AIG AMERICAN GENERAL

Part A Life Insurance Application
California Version

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

Members of American International Group, Inc.

In this application, "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.

Personal Information

1. Primary Proposed Insured

Name _____ Social Security # _____ Sex ☐ M ☐ F

Birthplace *(state, country)* _____ Date of Birth _____ 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 No. _____ State____ U.S.Citizen ☐ yes ☐ no If no, Date of Entry_____ Visa Type___

Address _____ City, State _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____ E-mail Address _____

Employer _____ Occupation _____ Length of Employment _____

Employer Address _____ City, State _____ ZIP _____

Duties _____

Personal Income $ _____ Household Income $ _____ Net Worth $ _____

2. Other Proposed Insured

Name _____ Social Security # _____ Sex ☐ M ☐ F

Birthplace *(state, country)* _____ Date of Birth _____ Age _____

Relationship to Primary Proposed Insured _____

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 No. _____ State____ U.S.Citizen ☐ yes ☐ no If no, Date of Entry_____ Visa Type___

Address _____ City, State _____ ZIP _____

Home Phone ( ) _____ Work Phone ( ) _____ E-mail Address _____

Employer _____ Occupation _____ Length of Employment _____

Employer Address _____ City, State _____ ZIP _____

Duties _____

Personal Income $ _____ Household Income $ _____ Net Worth $ _____

3. Child Rider *(Complete if a proposed insured requests child riders. If more than three children, list information in the Remarks section. Remember to complete Part B, sections 3–7, for all proposed insured children.)*

Child Name	Sex	Birthplace *(state, country)*	Date of Birth
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____
_____	☐ M ☐ F	_____	_____

Ownership

4. Owner ☐ Primary Proposed Insured ☐ Other Proposed Insured ☐ Trust ☐ Other than a Proposed Insured or Trust

A. Complete if the 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 _____

B. Complete if owner is a trust *(If trustee is premium payor, also complete section 14 D.)*

Exact Name of Trust _____ Trust Tax ID # _____

Current Trustee(s) _____ Date of Trust _____

Product Information

5. Product Name *(If variable, complete appropriate supplement.)* _____

Amount Applied For: Base Coverage $ _____ Supplemental Coverage *(If applicable)* $ _____

Death Benefit Compliance Test Used *(If applicable)*: ☐ Guideline Premium ☐ Cash Value Accumulation

Automatic Premium Loan *(If applicable)*: ☐ Yes ☐ No

Premium Class Quoted _____

Reason for Insurance _____

6. Dividend Options *(For participating policy only.)*

☐ Cash ☐ Premium Reduction ☐ Paid-up Additions ☐ Deposit Earning Interest ☐ Other *(Explain)* _____

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

8. Riders ☐ Waiver of Premium ☐ Waiver of Monthly Deduction ☐ Waiver of Monthly Guarantee Premium

☐ Maturity Extension Rider – Accumulation Value ☐ Maturity Extension Rider – Death Benefit ☐ Terminal Illness Rider

☐ Accidental Death Benefit $ _____ ☐ Other Insured $ _____ ☐ Child $ _____

☐ Spouse $ _____ Plan _____ ☐ Other Rider(s) _____

Beneficiary

9. Primary Name _____ Relationship _____ % Share _____

Name _____ Relationship _____ % Share _____

10. Contingent Name _____ Relationship _____ % Share _____

Name _____ Relationship _____ % Share _____

11. Trust Information Exact Name of Trust _____ Trust Tax ID # _____

Current Trustee(s) _____ Date of Trust _____

12. Rider Beneficiaries Spouse Rider _____ Child Rider _____

Business Coverage

13. Business Details *(Complete only if applying for business coverage.)*

Does any proposed insured have an ownership interest in the business? ☐ yes ☐ no

If yes, what is the percentage of ownership for the: Primary Proposed Insured _____ Other Proposed Insured _____

If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? ☐ yes ☐ no

Describe any special circumstances. _____

Premium

14. Premium Payment ☐ Modal $ _____ ☐ Single $ _____ ☐ Additional Initial $ _____

A. Frequency of modal premium: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (Bank draft)

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

☐ Other *(Please explain.)* _____

C. Amount submitted with application $ _____

D. Premium Payor *(Complete if other than proposed insured.)*

Name _____ Social Security or Tax ID # _____ Home Phone (_____) _____

Address _____ City, State _____ ZIP _____

Existing Coverage

15. Other Life Insurance or Annuities *(Indicate life insurance policies or annuities in force or pending for the proposed insured(s).)*

Does any proposed insured have any existing or pending annuity or life insurance contracts? ☐ yes ☐ no

(If yes, indicate life insurance policies or annuities in force or pending for the proposed insured(s).)

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

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) *(see above)*	Year of Issue	Face Amount	Replace*	1035 Ex
						☐ yes	☐ yes
						☐ yes	☐ yes
						☐ yes	☐ yes
						☐ yes	☐ yes

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

Limited Temporary Life Insurance Eligibility

16. Health and Age Questions *(If any proposed insured answers yes to either question, temporary insurance is not available, the agreement will be void and any payment submitted will be refunded.)*

A. Has any proposed insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? ☐ yes ☐ no

B. Is any proposed insured age 71 or above? ☐ yes ☐ no

Nonmedical Questions

17. Background Information *(Complete questions A through F for all proposed insureds who are applying. If yes answer applies to any proposed insured, provide details specified after each question.)*

A. Do any proposed insureds intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no

(If yes, list proposed insured's name, country, date, length of stay and purpose.) _____

_____

B. In the past five years, have any proposed insureds participated in, or do they 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** the applicable activities and complete the Aviation and/or Avocation Questionnaire.)*

C. Have any proposed insureds:

1) During the past 90 days submitted an application for life insurance to any other company or begun the process of filling out an application?

(If yes, list proposed insured's name, company name, amount applied for, purpose of insurance and if app will be placed.) ☐ yes ☐ no

_____

_____

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal?

(If yes, list proposed insured's name, date and reason.) ☐ yes ☐ no

_____

_____

D. Have any proposed insureds ever filed for bankruptcy? *(If yes, list proposed insured's name, chapter filed, date, reason and if discharged.)* ☐ yes ☐ no

_____

_____

E. In the past five years, have any proposed insureds been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? *(If yes, list proposed insured's name, date, state, license no. and specific violation.)* ☐ yes ☐ no

_____

_____

F. Have any proposed insureds ever been convicted of, or pled guilty or no contest to a felony, or do they have any such charge pending against them? *(If yes, list proposed insured name, date, state and felony.)* ☐ yes ☐ no

_____

Remarks

18. Details and Explanations _____

_____

Authorization and Signatures

American General Life Insurance Company, Houston, TX

The United States Life Insurance Company in the City of New York, New York, NY

The above listed life insurance company as selected on page one of this application 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. In this application, "Company" refers to the insurance company which was selected on page one.

Authorization to Obtain and Disclose Information and Declaration

I give my consent to all of the entities listed below to give to the Company, its legal representative, American General Life Companies (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; 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; 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.

I have read the above statements 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 forms; and (2) shall be the basis for any policy 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) it is within its contestable period; and (2) such misrepresentation materially affects the acceptance of the risk. Except as may be provided in a Limited Temporary Life Insurance Agreement (LTLIA), I understand and agree that no insurance will be in effect under this application, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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 insurer's rights or requirements.

I have received a copy of the Notices to the Proposed Insured.

Limited Temporary Life Insurance Agreement – If eligible, I have received and accepted the LTLIA. Such insurance is available only if: (1) the full first modal premium is submitted with this application; and (2) only "no" answers have been given by any proposed insured to the Health and Age Questions.

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

Proposed Insured(s)/Owner Signature(s)

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

X _____ **X** _____

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

X _____

Owner *(If other than proposed insured)*

Agent(s) Signature(s)

I certify that the information supplied by the proposed insured(s)/owner has been truthfully and accurately recorded on the Part A application.

_____ _____

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

X_____ **X** _____

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

If the Company needs to contact the proposed insured(s), when would be the best time to call?

Time Day of the Week Date Phone # ( )

Agent's Report

1. Statements

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

B. I have ordered/obtained the following requirements: ☐ APS ☐ Blood Profile/Urinalysis ☐ EKG ☐ Inspection Report ☐ MD Exam ☐ Oral Fluids *(as state permits)* ☐ Paramedical Exam ☐ Treadmill ☐ Urinalysis Only

C. If requirements are scheduled, please provide name of examiner, clinic and date ordered. _____

_____

D. Did you personally see the proposed insured(s) on the date of this application, ask each question, and accurately record the answers yourself? *(If no, please provide details in the Remarks section below.)* ☐ yes ☐ no

E. Does any proposed insured have any existing or pending annuity or life insurance contracts? ☐ yes ☐ no
If yes, do you have any information that indicates that any proposed insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance? ☐ yes ☐ no
(If yes, please provide details in the Remarks section below and attach all replacement-related forms. Certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for.)

F. Are you aware of any information that would adversely affect any proposed insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance.)* ☐ yes ☐ no

G. Did you provide the client with a Limited Temporary Life Insurance Agreement? ☐ yes ☐ no

H. Have any of the proposed insureds or the owner submitted an application for coverage with any insurance member of the American International Group, Inc. within the last 30 days? ☐ yes ☐ no

I. If primary proposed insured is a child or age 18 and over and not self-supporting, what amount of insurance is in force on the father? $ _____ and/or mother? $ _____ and/or siblings? $ _____

J. Are you related by blood or marriage to any proposed insured? ☐ yes ☐ no
(If yes, relationship) _____

Remarks

2. Details and Explanations *(Please include information on any split dollar, collateral assignment, etc.)* _____

_____

_____

_____

_____

_____

_____

Commission

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

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split	Broker-Dealer (if variable)
_____	_____	_____	_____	☐ AGSI ☐ Other: _____
_____	_____	_____	_____	☐ AGSI ☐ Other: _____
_____	_____	_____	_____	☐ AGSI ☐ Other: _____
_____	_____	_____	_____	☐ AGSI ☐ Other: _____

Writing Agent **X** _____ Date _____

Social Security or Tax ID # _____ Phone # _ _____

E-mail Address _____ Fax # _____

For Broker-Dealer use

Processing Center _____ Contact Person _____ Phone # ( ) _____

Servicing Agent (if other than writing agent) send policy/delivery requirements to _____

_____

Bank Draft Information

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

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

The company checked above will withdraw the premiums from the specified account. This company will be referred to hereafter as "Company". "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 a voided check.

Notices to the Proposed Insured

You have applied for life insurance with one of the following companies: American General Life Insurance Company or The United States Life Insurance Company in the City of New York. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies, an affiliated service company.

Fair Credit Reporting Act and Investigative Consumer Reporting Agencies Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), and your state's Investigative Consumer Reporting Agencies Act, notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that could include information about your character, general reputation, personal characteristics and mode of living, from one of the following consumer reporting agencies:

Systematic Business Services, Inc.
10101 Renner Boulevard
Lenexa, KS 66219-9752
800-444-7274

Portamedic
170 Mt. Airy Rd.
Basking Ridge, NJ 07920
800-444-3737

Examination Management Services, Inc.
3003 LBJ Freeway, Suite 200
Dallas, TX 75234
800-USA-EMSI

If an investigative consumer report is ordered a copy will be provided to you within three (3) days after our receipt of the report.

Medical Information Bureau

The designated insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB-member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and phone number of the MIB's information office are:

P.O. Box 105
Essex Station
Boston, Massachusetts 02112
617/426-3660

The designated insurer, or its reinsurer, may also release information in its file to other life 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:

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.

*** Detach this page and leave with proposed insured ***

*** Detach this page and leave with proposed insured, if qualified ***

Limited Temporary Life Insurance Agreement (LTLIA)

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

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

In this application, "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.

Primary Proposed Insured (Please print) _____

1. Premium Receipt

Received $ _____ Date _____

Date of policy application *(complete if different than premium receipt date)* _____
All premium checks must be made payable to the Company. Do not make check payable to the agent or leave payee blank.
Note: Agent does not have the authority to accept a premium (including automatic bank draft check, salary savings or government allotment) with this application if the conditions in the Authorization to Obtain and Disclose Information and Declaration cannot be met, or if any part of the Health and Age questions have been answered *yes* by any proposed insured, answered falsely, or left blank.

2. Conditions of Temporary Life Insurance

A. The first modal premium must be paid with Part A of the application. *(If premiums are being paid by credit card or automatic bank draft, no premium is considered paid until the Company actually receives funds unless otherwise provided by applicable law.)*

B. The answer to both Health and Age Questions in Section 16, Part A, must be *no* for both proposed insureds.

C. Upon receiving proof of the death of the primary proposed insured – or of both proposed insureds if this is a joint life or survivorship policy – during the period covered by this agreement, the total amount that will be paid by the Company pursuant to this and any other limited temporary life insurance agreements covering the proposed insured(s) will be the lesser of:
- The plan amount the proposed insured(s) applied for; or
- $500,000 plus the amount of any premium paid for coverage in excess of $500,000.

The Company will pay this sum to the beneficiary named in the application. If death is due to suicide, payment will be limited to the amount of premium paid.

D. Coverage under this agreement will begin on the date the later of the following events have been completed:
- The application has been signed by the proposed insured(s); or
- All required medical examinations have been taken.

E. Coverage under this agreement will end on the earliest of the following dates:
- The date the policy as applied for is delivered and accepted;
- The date the Company declines the application;
- The date the Company states the application will not be considered on a prepaid basis;
- 60 days from the date coverage begins under this agreement; or
- The date the Company issues a policy other than as applied for.

F. The prepayment for this temporary insurance will be:
- Applied to the first premium due if the policy is issued as applied for; or
- Refunded if the Company declines the application or if the owner does not accept the policy; or
- Applied to the first premium if a policy is issued other than as applied for and is accepted.

G. Any misrepresentation contained in this agreement and relied on by the Company may be used to deny a claim or to void this agreement.

No changes may be made in the terms and conditions of this agreement. No statement that tries to make such a change will bind the Company.

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

Writing Agent Signature **X** _____ Date _____

*** Detach this page and leave with proposed insured, if qualified ***

AIG AMERICAN GENERAL

HIV Testing and Consent
California Version

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

Members of American International Group, Inc.

In this form, the "Company" refers to the insurance company whose name is checked above.

The insurance company checked above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments.

Notice and Consent for AIDS Virus (HIV) Antibody Testing

To determine your insurability, the Company has requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) as may be allowed under state or jurisdictional law for testing and analysis. One of the tests to be performed will determine the presence or absence of antibodies to the Human Immunodeficiency Virus (HIV). The testing will be performed by a licensed laboratory in accordance with guidelines approved by the Centers for Disease Control. By signing and dating this form, you agree that this testing may be done and that underwriting decisions may be based upon the test results.

Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing. Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV antibody test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, before being tested.

Meaning of Test Results

A positive result, which is a series of three positive tests, does not mean you have Acquired Immune Deficiency Syndrome (AIDS). A positive test indicates that you have been infected with HIV, the causative agent for AIDS, and that you are at significantly increased risk of developing alterations of your immune system, including AIDS and AIDS-Related Complex (ARC). The test for HIV antibodies is extremely accurate and reliable. However, in rare instances, the test may be positive in individuals who are not infected with the virus (false positive) and occasionally it may be negative in persons infected with HIV (false negative), especially when infection occurred within the 3-6 months prior to testing. Your private physician, a public health clinic or an AIDS information organization in your city can provide you with further information on the medical implications of a positive test.

Disclosure of Test Results

All test results will be treated confidentially. The laboratory will report them only to the Company. The test results may be disclosed as required by law or may be disclosed to employees of the Company who have responsibility for making underwriting decisions on behalf of the Company or to outside legal counsel who needs such information to effectively represent the Company in regard to your application. The results may be disclosed to a reinsurer if the reinsurer is involved in the underwriting process. Please also be advised that the jurisdiction in which you reside may require reporting of positive HIV test results or other test results by the Company and/or the laboratory that conducts the test to a regulatory agency. Such reporting may include disclosure of personal information such as your name, address and date of birth.

If your HIV antibody test is normal (negative), no routine notification will be sent. You will be notified of an abnormal (positive or indeterminate) test result if you indicate that you desire this result be made known to you. You may also identify another person to whom you want the abnormal results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB) as described in the notice given you at the time of application. The MIB is an organization of life and health insurance companies, which operates as an information exchange on behalf of its members. There will be no records with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some laboratory abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request and with your authorization, will supply the information on you in its file to that member.

Notification of Abnormal Test Result
In the event of an abnormal result:

Send the result to me at:

Address: _____

_____

I authorize the Company to send the result to another person:

Name: _____

Address: _____

I authorize the Company to send the result to the following physician or health care provider:

Name: _____

Address: _____

Consent
I have read and I understand this HIV Testing Notice and Consent form. I voluntarily consent to the withdrawal of blood and/or collection of other bodily fluids from me, the testing of bodily fluids and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact my physician, a public health clinic or an AIDS information organization for further information and counseling if the test result is abnormal.

I understand 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.

This consent will be valid for six (6) months from the date of my signature below.

Authorization

_____ _____
Name of Proposed Insured *Date of birth*

X _____ _____
Signature of Proposed Insured or Parent/Guardian (if under age 15) *Date signed*

X _____ _____
Signature of Person Obtaining Consent *Date signed*

AIG AMERICAN GENERAL

Disclosure for Term Life Policies

American General Life Insurance Company
Member of American International Group, Inc.
P.O. Box 4373 • Houston, TX 77210-4373

Proposed Insured's Name: _____

The following disclosure is required by the state of California Department of Insurance.

This policy is similar to a term policy for the same level premium period, but does not provide any nonforfeiture benefits (such as cash surrender values) at any time during those years. This means that if you fail to pay a premium within a specified time of its due date, this policy will lapse without any value.

You should compare this policy to a level-premium term policy. Such a term policy would provide identical insurance coverage, but may also be required to provide nonforfeiture benefits at certain durations where this policy does not. However, the premiums for the term policy might be higher than the premiums for this policy.

When considering the purchase of this policy, you should compare the value of having nonforfeiture benefits (such as cash values) versus the level of the premiums that you will pay.

The agent has explained this disclosure to me and I have received a copy.

Applicant's Signature: _____ Date: _____

Agent's Signature: _____ Date: _____

AIG AMERICAN GENERAL

Sale of Life Insurance and Annuities to Senior in California

☐ **American General Life Insurance Company (AGL)**
☐ **American General Life & Accident (AGLA)**
Member companies of American International Group, Inc.

Appointment date and time: _____ AM/PM
Month/Date/Year/Time

Date form mailed to customer: _____
Month/Date/Year

1. During this visit or a follow-up visit, you will be given a sales presentation on the following: *(indicate all that apply)*

   ☐ Life insurance including annuities
   ☐ Other insurance products (please specify): _____

   _____

2. You have the right to have other persons present at the meeting, including family members, financial advisors, or attorneys.

3. You have the right to end the meeting at any time.

4. You have the right to contact the Department of Insurance for information or to file a complaint. The consumer assistance telephone number at the California Insurance Department is 1-800-927-4357 or 213-897-8921.

5. The following individuals will be coming to your home:

Attendees Name	California Insurance License No. *(if applicable)*
_____	_____
_____	_____
_____	_____
_____	_____

AIG AMERICAN GENERAL

Disclosure for Term Life Insurance Policies

American General Life Insurance Company
A member company of American International Group, Inc.

The following disclosure information is required by the Department of Insurance.

You are applying for a term policy with level premiums guaranteed for a specified period. After the specified period, premiums increase annually. Like many term policies, this policy does not provide nonforfeiture benefits (such as cash surrender values) at any time. This means that if you fail to pay a premium within the grace period, this policy lapses without value.

You may wish to compare this policy against another term policy with identical coverage containing nonforfeiture benefits (such as cash surrender values) at certain durations. Premiums might be higher for this other kind of term policy than the policy you are applying for.

You should consider the value of having nonforfeiture benefits versus the level of premiums that you will pay.

AIG AMERICAN GENERAL

HIPAA Authorization - Life New Business

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

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, American International Life Assurance Company of New York, 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, (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.

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 the Recipient for purposes of disclosing information related to other insurance policies that provide me with insurance coverage);
- 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; and
- if a policy is issued, determine my eligibility for benefits and contestability of the policy.

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.

_____	_____
Name of Proposed Insured	Date
_____	_____
Signature of Proposed Insured or Proposed Insured's Personal Representative	Description of Authority of Personal Representative (if applicable)

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.

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.