Final Expense Sample Application

This is a sample application, not a promise to issue coverage.

Important Notes:

You **cannot** buy this policy directly from AIG.

This policy is **sold only via licensed AIG agencies** such as Choice Mutual.

To apply, call us at 1-800-644-2926

Underwriting Authorization Form

☒ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

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.

The purpose of this form is to obtain consent and authorization from the Proposed Insured to allow the Company to begin underwriting the application for life insurance.

Product Name Simplified Issue Whole Life Face Amount _____

Proposed Insured

First Name _____ MI____ Last Name _____ Sex at Birth M☐ F☐

SSN _____ Birthplace* (US State, or country) _____ DOB _____

Driver's License yes☐ no☐ License State _____ Number _____

If over age of 16 and no license, please explain. _____

Address _____ City _____ State _____ ZIP _____

Home Phone: _____ ☐ Primary contact number ☐ Text me here

Mobile Phone: _____ ☐ Primary contact number ☐ Text me here

Work Phone: _____ ☐ Primary contact number ☐ Text me here

Email Address _____

Agent Name (Please Print) _____

I, the Proposed Insured, intend to apply for individual life insurance coverage offered by the Company checked above. For this reason, I immediately authorize any medical professional; any hospital, or clinic or health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the Medical Information Bureau (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information in whatever form, including electronic records 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 concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I understand this authorization may be revoked at any time, except to the extent action has been taken by the Company in reliance on this authorization, by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1937.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this authorization. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; 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 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 the earlier of: (i) the date I, or any person authorized to act on my behalf, revoke or withdraw such authorization or consent; or (ii) 24 months from the date this form is signed or for the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery.

** For identification purposes only*

All statements and answers in this Underwriting Authorization Form are true to the best of my knowledge and belief. I understand that any misrepresentation contained in this agreement 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.

I agree that this Underwriting Authorization Form will become a part of my application for insurance.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

I consent to receive phone calls and text messages from the Company and/or a Third Party Administrator on behalf of Company, regarding products and services, at the phone number(s) above, including my mobile phone number if provided. I understand these calls and texts may be generated using an automated technology. I understand that consent is not required to make a purchase. Standard messaging and data rates apply for text messages.

I agree that a copy of the consent and electronic agreement will be as valid as the original.

Owner's Signature

X

Date signed: _____

Proposed Insured Signature (if other than Owner)**:**

X

(If under age 16, signature of parent or guardian)

Date signed: _____

Application for Individual Life Insurance

American General Life Insurance Company ("The Company"), 2727-A Allen Parkway, Houston, TX 77019
A member of American International Group, Inc. (AIG)

PART 1: PROPOSED INSURED

First Name	Middle Initial	Last Name	
Home Street Address	City	State	Zip
Date of Birth / Place of Birth (State/Country)	Primary Phone _____ _____ Alternate Phone _____ _____		
Gender _____ / Height _____ Weight _____ / Social Security Number	Email Address		
Is the Proposed Insured a United States citizen or a Permanent Legal Resident (Green Card holder)? _____	**In the past 12 months,** has the Proposed Insured used tobacco or nicotine-delivery products in any form? _____		

PART 2: OWNER (Complete only if Owner is different from the Proposed Insured)

First Name	Middle Initial	Last Name	
Home Street Address	City	State	Zip
Date of Birth / Relationship to the Proposed Insured	Primary Phone _____ _____ Alternate Phone _____ _____		
Gender _____ / Social Security Number	Email Address		
Is the Owner a United States citizen or a Permanent Legal Resident (Green Card holder)? _____			

PART 3: UNDERWRITING

I agree to respond to all questions truthfully and not withhold any information that may be responsive to any question asked. I understand that the Company will be verifying my answers against my health records.

If the Proposed Insured answers Yes to any of the following questions (Steps 1 – 5), the Proposed Insured is not eligible for any coverage under this application.

Step 1	Yes	No
1. Is the Proposed Insured currently bedridden or confined to any hospital facility or skilled nursing facility; or receiving or been advised to receive care in a nursing home, hospice care, or home health care?	☐	☐
2. Is the Proposed Insured receiving assistance with activities of daily living, including eating, bathing, toileting, or dressing due to a chronic or debilitating condition?	☐	☐
3. Does the Proposed Insured require any of the following due to a debilitating condition: wheelchair, electric scooter, or oxygen equipment to assist breathing (excluding use for sleep apnea)?	☐	☐
4. Has the Proposed Insured been diagnosed by a licensed member of the medical profession with a terminal illness or terminal condition that is expected to result in death within 12 months or less?	☐	☐
5. Has the Proposed Insured been diagnosed with Brain Aneurysm or Transient Ischemic Attack (TIA) in the past 6 months, or EVER had recurrent episodes of TIA (more than once)?	☐	☐
6. Is the Proposed Insured currently incarcerated in a prison or jail?	☐	☐

Step 2 - Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed member of the medical profession for any of the following?	Yes	No
1. Alzheimer's Disease, Dementia, Huntington's Disease, Sickle Cell Anemia, Myelodysplastic Syndrome (MDS), Lou Gehrig's Disease (ALS), Mental Incapacity, Cirrhosis, Quadriplegia or Paraplegia	☐	☐
2. HIV infection, AIDS or AIDS-Related Complex (ARC)	☐	☐
3. Advanced or End Stage Renal Disease or in need of Dialysis	☐	☐
4. Bone Marrow, Organ Transplant or Lymphoma	☐	☐
5. Metastatic or Recurrent Cancer of the same type (Stage III or Stage IV cancer)	☐	☐
6. Amputation due to diabetic complications or a hospitalization in the past 24 months due to diabetes	☐	☐
7. Heart Failure or Defibrillator device implanted	☐	☐
8. Suicide Attempt	☐	☐
Step 3 - In the last 12 months has the Proposed Insured:	Yes	No
1. Been diagnosed or treated for, or consulted a licensed member of the medical profession for Stroke; or EVER had a Stroke AND Diabetes and/or Coronary Artery Disease)?	☐	☐
2. Been declined for life insurance?	☐	☐
3. Been advised by a licensed member of the medical profession to have any of the following which has not been done, or for which results are not known: surgical or medical treatment, hospitalization, any medical procedures or diagnostic testing other than for routine screening purposes or for those related to HIV?	☐	☐
Step 4 – In the last 24 months has the Proposed Insured:	Yes	No
1. Been diagnosed or treated for, or consulted a licensed member of the medical profession for the following types of cancer: Brain, Carcinoid or Neuroendocrine Tumor, Esophageal, Head or Neck, Leukemia, Liver, Lung, Lymphoma, Multiple Myeloma, Ovarian, Pancreas, Sarcoma, Small Intestine, Stomach?	☐	☐
2. Been convicted of, or pled guilty or no contest to, driving while impaired, intoxicated or under the influence of drugs or alcohol?	☐	☐
3. Used narcotics (other than marijuana) such as amphetamines, hallucinogens, heroin, or cocaine without a prescription from a licensed member of the medical profession?	☐	☐
4. Been hospitalized MORE THAN ONCE for Chronic Obstructive Pulmonary Disease (COPD), Emphysema or Chronic Bronchitis (Chronic Cough)?	☐	☐
5. Been convicted of, or pled guilty or no contest to, a felony?	☐	☐
Step 5 - In the last 36 months, has the Proposed Insured:	Yes	No
1. Been hospitalized for Schizophrenia or a Psychotic event?	☐	☐

If the Proposed Insured answers Yes to any of the following questions (Sections A - D), the Proposed Insured may only be eligible for the graded death benefit product.

Section A – Has the Proposed Insured ever been diagnosed or treated for, or consulted a licensed member of the medical profession for any of the following?	Yes	No
1. Chronic Obstructive Pulmonary Disease (COPD), Chronic Bronchitis (Chronic Cough)	☐	☐
2. Hepatitis B	☐	☐
3. Diabetes	☐	☐
4. Schizophrenia	☐	☐
5. Multiple Sclerosis	☐	☐
6. Parkinson's Disease	☐	☐
7. Cardiomyopathy	☐	☐

Section B – In the last 48 months has the Proposed Insured been diagnosed or treated for, or consulted a licensed member of the medical profession for any of the following?	Yes	No
1. Any Autoimmune Disease	☐	☐
2. Bipolar Disorder (or Manic Depressive Disorder)	☐	☐
3. Chronic Kidney Disease (including chronic renal insufficiency)	☐	☐
4. Cancer (except for non-melanoma skin cancer)	☐	☐
Section C – In the last 24 months has the Proposed Insured been diagnosed as having, been treated for, or consulted a licensed member of the medical profession for any of the following?	Yes	No
1. Coronary Artery Disease, Heart Attack, Unstable Angina (treated medically or with Stents) or Coronary Bypass Surgery	☐	☐
2. Aortic Aneurysm	☐	☐
3. Stroke or Brain Aneurysm	☐	☐
4. Atrial Fibrillation or irregular heart rhythm	☐	☐
5. Substance Abuse (Alcohol or Drugs)	☐	☐
Section D – In the last 12 months has the Proposed Insured been treated for, or consulted a licensed member of the medical profession for any of the following?	Yes	No
1. Unintentional weight loss in excess of 10 lbs	☐	☐

☐ Additional Underwriting Information can be found in the addendum

Part 4: PRODUCT INFORMATION

Product Type Whole Life

Rider/Benefits _____

Death Benefit $ _____

Premium Payment

Frequency of Payment _____

Your premium amount for the payment frequency selected above is: $ _____

Part 5: PAYOR: (Complete only if the Payor is different from Owner/Proposed Insured)

First Name	Middle Initial	Last Name	
Home Street Address	City	State	Zip
Date of Birth	Relationship to the Proposed Insured	Gender _____	
Social Security Number	Email Address		

Is the Premium Payor a United States citizen or a Permanent Legal Resident (Green Card holder)? _____

Part 6: BENEFICIARY DESIGNATION

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							
	Address		Email				_____
2							
	Address		Email				_____
3							
	Address		Email				_____

☐ Additional beneficiaries can be found in the addendum
☐ Supplemental detail if the beneficiary is a trust can be found in the addendum

Part 7: EXISTING COVERAGE AND REPLACEMENTS

"Replacements" means that the life insurance policy being applied for may replace or change an existing life insurance or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

1. Does the Proposed Insured have any pending applications or existing life insurance or annuity contracts with The Company or any other company? ☐ Yes ☐ No
2. Is the insurance applied for intended to replace or change any life insurance or annuity contract in force with The Company or any other company? ☐ Yes ☒ No

If "Yes" to questions #1 or #2, please give details below. If more space is needed, list on a separate sheet.

Company	Policy Number	Face Amount	Coverage Being Replaced?
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

☐ Additional life insurance policy information can be found in the addendum

Part 8: AGREEMENT AND SIGNATURES

I agree that:

- I have read the statements and answers and acknowledge that to the best of my knowledge and belief, they are all accurate, complete and completely documented.
- To the best of my knowledge and belief, all statements in this application for life insurance are true and complete.
- I am applying for an insurance policy from the Company that will be based on my answers to the questions on this application and information obtained by the Company as described in the Underwriting Authorization Form.
- This application includes my prior authorization provided in the Underwriting Authorization Form.
- No agent is authorized to: (1) accept risks or pass upon insurability; (2) make or modify contracts; or (3) waive any of the Company's rights or requirements.
- I have received a copy of or have been read the Notices to Proposed Insured(s).
- No information about me will be considered to have been given to the Company by me unless it is stated in the application or obtained by the Company pursuant to my authorization previously provided.
- I must inform the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy.
- 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.
- No insurance will take effect until a policy is delivered to me and the full first premium due is paid.
- I understand the total amount of all simplified issue whole life and guaranteed issue whole life insurance benefits issued by the Company on the Proposed Insured's life cannot be more than: (1) $35,000 if eligible for the Level Death Benefit plan, or; (2) $25,000 if eligible for the Graded Death Benefit plan.
- **If applying for the Graded Death Benefit Plan,** I understand that a reduced death benefit amount will be paid during the first two policy years if death results from sickness or other natural causes. The full face amount will be paid during the first two policy years if death results from an accident.
- Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Owner Signature

X

Owner signed on (date) _____

Proposed Insured Signature (if other than Owner)

X

Agent Signature

I certify that the information supplied has been truthfully and accurately recorded on the application.

Writing Agent Name *(please print)* _____

Writing Agent # _____

Writing Agent Signature _____

Agent Email Address _____

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

Name of Insured/Proposed Insured (Please Print) **Date of Birth**

I authorize the entities below to give American General Life Insurance Company, its affiliates and their authorized representatives, including insurance support organizations (collectively "Recipient") the following information:

- any and all information relating to my health (except psychotherapy notes) 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; prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance and benefits, and if a policy is issued, determine contestability of the policy;
- underwrite my application for insurance; and
- detect fraud or for compliance activities.

I hereby acknowledge that AGL and its affiliates are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the 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 understand that the Recipients requesting access to my (electronic or paper) medical records are acting as a patient authorized representative solely for the purpose of obtaining such records and will attempt to access my medical records in an efficient manner, including electronic interchange through a Health Information Exchange or directly through my Providers' electronic health record system.

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 AGL at the address provided on this form. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes listed above.

I understand that the signing of this authorization is voluntary; however, if I do not sign it, the Companies may not be able to obtain the 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 and I am entitled to receive a copy of this authorization.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) _____

Signor name (printed) _____

Relationship _____

Description of Authority of Personal Representative (if applicable) _____

_____

Control Number/Policy Numbe _____

_____

LEAVE THIS FORM 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

You have applied for life insurance with one of the insurance companies identified above. "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 LLC (AGLC), a company providing services to affiliated life insurance companies.

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, Inc., formerly known as Medical Information Bureau, 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 about you 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

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. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.