AIG AMERICAN GENERAL

Application for Individual Critical Illness Insurance
Florida Version

American General Life Insurance Company, Houston, TX

A member company of American International Group, Inc.

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

1. Primary Proposed Insured (Please print full name)

Last First Middle

2. Address

Street

City State Zip Code

Email

( ) ( )

Home Telephone Business Telephone

Contact Preference: ❑ Home ❑ Business

Driver's License Number State of Issue

3. Social Security No.

4. Birth Date and Place

Month | Day | Year | State | Country

5. Age

6. Sex ❑ M ❑ F

7. Marital Status

❑ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

8. U.S. Citizen ❑ Yes ❑ No

If no, date of entry _____ visa type _____

9. Coverage Period

- ❑ 10 years
- ❑ 15 years
- ❑ 20 years
- ❑ 30 years
- ❑ Lifetime

Proposed Insured(s)

- ❑ Primary
- ❑ Spouse
- ❑ Child(ren)

Amounts

$_____

$_____

$_____

10. Riders

- ❑ HIV Rider
  - ❑ Primary ❑ Spouse
- ❑ Benefit Extension Rider
  - ❑ Primary ❑ Primary/Spouse
  - ❑ Primary/Child(ren) ❑ Family
- ❑ ADD Rider/No. of Units (1 – 6) ($25,000 per unit)
  - ❑ Primary _____ ❑ Primary/Spouse _____
  - ❑ Primary/Child(ren) _____ ❑ Family _____
- ❑ Other Riders _____

11. Modal Premium

Primary $ _____ Spouse $ _____

Children $ _____ **Total $** _____

Payable

❑ A ❑ S ❑ Q ❑ Bank Draft ❑ Other _____

❑ Add to existing Bank Draft account, policy no. _____

❑ Add to existing Salary Allotment account no. _____

Deduction Frequency _____

Deduction Amount _____

12. Occupation _____ Employer _____

Employer Address _____

Street City State Zip Code

Duties _____ Length of Employment _____

If less than 2 years, Previous Employer _____

Personal Income _____ Household Income _____

13. Premium Payor (If other than Primary Proposed Insured)

Name _____ Social Security No. _____

Relationship _____

Address _____

Street City State Zip Code

14. Owner (If other than Primary Proposed Insured)

Name _____ Social Security No. _____

Relationship _____ Date of Birth _____

Address _____
Street City State Zip Code

Home Phone _____

Complete if owner is a Trust

Exact Name of Trust _____ Trust Tax ID _____

Current Trustee(s) _____ Date of Trust _____

15. Primary Beneficiary _____

_____
Date of Birth Relationship

Contingent Beneficiary _____

_____
Date of Birth Relationship

16. Spouse (If coverage applied for) _____
Occupation

_____
Birthplace Date of Birth Social Security No Age

Spouse Driver's License Number _____ State of Issue _____

U.S. Citizen ❑ Yes ❑ No If no, date of entry _____ visa type _____

17. List Dependent(s) Information:

Full Name	Age	Relationship	Birth Date Mo. Day Yr.	Sex M F
a.				❑ ❑
b.				❑ ❑
c.				❑ ❑
d.				❑ ❑

Background	**INSURED**	**SPOUSE**	**DEP #a**	**DEP #b**	**DEP #c**	**DEP #d**
18. In the 90 days immediately prior to the date of this application, has any Proposed Insured been physically incapable of working, or incapable of performing normal daily activities for more than 3 consecutive days?	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑
19. Has any Proposed Insured participated within the last 3 years or have any intention of participating in: (a) flight in any type of aircraft as a pilot, student pilot or crew member, including Ultralight aviation; or (b) extreme sports or other hazardous activity; or (c) parachute jumping, auto, boat or motorcycle racing, hang gliding or scuba diving? If yes, **circle** the applicable activities.	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑

Background (cont'd)	INSURED	SPOUSE	DEP #a	DEP #b	DEP #c	DEP #d
20. Has any Proposed Insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑
21. In the past 5 years, has any Proposed Insured been charged with or convicted of: (a) driving while intoxicated, or (b) driving under the influence of alcohol or drugs; or (c) any driving violations? If yes, list Proposed Insured's name, license no., state of issue, specific violation(s), and date. _____ _____	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
22. Has any Proposed Insured ever been convicted of, pled guilty or no contest to a felony, or do they have any such charge pending against them? If yes, list Proposed Insured's name, date, state and felony. _____ _____	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
23. Within the past 12 months, has the Primary Proposed Insured and/or Spouse, if proposed for coverage, used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine?	❑ ❑	❑ ❑				
Primary Proposed Insured: Type _____ Date of Last Use _____ Amount/Frequency _____						
Spouse: Type _____ Date of Last Use _____ Amount/Frequency _____						

24. To the best of your knowledge and belief, has any member of any Proposed Insured's immediate family (mother, father, sister, brother) ever been diagnosed as having or been treated for heart disease, stroke, cancer, cerebrovascular disorder, aneurysm or diabetes prior to age 55? Complete the information that follows if the answer is Yes. ❑ Yes ❑ No

Name of Proposed Insured	Relationship	Condition (from list on question 24)	Age at Diagnosis

HEALTH HISTORY - If yes answer applies to any Proposed Insured, provide details on page 4.	INSURED	SPOUSE	DEP #a	DEP #b	DEP #c	DEP #d
25. Height	_____	_____	_____	_____	_____	_____
26. Weight	_____	_____	_____	_____	_____	_____
27. Has any Proposed Insured ever tested positive for exposure to Human Immunodeficiency virus (HIV) infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑

HEALTH HISTORY (cont'd) - If yes answer applies to any Proposed Insured, provide details below.	INSURED		SPOUSE		DEP #a		DEP #b		DEP #c		DEP #d	
28. Has any Proposed Insured ever been diagnosed as having or been treated for, or consulted a legally qualified practitioner of the healing arts for any of the following?												
a) heart disease, stroke, or Transient Ischemia Attacks (TIA)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b) glaucoma, macular degeneration, or optic neuritis	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c) disease or disorder of the endocrine system (diabetes, thyroid or other glands), kidney failure, polycystic kidneys, or abnormal kidney function	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d) cancer, leukemia, melanoma, malignant tumor, Hodgkin's Disease or non-Hodgkin's Lymphoma, or familial adenomatous polyposis (Gardener's Syndrome) NOTE: If the Proposed Insured has been free from breast cancer for more than 2 years before making application for this coverage, coverage will be provided for that condition.	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e) need for an organ transplant	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f) liver disease, including Hepatitis B or C	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g) paralysis, Multiple Sclerosis (MS) or cerebral palsy	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
29. Within the past 10 years, has any Proposed Insured been diagnosed as having or treated for, or consulted a legally qualified practitioner of the healing arts for any of the following?												
a) high blood pressure, rheumatic fever, heart murmur, elevated cholesterol, or disease or disorder of the blood, heart or circulatory system	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b) polycystic ovary; breast tumor(s) or cyst(s); or colon polyp(s)	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c) disease or disorder of the respiratory system	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d) disease or disorder of the spinal cord; or disease or disorder of the musculoskeletal system, including lupus	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e) a disease or disorder of the kidney; disease or disorder of the digestive system; or congenital anomalies	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f) mental illness; seizures; disease or disorder of the nervous system	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g) loss of hearing (requiring the use of a hearing aid), speech or blindness	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
h) a condition related to alcohol or drug use	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
30. Within the past 24 months, has any Proposed Insured experienced unexplained chest pain, shortness of breath, palpitation, weight loss, dizziness, fatigue, numbness or paralysis?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
31. Within the past 12 months, has any Proposed Insured been advised by a legally qualified practitioner of the healing arts concerning any abnormal diagnostic test results or been advised to have any diagnostic tests (including self-administered), hospitalization, treatment or surgery which was not completed?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Health History - Details for "Yes" answers.

Identify Question #	Name of Proposed Insured	Nature of Illness/Injury	Date & Duration	Name and Address of Physician or Medical Facility

32. Is any Proposed Insured taking any medications? ❑ Yes ❑ No
Complete the information that follows if the answer is Yes.

Name of Insured	Drug Name	Dosage	Physician Name and Address

33. Existing and Pending Critical Illness Insurance or any other Existing and Pending Insurance being replaced

Name of Proposed Insured	Policy Number	Company Name	Type*	Face Amount	Year Issued	Replace** Yes No
						❑ ❑
						❑ ❑
						❑ ❑
						❑ ❑
						❑ ❑

* Type: I = individual or G =group AND = AC = accident, H = health, C = cancer, CI = critical illness, or DI = disability illness

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

Remarks/Special Instructions

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

X _____
Signature of Proposed Insured — Date

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING

I, the Primary Proposed Insured (and any Owner of Spouse signing below), **AGREE** that: (a) **NO insurance** shall begin ***unless*** a policy is issued and the first premium has been paid in full within 31 days of the date of issue; and (b) **No conditional, temporary or interim insurance** of any kind will be in effect from the date of this application until the date a policy, if any, is issued, regardless of whether I paid any premium. Any such premium paid will be refunded if a policy is not issued, and American General Life Insurance Company ("Company") will have no further liability regarding this application; and (c) I am applying for a policy that provides limited benefits for diagnosis of the critical illness or loss of independent living, as defined in the policy, with **No** benefits if manifestation and/or diagnosis of such critical illness or loss of independent living occurs before the end of the applicable waiting period. The waiting period begins on the date a policy, if any, is issued; and (d) The policy I am applying for is **Not** a major medical insurance policy; and (e) All statements and answers in this application are complete and true to the best of my knowledge and belief; and (f) No agent has authority to waive any answer or otherwise modify this application, or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. I **AUTHORIZE** the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. We will not release specific test results for exposure to HIV infection to MIB. As to this Authorization, I agree that a photocopy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this Authorization and may revoke this Authorization at any time by written notification to the Company at its Home Office. I **ACKNOWLEDGE** receipt of: (a) NOTICES TO THE PROPOSED INSURED, page 8; and (b) Outline of Coverage. I **UNDERSTAND** that if I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

Signed at _____ (City) _____ (State) _____ (Date)

X _____
Signature of Primary Proposed Insured (If Age 16 or Over)

X _____
Signature of Licensed Agent

X _____
Signature of Spouse (Including as a Proposed Insured)

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

AGENT'S REPORT

1. How long have you known any of the Proposed Insured(s)?

2. Are you related to any of the Proposed Insured(s)?
   ❑ Yes ❑ No If "Yes", give details in Remarks section below.

3. Do you have knowledge of any unfavorable information regarding the Proposed Insured(s) which has not been disclosed in the application?
   ❑ Yes ❑ No If "Yes", give details in Remarks section below.

4. Have you given the insured a copy of the Outline of Coverage and obtained a signed HIPAA Privacy Notification?
   ❑ Yes ❑ No

5. Do you have any information indicating that any Proposed Insured may replace any accident and sickness policies with any company, including health, cancer, accident or critical illness insurance, in connection with the insurance being applied for? ❑ Yes ❑ No
   If yes, please provide details in the Remarks section below and attach any replacement notice related forms.

AGENT'S CERTIFICATION

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge, concerning any Proposed Insured.

Date _____ Signature of Licensed Agent _____

Print Agent's Name _____

Agent Number _____ Agency Code Number _____

REMARKS

Detach this page and leave it with the Primary Proposed Insured

NOTICES TO THE PRIMARY PROPOSED INSURED

American General Life Insurance Company, Houston, TX

This notice is provided on behalf of American General Life Insurance Company ("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 insurance 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. We will not release specific test results for exposure to HIV infection to MIB.

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 heath 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

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.

AIG AMERICAN GENERAL

USA Patriot Act

(This notice is printed in compliance with Section 326 of the USA Patriot Act)

AIG Life Insurance Company
American General Life and Accident Insurance Company
American General Life Insurance Company
American International Life Assurance Company of New York
The United States Life Insurance Company in the City of New York
Member companies of American International Group, Inc.

This notice is for use with applications to any of the companies listed above.

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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.

AMERICAN GENERAL LIFE Insurance Company
2727-A Allen Parkway, Houston, Texas

OUTLINE OF COVERAGE
LIMITED BENEFIT INSURANCE
Policy Form 05130-10

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

Critical Illness Coverage

The policy provides Critical Illness coverage ONLY. It does NOT provide comprehensive medical or hospital insurance, long-term care insurance or nursing home and home care insurance.

Benefits Of The Policy

We will pay the benefits summarized in the chart on Page 2, (subject to all applicable Policy provisions), if a Critical Illness is initially Incurred or Manifests, whichever is applicable as stated in the policy, and/or Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective, or for Invasive and In Situ Cancer, 90 days after the coverage on the Insured Person becomes effective.

Benefit Payment Conditions

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions: (a) the Critical Illness initially Incurs and/or Manifests as stated in the Policy; (b) the Critical Illness is initially Diagnosed while the coverage on an Insured Person is effective under the Policy or post-mortem; and (c) the Critical Illness is Diagnosed within the United States or its territories; and (d) the benefit payment is not excluded by any general or specific exclusion or limitation.

This is NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available form the company.

Exclusions

For any Insured Person:

(a) We will pay **NO** benefits for any Critical Illness that is initially Incurred or Manifests, whichever is applicable as stated in the policy, and/or Diagnosed within the first 30 days after the date coverage on the Insured Person becomes effective under the policy, or for Invasive or In-Situ Cancer, within the first 90 days after the date coverage on the Insured Person becomes effective under the policy. However, an Insured Child born after the effective date of the policy or any subsequent reinstatement will be covered from birth for the Critical Illnesses stated in the Policy Schedule.

(b) There is a 180-day waiting period between Diagnosed Critical Illnesses that are medically related. During this period, we will pay NO benefits under the policy if Diagnosed Critical Illnesses are medically related.

(c) We will pay **NO** benefits for any Critical Illness or any loss caused in whole or in part by, or resulting in whole or in part from the following:

- (1) the Insured Person's attempt at suicide, or intentional self-inflicted injury or sickness, while sane or insane;
- (2) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic or other drugs or intoxicant, including those taken as prescribed by a Physician;
- (3) the Insured Person's commission of or attempt to commit an assault or felony;
- (4) the Insured Person engaging in an illegal activity or occupation;
- (5) the Insured Person's voluntary participation in a riot or civil insurrection;
- (6) any illness, loss, or condition specifically excluded from the definition of any Critical Illness;
- (7) war, or any act of war, whether declared or not;
- (8) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedures; and
- (9) the Insured Person practicing for or participating in any semi-professional or professional competitive athletic contest for which compensation or remuneration is paid or received.

Limitations

The indicated percentage of the Critical Illness Maximum Benefit Amount payable for a Critical Illness will be reduced by any amount paid or payable for any other Benefit provided under the policy. Once 100% of the Critical Illness Maximum Benefit has been paid for an Insured Person, coverage for that Insured Person terminates and no further Benefits are payable.

Preexisting Condition Limitation

We will not pay any benefit for a Preexisting Condition until the policy has been in force two years from the date of issue or reinstatement.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	$ _____
Insured Spouse	$ _____
Insured Child	$ _____

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

Coverage may expire prior to the Expiry Date, see the TERMINATION provision for more details.

There is NO coverage for a Critical Illness that is initially Incurred, Manifested and/or Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if an Insured Person initially Incurred and was Diagnosed with permanent loss of two or more Activities of Daily Living before the end of the Waiting Period.

The Waiting Period begins on the Effective Date and continues for the number of days stated below:

Waiting Period	**30 days for all Critical Illness, except for Invasive Cancer and In Situ Cancer.** **90 days for Invasive Cancer and In Situ Cancer.**

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
☐ Invasive Cancer	100%
☐ Heart Attack	100%
☐ Kidney (Renal) Failure	100%
☐ Stroke	100%
☐ Coma	100%
☐ Coronary Artery Bypass ***Any Benefits for Coronary Artery Bypass are payable only once per lifetime, per Insured Person.***	25% of the Maximum Benefit, or $50,000 whichever is less
☐ Major Organ Transplant	100%
☐ Paralysis: ***Any Benefits for the following types of Paralysis/Paralyzed are payable only once per lifetime, per Insured Person.***	

Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
☐ Severe Burn	100%
☐ Loss of Sight, Hearing or Speech	100%
☐ In-Situ Cancer ***Any Benefits for In Situ Cancer are payable only once per lifetime, per Insured Person.***	25% of the Maximum Benefit, or $25,000 whichever is less
☐ Loss Of Independent Living Elimination Period – 180 days	100%

PREVENTIVE CARE BENEFIT

Health Screening Test	**NOT** to exceed a total of $50.00, per Insured Person, Per Calendar Year. There is no Waiting Period for this Benefit.

RETURN OF PREMIUM UPON THE DEATH OF THE INSURED

Total Premium Paid – less any benefits previously paid under policy

*This policy will provide coverage for ONLY the Critical Illnesses that are checked on the above chart.

DEFINITIONS

Critical Illness means any of the following illnesses stated in the Benefit Schedule and described in the Policy:

(a) Invasive Cancer;
(b) Heart Attack;
(c) Kidney (Renal) Failure;
(d) Stroke;
(e) Coma;
(f) Coronary Artery Bypass;
(g) Major Organ Transplant;
(h) Paralysis;
(i) Severe Burn;
(j) Loss of Sight, Speech or Hearing;or
(k) In-Situ Cancer

Activities of Daily Living mean the following self-care functions: (1) **bathing**: washing in either a tub or shower, including the task of getting into or out of the tub or shower without the assistance of another person; (2) **dressing**: putting on or taking off all items of clothing and any necessary braces, fasteners or artificial limbs without the assistance of another person; (3) **toileting**: getting on and off the toilet and performing associated personal hygiene without the assistance of other person; (4) **transferring**: moving onto or out of a bed, chair, or wheelchair without the assistance of another person; (5) **continence**: the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel or bladder functions, the ability to perform the associated personal hygiene (including caring for catheter or colostomy bag) without the assistance of another person; or (6) **eating:** feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or a feeding tube, or intravenously without the assistance of another person.

Diagnosis/Diagnosed means a definitive diagnosis made by a physician, licensed and practicing in the United States or its territories and, where applicable, specializing in a particular area of medicine:

(a) based upon the use of diagnostic evaluations, clinical and/or laboratory investigations tests and observations; and the results are documented in and supported by the Insured Person's medical records;
(b) meeting all diagnostic requirements set forth in the policy for the particular Critical Illness being diagnosed.

Elimination Period means the number of days shown on the BENEFITS SCHEDULE during which an Insured Person must be prevented from performing at least two or more Activities of Daily Living. The Elimination Period begins after the end of the Waiting Period.

Expiry Date means the period of time the Insured elects for coverage, subject to the Termination provision.

Incurs/Incurred means an event or incident that occurs with the policy period, whether adjusted or paid during the same, and:

(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy;
(b) initially occurs while the policy is in force; and
(c) is not excluded by specific description or exclusion stated in the policy.

Insured means the person named as "Insured" in the Policy Data on Page 1 of the policy.

Insured Person means the Insured and any Insured Spouse or Insured Child indicated as an Insured Person in the Policy Data.

Loss of Independent Living means an Insured Person is permanently unable to perform two or more of the six activities of Daily Living.

Manifests/Manifested/Manifestation means the existence of a condition or symptom that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment.

Preexisting Condition means:

(a) the existence of a condition that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment within the 2 year period before the date coverage on the Insured becomes effective under the policy; or
(b) a condition for which medical advice, care, attention or treatment was contemplated, recommended by a physician, or received from a physician within the 2 year period before the date coverage on the Insured becomes effective under the policy.

Waiting Period means the period that begins on the Effective Date and continues for the period shown in the Policy Schedule. There is NO coverage for a Sickness that first manifests itself to the Insured during the Waiting Period.

RETURN OF PREMIUM UPON DEATH OF THE INSURED

If the Insured dies while the Policy is in force, We will return to the Owner, or to the Owner's Beneficiary if the Owner is deceased or to the Owner's estate if there is no surviving Beneficiary, 100% of all premiums paid for the Policy and any attached Riders, less any benefits paid under the Policy and any attached Riders. The premiums to be returned will be calculated without interest and after all pending claims have been settled. If the sum of all Benefits paid under the Policy and applicable Riders is equal to or greater than the sum of the Premiums paid, there will be no return of premiums.

TERMINATION

Coverage for each Insured Person will terminate on the earlier of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that 100% of the Critical Illness Maximum Benefit Amount is paid for that Insured Person; or

(c) the next policy anniversary date following the attainment of age 70, for all benefits, except the Loss of Independent Living; or

(d) the maximum age for an Insured Child, as shown in the Insured Child provision; or

(e) the Expiry Date.

Your policy may be continued, subject to the policy's conditions, by paying the appropriate premiums when they are due. A Grace Period of 31 days will be granted for each premium payment after the first. The Company retains no right to restrict your benefits after the policy has been issued. The premiums can be changed on a class basis only. Any such change will be based on the Insured's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

OPTIONAL RIDERS

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER – 05138-10

MEDICAL PERSONNEL HIV BENEFIT RIDER - 05139

BENEFIT EXTENSION RIDER – 05137-10

Plan: ☐ Individual ☐ Parent & Children ☐ Family

Premium Summary

Premiums: Payable _____ (mode) Until the Expiry Date

Primary	$ _____
Spouse	$ _____
Child	$ _____
Total Premium	$ _____

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED; THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

AIG AMERICAN GENERAL

American General Insurance Company
A Member Company of American International Group, Inc

2727-A Allen Parkway
Houston, TX 77019

The underwriting risks~ financial obligations and support functions associated with the products issued by American General Life Insurance Company are solely its responsibility. American General Life Insurance Company is responsible for its own financial condition and contractual obligations.

AIG AMERICAN GENERAL

HIPAA Authorization - Health 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, 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; and communicable diseases including HIV or AIDS; and
- demographic information about me, including my name, address, telephone number, gender and date of birth.

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

- any physician or medical practitioner;
- any hospital, clinic or other health care facility;
- 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)

I further authorize the Companies to use and/or disclose my demographic information as set forth above to provide me with information about other products and/or services offered by the Companies.

_____ _____

Signature of Proposed Insured or Proposed Insured's Personal Representative — Date

_____

Description of Authority of Personal Representative (if applicable)

AIG AMERICAN GENERAL

Electronic Funds Authorization

American General Life Insurance Company (AGL)
AIG Life Insurance Company
AIG Life Insurance Company of Puerto Rico
Member companies of American International Group, Inc.

☐ Fixed Life Service Center - P. O. Box 4373, Houston, TX 77210-4373
☐ Variable Life Service Center - P. O. Box 4880, Houston, TX 77210-4880

Instructions for completing this form are listed on the back.

Please print or type all information except signatures.

1. CONTRACT IDENTIFICATION

☐ Check Here if New Address

CONTRACT No.: _____

OWNER: _____ **SSN/TIN OR EIN:** _____

ADDRESS: _____ **PHONE No.:** _____

_____

EMAIL ADDRESS (optional): _____

INSURED/ANNUITANT (if other than Owner): _____

Name: _____

Address: _____

2. FINANCIAL INSTITUTION

Routing Number ☐☐☐☐☐☐☐☐☐

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

PLEASE ATTACH A VOIDED CHECK OR A DEPOSIT SLIP.

Type Of Account: ☐ Checking ☐ Savings Credit Union: ☐ Yes ☐ No

3. BANK ACCOUNT OWNER

Name(s) of Bank Account Owner(s) _____

4. PAYMENT ALLOCATION

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually Withdrawal Day _____ (1-28)

Contract No.	Insured/Annuitant	Premium/ Contribution Amount	Loan Repayment (if available)	Other

5. SIGN HERE FOR ABOVE REQUEST

I understand and agree to the Electronic Funds Agreement on page 2.

☐ Please initiate debits against my account for all outstanding premiums due.

_____

Signature(s) of Bank Account Owner(s) as it appears on account records Date

_____

Signature(s) of Bank Account Owner(s) as it appears on account records Date

RETURN COMPLETED FORM TO THE ADDRESS OF THE COMPANY CHECKED ABOVE.

- Instructions and Conditions -

1.	**CONTRACT IDENTIFICATION**	Complete all contract information in this section. You may use this form for multiple contracts that have the same payment instructions. This form may be used to change the bank or bank account number from which debits will be made, or to change the bank account owner making payments.
2.	**FINANCIAL INSTITUTION**	Complete the name and address of the financial institution from which funds are to be withdrawn. Please provide the Routing Number and the Account Number of the financial institution. Indicate the type of account and whether or not it is with a credit union. **Submit the authorization with a voided check or a deposit slip. We cannot process a request without a voided check (checking account) or deposit slip (saving account).**
3.	**BANK ACCOUNT OWNER**	Print the name of the owner of the account from which funds will be debited.
4.	**PAYMENT ALLOCATION**	a. Indicate the frequency of the payment. b. Indicate the withdrawal day (day must be 1 through 28). **Withdrawals or debits from your account may occur earlier if the deduction day falls on a week-end or holiday.** c. Include all contract numbers on the Authorization with the corresponding Insured/Annuitant name, Premium/Contribution Amount, etc. d. Please contact your Service Center for availability. Loan repayment via electronic funds transfer is not available for all contracts.
5.	**SIGN HERE FOR ABOVE REQUEST**	**Electronic Funds 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 contract(s) listed, 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 in its Service Center. 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 non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request 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.