BBVA

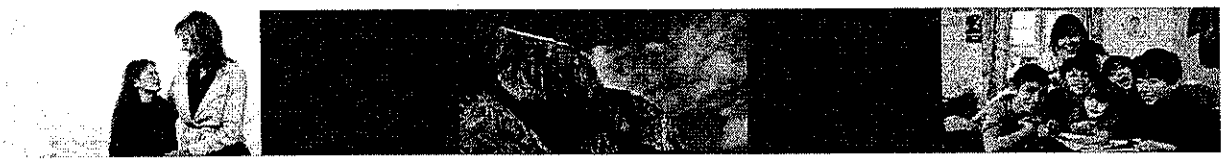
VIP

American General Term Instructions

1. Inspection Report is needed on any case:
   Age 18 and above and on any death benefit above $1.5 Million

2. Copy of Passport

3. Personal History Interview at the underwriter's discretion



Age & Amount Requirements

Last Updated 09/08/2008

Age & Amount Requirements provides you with the types of exams and reports the company requires based on the 'insurance age' of the proposed insured and the face amount of coverage requested. Face amount is based on the total amount of coverage issued and placed in force by all AIG American General life insurance companies within the past 12 months. Use the applicant's 'Age Nearest' when determining examinations required for any given amount of coverage.

UW SUPPORT

Field Underwriting Guide AGLC101638

"Standard" is no longer the AUTOMATIC classification!

Face Amount	Ages 0-15	Ages 16-17	Ages 18-39	Ages 40-44	Ages 45-49	Ages 50-55	Ages 56-70	Ages 71+
0 to $49,999	NM	NM	NM	NM	NM	NM	PM, HOS	PM, B/U*, FT, 71IR
$50,000 to $99,999	NM	NM	PM, B/U	PM, B/U	PM, B/U	PM, B/U	PM, B/U	PM, B/U*, FT, 71IR
$100,000 to $249,999	NM	NM, MVR	PM, B/U, MVR	PM, B/U	PM, B/U	PM, B/U	PM, B/U, EKG	PM, B/U*, FT, EKG, 71IR
$250,000	NM	NM, MVR	PM, B/U, MVR	PM, B/U	PM, B/U	PM, B/U	PM, B/U, EKG	MD, B/U*, FT, EKG, MVR, 71IR
$250,001 to $499,999	NM	NM, MVR	PM, B/U, MVR	PM, B/U	PM, B/U	PM, B/U, EKG	PM, B/U, EKG	MD, B/U*, FT, EKG, MVR, 71IR
$500,000	NM	NM, MVR	PM, B/U, MVR	PM, B/U	PM, B/U, EKG	PM, B/U, EKG	PM, B/U, EKG	MD, B/U*, FT, EKG, MVR, 71IR
$500,001 to $1.5 million	IC, FQ	IC, MVR, FQ	PM, B/U, MVR	PM, B/U, EKG	PM, B/U, EKG	PM, B/U, EKG	PM, B/U, EKG	MD, B/U*, FT, EKG, MVR, 71IR
$1,500,001 to $3 million	IC, FQ	IC, MVR, FQ	PM, B/U, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	MD, B/U*, FT, EKG, MVR, FQ, 71IR
$3,000,001 to $5 million	IC, FQ	IC, MVR, FQ	PM, B/U, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	PM, B/U, EKG, IR, MVR, FQ	MD, B/U, EKG, IR, MVR, FQ	MD, B/U*, FT, EKG, MVR, FQ, 71IR
$5,000,001 to $10 million	IC, TPF	IC, MVR, TPF	PM, B/U, EKG, IR, MVR, TPF	MD, B/U, EKG, IR, MVR, TPF	MD, B/U, EKG, IR, MVR, TPF	MD, B/U, EKG, IR, MVR, TPF	MD, B/U, EKG, IR, MVR, TPF	MD, B/U*, FT, EKG[3], MVR, TPF, 71IR
> $10 million[2]	IC, TPF	IC, MVR, TPF	PM, B/U, EKG, IR, MVR, TPF	MD, B/U, Treadmill EKG, IR, MVR, TPF	MD, B/U, Treadmill EKG, IR, MVR, TPF	MD, B/U, Treadmill EKG, IR, MVR, TPF	MD, B/U, Treadmill EKG, IR, MVR, TPF	MD, B/U*, FT, EKG[3], MVR, TPF, 71IR

A HIPPA authorization is required for all ages and amounts.
Face amount is based on the total amount of coverage issued and place in force by all AIG American General life insurance companies within the last 12 months.

Inspection reports are required on face amounts over $1.5 million.

[2] For ages 40-70, where survivorship coverage is applied for, treadmill will not be required until the face amount exceeds $20 million

[3] Treadmill EKG for cause only

AIG AMERICAN GENERAL

Term Insurance Application Part A

☐ **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.

1. Primary Proposed Insured

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 If yes, date of last use _____
If yes, *type* and *quantity* of tobacco or nicotine products used _____
Driver's License ☐ yes ☐ no Number _____ License State _____
U.S. Citizen ☐ yes ☐ no If no, Date of Entry _____ 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 $ _____
If Primary Proposed Insured is a child or is age 18 or over and not self-supporting, 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.)*

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 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 _____ 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 $ _____
☐ Disability Income Rider *(Complete the following if DI Rider is requested)*
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 _____%

Name _____ Relationship _____ Share _____%

Name _____ Relationship _____ Share _____%

5. Contingent Beneficiary Name _____ Relationship _____ Share _____%

Name _____ Relationship _____ Share _____%

Name _____ Relationship _____ Share _____%

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

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.)* Relationship to Primary Proposed Insured _____

Name _____

Social Security or Tax ID # _____

Address _____ City, State _____ ZIP _____

9. Health and Age Questions *(Regarding the Primary Proposed Insured, 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 the Primary 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 the Primary Proposed Insured age 71 or above? ☐ yes ☐ no

10. Existing Coverage

A. Life and Annuity Coverage

Does the Primary 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

Policy Number	Insurance Company	Type(s) *(see above)*	Year of Issue	Face Amount	Replace*
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no
					☐ yes ☐ no

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

10. Existing Coverage ***(continued)***

B. 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

11. Background Information *(Complete questions A through F. 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, date, length of stay and purpose.) _____

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, circle or list the applicable activities and 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 Primary 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 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, state and charge.) _____

REMARKS

12. Details and Explanations _____

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

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 Health and Age Questions in section 9; 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).

Primary Proposed Insured/Owner Signature

Signed at (city, state) _____ On (date) _____

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

Owner *(If other than Primary Proposed Insured)* **X** _____

Agent Signature

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

Writing Agent Name *(please print)* _____ Writing Agent # _____

Writing Agent Signature **X** _____ Countersigned _____
(Licensed resident agent if state required)

Agent's Report

1. Statements

A. Number of years you have known the Primary Proposed Insured: _____

B. Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? ☐ yes ☐ no
If yes, do you have any information that indicates that the Primary 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 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

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 _____

_____

AIG AMERICAN GENERAL

HIPAA Authorization - Life New Business

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, AIG Life Insurance Company of Puerto Rico, 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)

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**

☐ **AIG Life Insurance Company, 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 life insurance premiums. The Company will collect the life 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 _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number ⑆ _____ ⑆

Account Number _____ ⑈

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

Name of Primary Proposed Insured _____ Premium Amount $ _____

Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

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

Print Bank Account Owner(s) Name _____

Signature(s) of Bank Account Owner(s) **X** _____

Please attach voided check or deposit slip.

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.

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.

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.

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

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.

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:

	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?	☐	☐
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, 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
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?	☐	☐
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 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 _____

Signature of Other Proposed Insured *(if applicable)* _____ Date _____

Writing Agent Name *(please print)* _____ Writing Agent # _____

AIG American General

Disclosure of Accelerated Death Benefits (Also known as Terminal Illness Rider)

American General Life Insurance Company
A subsidiary of American International Group, Inc. (AIG)

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.

AIG AMERICAN GENERAL

HIV Testing and Consent
Texas Version

☐ **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 Form for HIV-Related Testing

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your blood, oral fluid extracted from cheek and gum tissue, or urine for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of three tests will be performed by a licensed laboratory through a medically accepted procedure.

Pre-Testing Considerations. Many public health organizations have recommended that before taking an HIV-related 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.

Meaning of Positive Test Result. The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

Positive HIV antibody test results 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.

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 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, or for the preparation of statistical reports that do not disclose the identity of any particular person.

Notification of Test Result. 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, you will receive written notification of such results from a physician you have designated or, in the absence of such designation, from the Texas Department of Health. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of Physician for reporting a possible positive test result: _____

Address: _____

In the event the test is positive and you are denied coverage because of that fact and you request the reason for the denial, the Insurer may require you to name a physician at that time in order to receive the information.

If the test indicates a positive result, but you do not designate a private physician, the test results will be provided to you by a representative of the Texas Department of Health.

Consent. I have read and I understand this Notice and Consent for HIV-Related Blood Testing. I voluntarily consent to the collection of blood, oral fluid extracted from cheek and gum tissue, or urine from me, the testing of that sample, and the disclosure of the test results as described above. I have read the information on this form about what a test result means.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

_____	_____
Name of Proposed Insured (Please Print)	Signature of Proposed Insured or Parent/Guardian
_____	_____
Address	Date

AIG American General

Summary of Premium Provisions

American General Life Insurance Company
A subsidiary of American International Group, Inc. (AIG)
2727 A Allen Parkway • Houston, TX 77019

This notice highlights important premium provisions of the life insurance plan that you are applying for.

The policy form issued under the plan will include a table of current life insurance premiums and maximum life insurance premiums for each policy year.

The annual (or modal) policy premium as shown on this policy is applicable only for the level guarantee period stated in the policy.

After the end of the level guarantee period, and any policy year thereafter, the Company reserves the right to change the current premiums. Such premiums will not exceed the applicable maximum premiums shown in the policy.

Any change in premium will:

1. be based on changes in the Company's expectations of future investment earnings, mortality persistency, administrative and maintenance expenses, premium taxes, corporate income taxes or interest rates;

2. take effect only on a policy anniversary and only after 30 days' prior notice to the owner; and

3. apply to all insureds with the same benefits and provisions who have the same date of issue, age at issue, sex and underwriting class.

No change in premium will occur due to any change in an insured's health, occupation or avocation.

I have read the foregoing summary of premium provisions.

_____
Signature of Proposed Insured

The original of this form must accompany the application(s) for this plan.

AIG AMERICAN GENERAL

Notice Regarding Replacement

☐ **American General Life Insurance Company**
☐ **American General Life and Accident Insurance Company**
Member companies of American International Group, Inc.

Please check the appropriate Company box

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A *replacement* occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A *financed purchase* occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

Are You Replacing Coverage? We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

Applicant's and Producer's Non-Replacement Certification. Having answered "no" to questions 1 and 2, no replacement of coverage is occurring. We certify that the above two responses are, to the best of our knowledge, accurate.

X _____ _____
Applicant's Signature and Printed Name **Date**

X _____ _____
Producer's Signature and Printed Name **Date**

If signed above, do not complete the remainder of the form.
If you answered "yes" to either question 1 or 2, complete the remainder of this form, as directed.

List each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

Reason for Replacement: The existing policy or contract is being replaced because _____

_____.

Sales Materials. A copy of all printed sales materials used in connection with this transaction must be provided to the applicant. In addition, the producer should attach to the application all individualized sales materials used and list below all other sales materials used. *(List form number and brief description or name of sales materials used. If no sales materials were used, indicate "None".)*

_____

_____

Replacement Factors. A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as the sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.
Acquisition costs for the old policy may have been paid; you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

Applicant's Certification. I certify that the responses in this document are, to the best of my knowledge, accurate. I recognize that, for a period of 30 days from the date I receive my new policy or contract, I have the right to return it for an unconditional refund according to its terms.

X _____ _____
Applicant's Signature and Printed Name **Date**

Producer's Certification. I certify that the responses in this document are, to the best of my knowledge, accurate and that this replacement transaction is in accord with the Company's replacement guidelines with respect to the acceptability and appropriateness of such transactions.

X _____ _____
Producer's Signature and Printed Name **Date**

AIG AMERICAN GENERAL

Financial Questionnaire

☐ **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 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

Please complete questions 1 through 4 for personal insurance or questions 1 through 11 if the insurance is for business purposes, then date and sign the questionnaire.

Proposed insured _____ 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*		
TOTAL		

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)

5. Purpose of business insurance
☐ Key Executive ☐ 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, give details, 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 (Date / / thru / /)	Previous fiscal year
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) _____

_____

_____

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.

X Owner _____ Date _____

Signed at (City, State) _____

X Witness _____ Date _____

X Proposed insured _____ Date _____

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

AIG AMERICAN GENERAL

Foreign Travel or Residence Supplement to Application for Insurance

☐ **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.

1. Name _____

2. Date of Birth _____

3. Place of Birth _____

4. Occupation _____

5. Of what country are you a citizen? _____

6. To what foreign country (or countries) do you intend to travel? _____

_____

7. By what mode of transportation? _____

8. How long do you plan to remain? _____

9. For what purpose is the trip made? (Give full details) _____

_____

_____

_____

10. In what cities will you be located? _____

_____

11. Do you anticipate any flying other than as a passenger on regularly scheduled commercial airlines? (If yes, give full details). _____

_____

I hereby agree that all statements and answers to the above questions are complete and true.

Dated at _____ this _____ day of _____ 20 ____

_____ Witness

_____ Signature of Proposed Insured

Form **W-8BEN**
(Rev. February 2006)
Department of the Treasury
Internal Revenue Service

Certificate of Foreign Status of Beneficial Owner for United States Tax Withholding

▶ **Section references are to the Internal Revenue Code.** ▶ **See separate instructions.**
▶ **Give this form to the withholding agent or payer. Do not send to the IRS.**

OMB No. 1545-1621

Do not use this form for:	**Instead, use Form:**
• A U.S. citizen or other U.S. person, including a resident alien individual	W-9
• A person claiming that income is effectively connected with the conduct of a trade or business in the United States	W-8ECI
• A foreign partnership, a foreign simple trust, or a foreign grantor trust (see instructions for exceptions)	W-8ECI or W-8IMY
• A foreign government, international organization, foreign central bank of issue, foreign tax-exempt organization, foreign private foundation, or government of a U.S. possession that received effectively connected income or that is claiming the applicability of section(s) 115(2), 501(c), 892, 895, or 1443(b) (see instructions)	W-8ECI or W-8EXP

Note: *These entities should use Form W-8BEN if they are claiming treaty benefits or are providing the form only to claim they are a foreign person exempt from backup withholding.*

• A person acting as an intermediary	W-8IMY

Note: *See instructions for additional exceptions.*

Part I Identification of Beneficial Owner (See instructions.)

1 Name of individual or organization that is the beneficial owner

2 Country of incorporation or organization

3 Type of beneficial owner: ☐ Individual ☐ Corporation ☐ Disregarded entity ☐ Partnership ☐ Simple trust ☐ Grantor trust ☐ Complex trust ☐ Estate ☐ Government ☐ International organization ☐ Central bank of issue ☐ Tax-exempt organization ☐ Private foundation

4 Permanent residence address (street, apt. or suite no., or rural route). **Do not use a P.O. box or in-care-of address.**

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

5 Mailing address (if different from above)

City or town, state or province. Include postal code where appropriate.

Country (do not abbreviate)

6 U.S. taxpayer identification number, if required (see instructions) ☐ SSN or ITIN ☐ EIN

7 Foreign tax identifying number, if any (optional)

8 Reference number(s) (see instructions)

Part II Claim of Tax Treaty Benefits (if applicable)

9 **I certify that (check all that apply):**

a ☐ The beneficial owner is a resident of ..... within the meaning of the income tax treaty between the United States and that country.

b ☐ If required, the U.S. taxpayer identification number is stated on line 6 (see instructions).

c ☐ The beneficial owner is not an individual, derives the item (or items) of income for which the treaty benefits are claimed, and, if applicable, meets the requirements of the treaty provision dealing with limitation on benefits (see instructions).

d ☐ The beneficial owner is not an individual, is claiming treaty benefits for dividends received from a foreign corporation or interest from a U.S. trade or business of a foreign corporation, and meets qualified resident status (see instructions).

e ☐ The beneficial owner is related to the person obligated to pay the income within the meaning of section 267(b) or 707(b), and will file Form 8833 if the amount subject to withholding received during a calendar year exceeds, in the aggregate, $500,000.

10 **Special rates and conditions** (if applicable—see instructions): The beneficial owner is claiming the provisions of Article ..... of the treaty identified on line 9a above to claim a ..... % rate of withholding on (specify type of income): .....

Explain the reasons the beneficial owner meets the terms of the treaty article: .....

Part III Notional Principal Contracts

11 ☐ I have provided or will provide a statement that identifies those notional principal contracts from which the income is **not** effectively connected with the conduct of a trade or business in the United States. I agree to update this statement as required.

Part IV Certification

Under penalties of perjury, I declare that I have examined the information on this form and to the best of my knowledge and belief it is true, correct, and complete. I further certify under penalties of perjury that:

1 I am the beneficial owner (or am authorized to sign for the beneficial owner) of all the income to which this form relates,

2 The beneficial owner is not a U.S. person,

3 The income to which this form relates is (a) not effectively connected with the conduct of a trade or business in the United States, (b) effectively connected but is not subject to tax under an income tax treaty, or (c) the partner's share of a partnership's effectively connected income, **and**

4 For broker transactions or barter exchanges, the beneficial owner is an exempt foreign person as defined in the instructions.

Furthermore, I authorize this form to be provided to any withholding agent that has control, receipt, or custody of the income of which I am the beneficial owner or any withholding agent that can disburse or make payments of the income of which I am the beneficial owner.

Sign Here ▶ Signature of beneficial owner (or individual authorized to sign for beneficial owner) | Date (MM-DD-YYYY) | Capacity in which acting

BBVA Investments

Compañias

21st Century
American General Life
Allianz
Allstate
American National
AXA Equitable
Banner
Coventry
EMSI
Genworth Financial
Hartford
Indianapolis Life
ING
Integrity Life Solutions
Jefferson Pilot
John Hancock
Lincoln Benefit
Lincoln Financial
Mass Mutual
Met Life
Midland National
Mutual of Omaha
New York Life
North American
Northwestern Mutual
Pacific Life
Phoenix Mutual
Principal Financial
Protective
Prudential
Strategic Medical Consulting, Inc.
Sun Life
Transamerica Occidental Life Ins. Co.
United of Omaha
United States Life
US Financial
West Coast Life

Autorización para que la información de salud se pueda comunicar a la aseguradora VIP Insurance y sus compañias asociadas

La presente autorización se ajusta a la privacidad establecida por la ley de responsabilidad y portabilidad de los seguros médicos de Estados Unidos (HIPAA, por sus siglas en ingles)

_____ ___/___/_____ _____-____-_____

Nombre del asegurado / paciente (En letras de imprenta) | Fecha de nacimiento | Numero de Seguro Social

Yo autorizo que todo proveedor de un plan de salud, médico, profesional de la salud, hospital, clínica, laboratorio, farmacia, administrador de prestaciones farmacéuticas, centro médico, compañía de seguro, organización de apoyo para compañías de seguro u otro proveedor de servicios de salud (los "Proveedores") que, en forma directa o indirecta, haya hecho un pago en mi nombre, o me haya proporcionado un tratamiento o prestado servicios, comunique a Volente Insurance Partners, LLC (la "Compañía"), así como a sus empleados, agentes, representantes y filiales, la historia clínica completa, incluidos los informes de los exámenes personales y cualquier otra información de salud protegida. Esta autorización abarca la información sobre el diagnóstico o el tratamiento del virus de inmunodeficiencia humana (VIH) y de enfermedades de transmisión sexual. Asimismo, comprende la información sobre el diagnóstico o el tratamiento de las enfermedades mentales y del consumo de alcohol, estupefacientes y tabaco, con exclusión de las notas de las sesiones de psicoterapia.

Con su firma al pie de esta autorización, el que suscribe concluye todos los acuerdos que haya celebrado con los Proveedores para restringir la divulgación de la información de salud protegida, autorizándolos para comunicar su historia clínica completa sin limitación.

La información de salud protegida de quien suscribe se comunicará conforme a la presente Autorización, con la que la Compañía podrá: 1) transmitirla a otras compañías para que puedan proporcionarle al interesado un contrato de seguro mediante la evaluación de los requisitos, los riesgos, la emisión de la póliza y la solicitud de la cobertura; 2) procurar el reaseguro de otras compañías; 3) administrar los reclamos de seguro, así como evaluar o satisfacer la cobertura y la provisión de las prestaciones; 4) administrar la cobertura; y 5) llevar a cabo otras actividades permitidas por la legislación aplicable que se relacionen con la cobertura que el interesado tenga o haya solicitado en la Compañía.

Esta autorización será válida por veinticuatro meses desde su firma al pie. Por su parte, las copias de esta autorización tendrán la misma validez que el documento original. El interesado entiende que tiene el derecho de revocar la autorización en cualquier momento, por medio de una solicitud a tal fin dirigida al Ejecutivo de Privacidad HIPPA, o HIPPA Privacy Official en idioma inglés, de la Compañía, al domicilio 355 County Road 185, Suite 800, Cedar Park, TX 78613. La autorización también se podrá revocar enviando la solicitud mencionada a los Proveedores. La revocación no surtirá efecto cuando alguno de los Proveedores haya actuado en virtud de esta autorización ni cuando la Compañía tenga el derecho de impugnar un reclamo o la cobertura conforme a las pólizas de seguro. Por su parte, la información que se comunique conforme a esta autorización podrá quedar sujeta a retransmisión por parte de sus destinatarios, caso en el que ya no contará con la protección de la normativa federal que contempla la privacidad y la confidencialidad de la información de salud (p. ej., la privacidad establecida por la ley mencionada en el encabezado).

El que suscribe entiende que si decide no firmar esta autorización, la Compañía podrá no procesar su solicitud y, en caso de que ya se haya emitido una póliza de seguro, podrá no cubrir sus prestaciones; y declara que ha recibido una copia de esta autorización.

X _____ _____

Firma del asegurado / paciente o de su representante personal | Fecha

_____

Descripción de la relación o el poder del representante personal del asegurado / paciente

REPORTE MEDICO

Nombre del asegurado / paciente

Nombre del Doctor

Ciudad, Estado

Fecha de Nacimiento

Estimado Doctor:

En orden para poder establecer elegibilidad para un seguro de vida de este paciente, favor de completar la forma adjunta. Estamos interesados en información relacionada a visitas de consultas de este paciente con Usted en los últimos 5 años. Si es posible, favor de incluir copias de los resultados de posibles estudios y procedimientos diagnósticos. Autorización para que Usted pueda remitir esta información acompaña esta forma.

Si requiere más espacio para completar esta información, favor de copiar la hoja adherida las veces que sea necesario. Si Usted prefiere no usar esta forma, regrésela con el reporte que usted desee mandar. Favor de enviar esta información vía fax al (512)-794-0126.

Gracias por su cooperación.

Atentamente,

REPORTE MEDICO

Nombre del asegurado / paciente _____ Ciudad, Estado _____

FECHA	QUEJAS Y DESCUBRIMIENTOS FISICOS Y ABNORMALES	DURACION DE ENFERMEDAD	DIAGNOSIS	TRATAMIENTO

- Resultados de exámenes o laboratorios (Radiografías, Electrocardiogramas, Reportes Patológicos, Etc., incluyendo fechas.) _____

_____

- Condición presente. _____

_____

- Se a consultado algún otro o cirujano? Fecha y diagnosis. _____

_____

- Favor de anotar cualquier otra información pertinente a la salud de este paciente. _____

_____

- En su conocimiento, sabe Usted si este paciente a fumado en los últimos 12 meses? _____

_____

Nombre: _____

Firma: _____ Fecha: _____