit of his/her beneficiaries and those beneficiaries will receive more than 50% of the policy death benefit.
- 3) The insured is not receiving any cash payment, borrowing funds in excess of those required to pay the scheduled premiums and interest or receiving any other consideration as an inducement to participate in this transaction.
- 4) There is no prearranged agreement to transfer the policy nor will the policyholder have a prearranged option or right of first refusal to transfer the policy to a third party.
- 5) All materials used in connection with the solicitation and sale of this policy or financing of the policy premiums were either produced by the life insurance company or have been submitted to the life insurer for its review and approval.
- 6) I have read the Field Bulletins regarding Investor Owned Life Insurance, Stranger Owned Life Insurance and Viatical Transactions, and believe this transaction is in compliance with the company policies as set forth in those Bulletins regardless of whether the lending program is a recourse or non-recourse transaction.

**Yes** All or part of the premiums paid towards this policy are being financed. I have read the statements set forth above and hereby certify that the statements are all true with regard to the application for \_\_\_\_\_ (Insured) dated \_\_\_\_\_.

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

\_\_\_\_\_  
Date

**No** None of the premiums for the policy sought with the application for \_\_\_\_\_ (Insured) dated \_\_\_\_\_ will be financed other than pursuant to a split dollar agreement.

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

\_\_\_\_\_  
Date



**American General Life Insurance Company**

*A member company of American International Group, Inc.*

P.O. Box 2764 • Houston, TX 77252 • 713-522-1111

**REPLACING YOUR LIFE INSURANCE POLICY OR ANNUITY?**

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Ask the company or agent that sold you your existing policy to provide you with a policy summary statement.

The "Items to Consider" section contains a checklist of some of the items you should consider in making your decision. **TAKE TIME TO READ IT.**

Do not let one agent or insurer prevent you from obtaining information from another agent or insurer which may be to your advantage.

Hear both sides before you decide. This way, you can be sure you are making a decision that is in your best interest.

We are required to notify your existing company that you may be replacing their policy.

<b>X</b> _____	<b>X</b> _____
APPLICANT'S SIGNATURE	AGENT'S SIGNATURE
DATE	DATE

APPLICANT'S NAME AND ADDRESS (PRINTED)

AGENT'S NAME, ADDRESS, PHONE NUMBER, AND LICENSE NUMBER (PRINTED)

**ITEMS TO CONSIDER**

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change in terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change—up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. **CAUTION:** you are urged not to take action to terminate, assign, or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and have found it to be acceptable to you.  
and...

**REMEMBER:** you have twenty (20) days following receipt to examine the contents of any individual life insurance policy or annuity. If you are not satisfied with it for any reason, you have the right to return it to the insurer at its home or branch office, or to the agent through whom it was purchased, for a full refund of premium.



American General Life Insurance Company

Member of American International Group, Inc.

To Effect Section 1035 (a) Exchange and Rollover of a Life Insurance Policy or Annuity Contract

Policy/Contract No.	Cash Value
Owner	Insured
Insurer	

I hereby assign and transfer from Insurer to (new company) \_\_\_\_\_ (the "Company") all rights, title and interest of every nature and transfer to character in and to the Policy/Contract described above ("the Policy") in an exchange intended to qualify under Section 1035 (a) of the Internal Revenue Code.

I understand that if the Company underwrites, approves my application for, and issues to me a new life insurance policy or annuity contract which I accept on the life of the same insured in the Policy, then the Company intends to surrender the Policy for its cash value.

**I understand that as of the date of surrender of the Policy by the Company, the Policy will no longer provide any coverage.**

**I understand that upon receipt of the surrender value by the Company, the proceeds will be applied as an additional premium for the new life insurance policy or annuity contract.** The first premium must be paid no later than when the new policy or contract is delivered. The Policy assigned shall not be considered a premium until the cash surrender value is actually received by the Company. There will be no policy or contract in effect unless the first premium is paid while all statements and answers in all parts of my application remain correct.

I understand that by executing this assignment, I irrevocably waive all rights, claims and demands under the Policy.

I represent and agree that the Company is furnishing this form and is participating in this transaction at my specific request and as an accommodation to me. I represent and agree that the Company has made no representations concerning my tax treatment under Internal Revenue Code Section 1035 or otherwise.

The Company assumes no responsibility or liability for the undersigned's tax treatment under Internal Revenue Code Section 1035 or otherwise.

I represent and warrant that no person, firm or corporation has a legal or equitable interest in the Policy, except the undersigned, and that no proceedings of either a legal or equitable nature have been instituted or are pending against undersigned.

**I understand that the first premium must be paid no later than the time the policy applied for is delivered and that the cash value of the assigned Policy shall not be considered part of the premium until the cash surrender value is actually received by the Company. I further understand that no policy or contract comes into force as a result of this assignment.**

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

Witness \_\_\_\_\_ Signature of policyowner (Assignor) \_\_\_\_\_

Received and duplicate filed at the Home Office of the Company: \_\_\_\_\_ Company name \_\_\_\_\_

By company representative \_\_\_\_\_ Address \_\_\_\_\_

Title \_\_\_\_\_ City/State/Zip \_\_\_\_\_