Filing at a Glance

Company: American General Life and Accident Insurance Company

Product Name: AGLA 91008 R Critical Illness Policy, etal	SERFF Tr Num: AMGN-125785643	State: ArkansasLH
TOI: H07I Individual Health - Specified Disease - Limited Benefit	SERFF Status: Closed	State Tr Num: 40028
Sub-TOI: H07I.001 Critical Illness	Co Tr Num: AGLA 91008 R	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Marilyn Ellis	Disposition Date: 08/27/2008
	Date Submitted: 08/22/2008	Disposition Status: Approved-Closed
Implementation Date Requested: On Approval		Implementation Date:

State Filing Description:

General Information

Project Name: Critical Illness Policy, etal	Status of Filing in Domicile: Pending
Project Number: AGLA 91008 R	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	Domicile Status Comments:
Explanation for Combination/Other:	Market Type: Individual
Submission Type: New Submission	Group Market Size:
Overall Rate Impact:	Group Market Type:
Filing Status Changed: 08/27/2008	
State Status Changed: 08/27/2008	Deemer Date:

Corresponding Filing Tracking Number: AGLA 91008 R

Filing Description:

AGLA 91008 R Critical Illness Policy

AGLA1060-CI-AR (0808) Outline of Coverage

AGLA1060-OCI-AR (0808) Outline of coverage (If Issued Other Than As Applied For)

AGLA 91208 Accidental Death and Dismemberment Rider

AGLA 91308 Medical Personnel HIV Benefit Rider

AGLA 91408 Endorsement

AGLA 1000-2C-AR (0508) Critical Illness Application

AGLA 1000E-2C-AR (0508) Critical Illness Application

The above forms are being submitted for your consideration and approval. They are new and do not replace any forms previously approved by your department. The referenced forms have been submitted to our domicile state of Tennessee.

Form AGLA 91008 R is an individual health policy that provides a lump sum benefit in the event an Insured Person suffers a Critical Illness as defined in the policy, subject to the policy exclusions and limitations. If a specific Critical Illness is not listed on the Policy Schedule, the policy provisions regarding such Critical Illness will not apply and no benefits will be paid for that Critical Illness. The policy also provides a Preventive Care Benefit and a Return of Premium Upon The Death Of The Insured Benefit. The proposed Insured can elect coverage periods of 10 years, 15 years, 20 years, 30 years or lifetime. Regardless of the coverage period elected, all Critical Illness Benefits, other than Loss of Independent Living, will expire at age 70. Policy AGLA 91008 R is guaranteed renewable to the elected Expiry Date.

AGLA1060-CI-AR (0808) is the required Outline of Coverage provided to the applicant at the time of application for policy AGLA 91008 R. The required acknowledgement of the receipt of the Outline is contained on the application. If policy AGLA 91008 R is issued other than as applied for, the policy is accompanied by Outline of Coverage AGLA1000-OCI-AR (0808).

Form AGLA 91208 is an individual, optional rider. The rider provides a benefit for death or dismemberment of an Insured Person as a result of accidental injury.

Form AGLA 91308 is an individual, optional Medical Personnel HIV Benefit Rider. The rider provides a benefit for medical personnel who, through the performance of their normal occupation, are exposed to HIV.

Form AGLA 91408 is a United Network of Organ Sharing Scientific Registry (UNOS) Endorsement. The endorsement provides a benefit of 25% of the Critical Illness Maximum Benefit for an Insured Person who is placed on the UNOS registry as a potential recipient of a major organ transplant.

AGLA1000-2C-AR508) is the paper application and AGLA 1000E-2C-AR (0508) is the electronic application for applying for critical illness coverage. Two copies of the electronic application are enclosed. One copy shows the maximum number of information fields that can be collected on the application by including details below the application questions. The other copy shows the minimum amount of information that can be collected on the application.

Flesch readability scores for the referenced forms are as follows:

Form Number Flesch Score
AGLA 91008 R 50.0
AGLA1060-CI-AR (0808) 51.2
AGLA1060-OCI-AR (0808) 51.2
AGLA 91108 54.7
AGLA 91208 50.9
AGLA 91308 50.0
AGLA 91408 50.6
AGLA 1000-2C-AR (0508) 52.4 (Agreement Section)
AGLA 1000E-2C-AR (0508 50.3 (Agreement Section)

Company and Contact

Filing Contact Information

Kathryn Mitchell, Manager kathryn_mitchell@aigag.com
American General Center (615) 749-1139 [Phone]
Nashville, TN 37250-0001 (615) 749-2521[FAX]

Filing Company Information

American General Life and Accident Insurance CoCode: 66672 State of Domicile: Tennessee

Company

American General Center
Nashville, TN 37250-0001
(615) 749-1139 ext. [Phone]

Group Code: 12
Group Name: AIG
FEIN Number: 62-0306330

Company Type:
State ID Number:

Filing Fees

Fee Required?	Yes
Fee Amount:	$50.00
Retaliatory?	No
Fee Explanation:	1 filing x $50 = $50.00
Per Company:	No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life and Accident Insurance Company	$50.00	08/22/2008	22079058

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	08/27/2008	08/27/2008

SERFF Tracking Number:	*AMGN-125785643*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40028*
Company Tracking Number:	*AGLA 91008 R*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*AGLA 91008 R Critical Illness Policy, etal*		
Project Name/Number:	*Critical Illness Policy, etal/AGLA 91008 R*		

Disposition

Disposition Date: 08/27/2008
Implementation Date:
Status: Approved-Closed
Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-125785643*	*State:*	*Arkansas*
Filing Company:	*American General Life and Accident Insurance Company*	*State Tracking Number:*	*40028*
Company Tracking Number:	*AGLA 91008 R*		
TOI:	*H07I Individual Health - Specified Disease - Limited Benefit*	*Sub-TOI:*	*H07I.001 Critical Illness*
Product Name:	*AGLA 91008 R Critical Illness Policy, etal*		
Project Name/Number:	*Critical Illness Policy, etal/AGLA 91008 R*		

Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Form	Critical Illness Policy	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Accidental Death and Dismemberment Rider	Approved-Closed	Yes
Form	Medical personnel HIV Benefit Rider	Approved-Closed	Yes
Form	Endorsement	Approved-Closed	Yes
Form	Critical Illness Application	Approved-Closed	Yes
Form	Critical Illness Applciation	Approved-Closed	Yes

Form Schedule

Lead Form Number: AGLA 91008

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	AGLA 91008 R	Policy/Contract/Fraternal Certificate	Critical Illness Policy	Initial		50	AGLA91008AR.pdf
Approved-Closed	AGLA1060CI-AR (0808)	Outline of Coverage	Outline of Coverage	Initial		51	1060CI-SC.pdf
Approved-Closed	AGLA1060-OCI-AR (0808)	Outline of Coverage	Outline of Coverage	Initial		51	AGLA1060-OCI-SC(0808).pdf
Approved-Closed	AGLA 91208	Certificate Amendment, Insert Page, Endorsement or Rider	Accidental Death and Dismemberment Rider	Initial		51	AGLA91208.pdf
Approved-Closed	AGLA 91308	Certificate Amendment, Insert Page, Endorsement or Rider	Medical personnel HIV Benefit Rider	Initial		50	AGLA91308.pdf
Approved-Closed	AGLA 91408	Certificate Amendment, Insert Page, Endorsement or Rider	Endorsement	Initial		51	AGLA91408.pdf
Approved-Closed	AGLA1000-2C-AR	Application/Enrollment	Critical Illness Application	Initial		52	1000-2C-ARJD.pdf

	(0508)	Form				
Approved-Closed	AGLA1000E-2C-AR (0508)	Application/Enrollment Form	Critical Illness Applciation	Initial	50	1000E-2C-AR No.pdf 1000E-2C-AR Yes.pdf

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY
A Member Company of American International Group, Inc.
American General Center • Nashville, Tennessee 37250-0001
(615) 749-1523

Service for the attached policy will be provided by:

The Arkansas Department of Insurance has requested we provide you with the addresses and telephone numbers, as follow:

Customer Services
American General Life and Accident Insurance Company
American General Center - 305N
Nashville, Tennessee 37250
PH: 1-800-888-2452

State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904
PH: 1-800-852-5494

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

(please turn to back of page)

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

American General Life and Accident Insurance Company

A member company of American International Group, Inc.

American General Center • Nashville, Tennessee 37250-0001

AIG® AMERICAN GENERAL

American General Life and Accident Insurance Company

American General Center • Nashville, Tennessee 37250-0001
(A STOCK COMPANY)
1-800-888-2452

GUARANTEED RENEWABLE TO THE POLICY EXPIRY DATE, SUBJECT TO CHANGE IN PREMIUMS BY CLASS; THE POLICY'S TERMINATION PROVISION; AND PAYMENT OF THE MAXIMUM BENEFIT AMOUNT - BENEFITS FOR DIAGNOSIS OF A CRITICAL ILLNESS, AS DEFINED AND LIMITED IN THIS POLICY NONPARTICIPATING

THE COMPANY AGREES TO PAY the benefits described in this Policy, subject to its provisions, exclusions and limitations.

LEGAL CONTRACT. This Policy is a legal contract between You and Us. You should READ THIS CONTRACT CAREFULLY. Refer to DEFINITIONS to understand the meaning of defined words.

GUARANTEED RENEWABLE TO THE POLICY EXPIRY DATE, AS SHOWN IN THE POLICY DATA, SUBJECT TO CHANGE IN PREMIUMS BY CLASS. You may continue the coverage provided by this Policy on each Insured Person by paying all premiums when they are due, until the Policy anniverary on or following the Expiry Date, subject to the Policy's Termination provision and the payment of the Maximum Amount. We will not add any restrictive riders or endorsements while this Policy is in force. We reserve the right to change the premium charged for this Policy. Any change in premium will be made on a class basis only, as We determine, and will be based on the Insured Person's Age on the Date of Issue. No change in premium will become effective until 40 days after We deliver to You, or mail to Your last known address, on Our Home Office records a written notice of premium change.

TEN DAYS TO EXAMINE POLICY. You may return this Policy within ten (10) days after delivery, either to Us or to Our authorized agent, if You are not satisfied with it for any reason. The return of this Policy will void it from the Effective Date and any premium paid will be refunded.

CAUTION: THIS IS A LIMITED BENEFIT POLICY...PLEASE READ IT CAREFULLY WITH THE OUTLINE OF COVERAGE.

POLICY DATA

Insured Person - [Insured, Insured Spouse, and/or Insured Child]

Insured - [John Doe]
Policy Number - [126T03007]
Age/Gender - [35/Male]
Date of Issue - [August 1, 2008]
Premium Class - [Standard-Tobacco]
Premium Period - [Monthly]
Expiry Date - [August 1, 2018]
Premium - [$24.70 Monthly; $255.30 Annually]

Signed for American General Life and Accident Insurance Company at Nashville, Tennessee.

SECRETARY

PRESIDENT

THIS IS A LIMITED BENEFIT POLICY FOR DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. PLEASE READ IT CAREFULLY - IT CONTAINS WAITING PERIODS, EXCLUSIONS AND A PREEXISTING CONDITION LIMITATION.

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POLICY SCHEDULE

CRITICAL ILLNESS DIAGNOSIS BENEFITS

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT*

INSURED	**[$10,000]**
[INSURED SPOUSE]	**[$10,000]**
[INSURED CHILD]	**[$10,000]**

There is NO coverage for a Critical Illness that initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if the Insured Person initially Incurred or 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.**

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
[Invasive Cancer If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective	100%]
[Heart Attack	100%]
[Kidney (Renal) Failure	100%]
[Stroke	100%]
[Coma	100%]
[Coronary Artery Bypass	25% of the Maximum Benefit Amount, or $50,000 whichever is less]
Any Benefits for Coronary Artery Bypass are payable only once per lifetime, per Insured Person.	
[Major Organ Transplant	100%]
[Paralysis/Paralyzed	
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, Speech or Hearing	100%]

(Continued on Back)

POLICY SCHEDULE

(Continued)

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
[In Situ Cancer If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective	25% of the Maximum Benefit Amount, or $25,000, whichever is less]
Any Benefits for In Situ Cancer are payble only once per lifetime, per Insured Person	
[Loss of Independent Living	100%]
Elimination Period - [180 days]	
PREVENTATIVE CARE BENEFITS	
Health Screening Tests	**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 the Policy and any attached rider

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

DEFINITIONS

ACTIVITIES OF DAILY LIVING mean the following self-care functions: (a) 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; (b) dressing: putting on or taking off all items of clothing and any necessary braces, fasteners or artificial limbs without the assistance of another person; (c) toileting: getting on and off the toilet and performing associated personal hygiene without the assistance of another person; (d) transferring: moving onto or out of a bed, chair, or wheelchair without the assistance of another person; (e) 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 (f) 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.

AGE means the attained age as of the last birthday.

CALENDAR YEAR means the period from January 1 through December 31.

CRITICAL ILLNESS means only the illnesses listed in the Policy Schedule. See the Critical Illness Diagnosis Benefits Provision for definitions, exclusions and limitations.

DIAGNOSED/DIAGNOSIS/DIAGNOSTIC means a definitive diagnosis made by a Physician (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 must be documented in and supported by the Insured Person's medical records; and

(b) meeting any Diagnostic Requirements stated in this Policy for the particular Critical Illness being Diagnosed.

ELIMINATION PERIOD means the number of consecutive days shown on the Policy Schedule during which the Insured Person must be prevented from performing 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, as shown in the Application, subject to the Termination provision.

IMMEDIATE FAMILY MEMBER means a person who is related to the Insured in any of the following ways: spouse; child (including a legally adopted child, or stepchild providing a biological parent is also covered; son-in-law; and daughter-in-law); parents, (includes stepparent, mother-in-law, and father-in-law); and brother or sister (including stepbrother, or stepsister, brother-in-law, and sister-in-law).

INCURS/INCURRED means an event or incident that:

(a) initially occurs on or after the date coverage on an Insured Person becomes effective under this Policy; and

(b) initially occurs while coverage on an Insured Person under this Policy is in force; and

(c) is not excluded by any specific description or exclusion stated in this Policy.

INSURED means the person named as "Insured" in the Policy Data.

INSURED PERSON means the Insured and any Insured Spouse or Insured Child indicated as an Insured Person in the Policy Data. An Insured Spouse will become the Insured upon the death or termination of coverage on the person otherwise named as Insured 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 a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:

(a) on or after the date coverage on an Insured Person becomes effective under this Policy; and

(b) while coverage on an Insured Person under this Policy is in force; and

(c) that is not excluded by any specific description or exclusion stated in this Policy.

(Continued on Back)

DEFINITIONS

(Continued)

MEDICALLY RELATED means a successive Critical Illness stated in the Policy Schedule that: (a) results from the same or related organic, pathological, or physiological causes, conditions, or symptoms as a previous Critical Illness; and (b) is Incurred or Manifests more than 180 days after the previous Critical Illness ended. A successive Critical Illness that is NOT Medically Related to previous Critical Illness must be Diagnosed by a Physician.

MONTH means calendar month.

PHYSICIAN means a person who:

(a) is a legally qualified practitioner of the healing arts licensed in the United States or its territories; by a federal, state, or territorial licensing authority for such practitioners; and

(b) practices within the scope of his or her license in the United States or its territories; and

(c) is not the Insured Person; and

(d) is not the Insured Person's Immediate Family Member; and

(e) does not customarily reside in the same household as the Insured Person.

PREEXISTING CONDITION means:

(a) the existence of a condition or symptom that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment within the two (2) year period before the date coverage on the Insured Person becomes effective under this Policy; or

(b) a condition or symptom for which medical advice, care, attention or treatment was recommended by a Physician or received from a Physician within the two (2) year period before the date coverage on the Insured Person becomes effective under this Policy.

TRANSIENT ISCHEMIC ATTACK (TIA): A neurological condition or event with the signs and symptoms of a stroke, but which disappear clinically within a twenty-four hour period with no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

WE, OUR, COMPANY or **US** refer to American General Life and Accident Insurance Company.

YEAR means a consecutive 365-day period.

YOU or **YOUR** refers to the Owner of this Policy, which means the Insured unless otherwise stated in the application or later changed.

CRITICAL ILLNESS DIAGNOSIS

We will pay the Critical Illness Maximum Benefit Percentage stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both initially Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective.

BENEFITS

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT
The Critical Illness Maximum Benefit Amount for all Critical Illnesses for each Insured Person is as stated in the Policy Schedule.

CRITICAL ILLNESS BENEFIT AMOUNT
The Critical Illness Benefit Amount for each covered Critical Illness shown on the Policy Schedule will be calculated as the lesser of:

(a) the Critical Illness Maximum Benefit Amount multiplied by the applicable Critical Illness Maximum Benefit Percentage stated in the Policy Schedule; or

(b) the Critical Illness Maximum Benefit Amount less any previous benefits.

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 or Manifests as stated in the Policy (if required by the Policy); and

(b) the Critical Illness is initially Diagnosed while the coverage on an Insured Person is effective under this Policy; 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.

CRITICAL ILLNESS DIAGNOSIS BENEFITS

INVASIVE CANCER
INVASIVE CANCER. If the words "Invasive Cancer" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO Benefits for this illness.

INVASIVE CANCER means the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tumor.

For the purpose of this definition, Invasive Cancer does NOT include:

(a) any carcinoma in situ lesion regardless of origin, classified as $TisN_0M_0$;

(b) any $T_1N_0M_0$ lesion treated by endoscopic procedures;

(c) Melanoma, $T_1N_0M_0$ with maximum Breslow thickness of less or equal to 1.0mm; or Prostate cancer $T_1bN_0M_0$.

INVASIVE CANCER BENEFIT
If Invasive Cancer initially both Manifests and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

This Critical Illness must not have Manifested itself or been Diagnosed within the first 30 days after the date coverage on the Insured Person becomes effective under this Policy.

DIAGNOSTIC REQUIREMENTS FOR INVASIVE CANCER
Invasive Cancer must be Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on a microscopic examination of fixed tissues or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue, and/or specimen. Clinical diagnosis of Invasive Cancer will be accepted as evidence that Invasive Cancer exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the clinical diagnosis of Invasive Cancer and the Insured Person receives treatment for Invasive Cancer.

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HEART ATTACK
HEART ATTACK. If the words "Heart Attack" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

HEART ATTACK means the death of a portion of the heart muscle because of inadequate cardiac blood supply to the relevant area.

HEART ATTACK BENEFIT
If a Heart Attack initially both is Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

This Critical Illness must not have Manifested itself and/or been Diagnosed within the first 30 days following the date coverage on the Insured Person becomes effective under this Policy.

DIAGNOSTIC REQUIREMENTS FOR HEART ATTACK
This Diagnosis must be supported by the following criteria which are consistent with a new Heart Attack:

(a) typical clinical presentation; and

(b) new electrocardiographic (EKG) changes consistent with acute myocardial infarction; and

(c) serial measurements of cardiac biomarkers showing a pattern and a level consistent with a heart attack.

KIDNEY (RENAL) FAILURE
KIDNEY (RENAL) FAILURE. If the words "Kidney (Renal) Failure" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

KIDNEY (RENAL) FAILURE means the end stage failure which:

(a) presents a chronic irreversible failure of both kidneys as described below; and

(b) requires treatment by renal dialysis or kidney transplant.

KIDNEY (RENAL) FAILURE BENEFIT
If Kidney (Renal) Failure initially both Manifests and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

This Critical Illness must not have Manifested itself and/or been Diagnosed within the first 30 days following the date coverage on the Insured Person becomes effective under this Policy.

DIAGNOSTIC REQUIREMENTS FOR KIDNEY (RENAL) FAILURE
The Diagnosis of Kidney (Renal) Failure must be based on the chronic irreversible failure of the function of both kidneys, requiring regular dialysis or kidney transplant.

CRITICAL ILLNESS DIAGNOSIS BENEFITS

(Continued)

STROKE

STROKE. If the word "Stroke" is NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

STROKE means a cerebrovascular incident caused by infarction of brain tissue, cerebral or subarachnoid hemorrhage, cerebral embolism or cerebral thrombosis. This diagnosis must be supported by all of the following conditions:

(a) evidence of permanent neurological damage at least 6 weeks after the event; and

(b) findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

*For the purpose of this definition, Stroke does **NOT** mean:*

(a) Transient Ischemic Attacks (TIAs); or

(b) Brain damage due to accident or injury, infection, vasculities, and inflammatory disease, a demylenating process; or

(c) Vascular disease affecting the eye or optic nerve; or

(d) Ischemic disorders of the vestibular system.

STROKE BENEFIT

If a Stroke is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

DIAGNOSTIC REQUIREMENTS FOR STROKE

The Diagnosis of Stroke must be made by a neurologist based on documented neurological deficits and confirmatory neuroimaging studies.

COMA

COMA. If the word "Coma" is NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

COMA/COMATOSE means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, and in which stimulation will produce no more than primitive avoidance reflexes, which lasts for a period of at least 96 hours.

COMA BENEFIT

If a Coma is both initially Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

DIAGNOSTIC REQUIREMENTS FOR COMA

The Diagnosis of Coma must be documented by evidence of a neurological deficit that is expected to last for a continuous 12-month period or longer from the date of the Diagnosis to determine Coma.

CORONARY ARTERY BYPASS

CORONARY ARTERY BYPASS. If the words "Coronary Artery Bypass" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

CORONARY ARTERY BYPASS means the use of a non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries.

CORONARY ARTERY BYPASS BENEFIT

We will pay the applicable Critical Illness Benefit Amount if more than 30 days after the date coverage on the Insured Person becomes effective under this Policy both:

(a) the need for a Coronary Artery Bypass is first Diagnosed; and

(b) the Insured Person undergoes a Coronary Artery Bypass.

We will pay this benefit once per lifetime per Insured Person.

An illness that does not require surgery but requires a medical procedure such as balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedures is NOT covered.

DIAGNOSTIC REQUIREMENTS FOR CORONARY ARTERY BYPASS

The Diagnosis of the need for a Coronary Artery Bypass must be made by a cardiologist based on angiographic evidence of the underlying disease.

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MAJOR ORGAN TRANSPLANT

MAJOR ORGAN TRANSPLANT. If the words "Major Organ Transplant" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

MAJOR ORGAN TRANSPLANT means having undergone surgery as a recipient of a transplant as follows:

(a) human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or

(b) whole human organs limited to: heart, lung, liver, or pancreas because of the irreversible end stage failure of such organ.

*For the purpose of this definition, Major Organ Transplant does **NOT** mean:*

(a) other stem cell transplant; or

(b) part of an organ transplant or any other whole organ not listed above.

MAJOR ORGAN TRANSPLANT BENEFIT

We will pay the applicable Critical Illness Benefit Amount, if more than 30 days after the date coverage on the Insured Person becomes effective under this Policy both:

(a) the need for a Major Organ Transplant is first Diagnosed; and

(b) the Insured Person undergoes a Major Organ Transplant.

PARALYSIS/PARALYZED

PARALYSIS/PARALYZED. If the words "Paralysis/Paralyzed" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

PARALYSIS/PARALYZED means quadriplegia, paraplegia, or hemiplegia that is expected to last for a continuous 12-month period or longer from the date of the Diagnosis to determine if Paralysis is permanent. "Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. "Limb" means entire arm or an entire leg.

PARALYSIS BENEFIT

If Paralysis is both initially Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount. ***We will pay this benefit once per lifetime per Insured Person.***

If an Insured Person is Diagnosed with more than one type of Paralysis, only the largest benefit amount for the separate types of Paralysis will be paid. ***We will NOT pay any benefit for a Paralysis that results from psychiatric related causes.***

DIAGNOSTIC REQUIREMENTS FOR PARALYSIS

The Diagnosis of Paralysis must be based on documented evidence of the illness or injury that caused the Paralysis.

SEVERE BURN

SEVERE BURN. If the words "Severe Burn" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

SEVERE BURN means the cosmetic disfigurement of body surface or area that is a full-thickness or third-degree burn covering at least 20% of the body surface.

SEVERE BURN BENEFIT

If a Severe Burn is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount.

CRITICAL ILLNESS DIAGNOSIS BENEFITS

(Continued)

LOSS of SIGHT, SPEECH, or HEARING

LOSS OF SIGHT, SPEECH, OR HEARING. If the words "Loss of Sight, Speech or Hearing" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.

LOSS OF SIGHT, SPEECH, OR HEARING means the irreversible loss of sight in both eyes as described below, the irreversible loss of the ability to speak as described below, or the irreversible loss of hearing for all sounds in both ears as described below.

LOSS OF SIGHT, SPEECH, OR HEARING BENEFIT

If a Loss of Sight, Speech, or Hearing is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay applicable Critical Illness Benefit Amount.

We will NOT pay any benefit for a Loss of Sight, Speech, or Hearing that results from psychiatric related causes.

DIAGNOSTIC REQUIREMENTS FOR LOSS OF SIGHT, SPEECH, OR HEARING

The Diagnosis of Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine. The Diagnosis of Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes. The Diagnosis of Loss of Speech must include documented evidence of the illness, which results in the loss of the ability to communicate orally for the continuous 12-month period prior to the Diagnosis. The Diagnosis of Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

IN SITU CANCER BENEFIT

If In Situ Cancer initially both Manifests and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Benefit Amount not to exceed $25,000. **We will pay this benefit once per lifetime per Insured Person.**

DIAGNOSTIC REQUIREMENTS FOR IN SITU CANCER

In Situ Cancer must be Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on a microscopic examination of fixed tissues or preparations from the hemic system. If a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof. **A clinical diagnosis alone does not meet the requirements of this provision.**

LOSS OF INDEPENDENT LIVING

LOSS OF INDEPENDENT LIVING. If the words "Loss Of Independent Living" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits.

LOSS OF INDEPENDENT LIVING BENEFIT

If an Insured Person both initially Incurred and was Diagnosed with permanent loss of two or more Activities of Daily Living after the Waiting Period, We will pay any remaining applicable Critical Illness Benefit Amount if we receive proof that such permanent loss continues after the end of the Elimination Period.

There is NO coverage for Loss of Independent Living, if the Insured Person initially Incurred or was Diagnosed with permanent loss of two or more Activities of Daily Living before the end of the Waiting Period.

Loss of two or more Activities of Daily Living must be diagnosed by a Physician. An Insured Person must also be under the regular and appropriate care of a Physician.

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DIAGNOSTIC REQUIREMENTS

ALL CRITICAL ILLNESSES
We reserve the right to require that a physical examination of the Insured Person and/or the review of any Critical Illness Diagnosis by a Physician of Our choice in the United States at Our expense. Such Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all standardly accepted procedures and protocols in the Diagnosis of the Critical Illness.

We will not pay for any travel or other expenses of the Insured Person related to any such examination. We reserve the right to select an independent and acknowledged expert in the applicable field of medicine to review the evidence used in making any disputed Critical Illness Diagnosis. Such expert's opinion regarding the disputed Critical Illness Diagnosis shall be binding on both You and the Company.

PREVENTIVE CARE BENEFIT

If an Insured Person undergoes any of the health screening tests listed below while covered by this Policy, We will pay up to the Preventive Care Benefit stated in the Policy Schedule.

Payment of this benefit does not reduce the Critical Illness Maximum Benefit Amount provided by this Policy for any covered Critical Illness.

HEALTH SCREENING TESTS
Tests are limited to:

(a) Blood test for triglycerides;

(b) Breast ultrasound;

(c) Chest X-ray;

(d) Colonoscopy;

(e) Electrocardiogram;

(f) Fasting blood glucose test;

(g) Flexible sigmoidoscopy;

(h) Hemocult stool analysis;

(i) Mammography;

(j) Pap test;

(k) PSA (blood test for prostate cancer);

(l) Serum cholesterol test to determine level of HDL and LDL;

(m) Serum Protein Electrophoresis (blood test for myeloma); and

(n) Stress test on a bicycle or treadmill.

RETURN OF PREMIUM UPON DEATH OF THE INSURED

If the Insured dies while this 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 this Policy and any attached Riders, less any benefits paid under this 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 this Policy and applicable Riders is equal to or greater than the sum of the Premiums paid, there will be no return of premiums.

EXCLUSIONS

EXCLUSIONS

For any Insured Person:

(a) We will pay NO benefits for a Critical Illness that is initially Incurred or Manifests or is Diagnosed before the end of the Waiting Period. However, an Insured Child born after the Effective Date of this Policy or any subsequent reinstatement will be covered from birth for the Critical Illnesses stated in the Policy Schedule.

(b) 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; or

(2) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic; or any other drug or intoxicant including those prescribed by a Physician that are misused by the Insured Person; or

(3) the Insured Person's commission of or attempt to commit an assault or a felony; or

(4) the Insured Person engaging in an illegal activity or occupation; or

(5) the Insured Person's voluntary participation in any riot or civil insurrection; or

(6) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(7) war, or any act of war, whether declared or not; or

(8) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedure; or

(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; or

(10) injury incurred while the Insured Person was operating any type of land, water, or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the injury occurred.

PREEXISTING CONDITION LIMITATION

We will pay **NO** benefits for Critical Illness that are caused by a Preexisting Condition unless the Critical Illness commences after this Policy has been in force for two (2) years from the Effective Date or most recent reinstatement date. Preexisting Conditions are subject to the Incontestable Provision.

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PREMIUMS

This Policy is effective for an initial term of one Premium Period as stated in the Policy Data. It may be renewed by the timely payment of the renewal premium. The first premium is due on or before the Effective Date. Each renewal premium is due at the expiration of the period for which the preceding premium was paid. Each renewal premium must be paid on or before its due date, or within the Grace Period. You may pay premiums at Our Home Office. You may, by written request to Us, change the Premium Period, subject to Our rules at the time of Your request.

You can save money if you pay an annual premium. There is a greater cost if you pay premiums on a more frequent basis.

GRACE PERIOD
If a premium, other than the first, is not paid on its due date, Your Policy will remain in force for a period of 31 days from the premium due date.

LAPSE
If any premium is not paid before the end of the Grace Period, Your Policy will lapse. The date of lapse will be the date on which the unpaid premium was due. ***Your Policy will terminate upon lapse and provide NO further benefits.***

REINSTATEMENT
If Your Policy lapses, You may apply to reinstate it by:

(a) paying the required premium;

(b) providing evidence of insurability, if We so require; and

(c) submitting an application for reinstatement, if We so require.

If We accept the premium without requiring an application, this Policy will be reinstated.

If We ask for an application, We will issue a receipt for the premium. If We approve the application, this Policy will be reinstated as of the approval date. If We disapprove the application, We will notify You in writing. If We fail to notify You of Our disapproval, this Policy will be reinstated 45 days after the date of the premium receipt.

The reinstated Policy will only cover losses resulting from a Critical Illness that is Incurred or Manifests, whichever is applicable, more than 10 days after the date of reinstatement.

Except for the above and any new provisions We may require for reinstatement, Your rights and Ours under this Policy will be the same as just before the Policy lapsed.

UNEARNED PREMIUM REFUND
If the Insured or the Insured Spouse, if covered under this Policy, dies before the end of a Premium Period for which premium has been paid, We will refund the portion of premium that was applied to coverage for the decedent for the time period beyond the end of the Month in which death occurred.

CLAIMS

NOTICE OF CLAIM
You must provide to Us written notice of loss within 60 days from the date of loss or as soon as reasonably possible, but in no event more than 180 days thereafter. You may provide notice of loss at Our Home Office. Your notice should include Your name and Policy Number as shown in the Policy Data.

CLAIM FORMS
When We receive Your notice of loss, We will send You the forms required to file a claim. If the forms are not sent within 15 days, You will have met the time frame for filing proof of loss if You have provided to Us a written statement of the nature and extent of Your loss within the time allowed for filing a proof of loss.

PROOF OF LOSS
You must provide to Us, at Your expense, a written proof of loss determined to be satisfactory to Us within 90 days from the date of loss. If it is not reasonably possible for You to provide such written proof of loss within the stated time, Your claim will not be affected if You provide such written proof of loss as soon as reasonably possible. However, unless You are legally incapacitated, You must file a written proof of loss no later than 15 months from the date of loss.

You must provide to Us any authorizations necessary to obtain medical or other records to verify Critical Illness.

TIME OF PAYMENT OF CLAIMS
We will pay benefits, upon receipt of written proof of loss determined to be satisfactory by Us.

PAYMENT OF CLAIMS
Except as described in the Medicaid Eligibility provision, all benefits becoming payable will be paid to You or to Your designated beneficiary in the event of Your death, unless You have assigned the benefits. If We have recorded, at Our Home Office, Your written assignment of benefits, either before or with Your written proof of loss, We can pay all or part of any benefit to a hospital or person that provided medical care or treatment.

If any Benefits are payable to Your estate or to a person who is without legal capacity, We can pay up to $1,000 of Benefits to any relative by blood or connection by marriage whom We determine is entitled to payment. Such payment will discharge Our liability for that payment.

ASSIGNMENT
You may assign the benefits payable under this Policy. Your rights and those of any other person referred to in this Policy will be subject to the assignment. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed at Our Home Office. We assume no responsibility regarding the validity of any assignment.

UNPAID PREMIUMS
We will deduct any premium due from any benefits that becomes payable under this Policy.

PHYSICAL EXAMINATION AND AUTOPSY
At Our expense We can require:

(a) a physical examination on an Insured Person by a Physician of Our choice in the United States, as often as We deem necessary while a claim is pending. We will not pay for any travel or other expenses of the Insured Person related to such examination; or

(b) an autopsy to be performed after an Insured Person's death, if allowed by law or if this Policy was not issued for delivery in the State of Mississippi.

No benefit under this Policy will be paid until such examination, or autopsy as allowed by law, is conducted from which We receive written proof of loss determined to be satisfactory by Us.

LEGAL ACTIONS
No legal action may be brought to recover any benefits provided by this Policy until 60 days after the date We receive written proof of loss. No action may be brought after three (3) years from the date written proof must have been provided.

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GENERAL PROVISIONS

ENTIRE CONTRACT
This Policy, riders, endorsements and the attached application and any application for reinstatement are the entire contract. This contract is made in consideration of the application and the payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being true to the best of the knowledge and belief of the person signing the application.

AGENT'S AUTHORITY
No change to this Policy will be valid unless it is in writing and signed by one of Our officers at Our Home Office. No agent or other representative has authority to change or waive any Policy provision or extend the time for paying a premium.

AGE AND GENDER
If an Insured Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct Age is such that We would not have issued this Policy or an Insured Person's coverage under this Policy would have terminated, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

INCONTESTABLE
After this Policy has been in force for a period of two years during the lifetime of the Insured Person, it shall become incontestable as to the statements contained in the application, except for any fraudulent misrepresentation. After this Policy has been in force for a period of two years during the lifetime of the Insured Person following any reinstatement, it shall become incontestable as to the statements contained in any application for reinstatement, except for any fraudulent misrepresentation. After this Policy has been in force for a period of two years during the lifetime of the Insured Person following any additional coverage for an Insured Spouse or Insured Child added by rider after this Policy is issued, it shall become incontestable as to the statements contained in any such supplemental application, except for any fraudulent misrepresentation.

EFFECTIVE DATE
This Policy's Effective Date is the Date of Issue shown on the Policy Data. This Policy will take effect at 12:01 AM (Central Time) on the Effective Date and will terminate at 11:59 PM (Central Time) on the date provided for termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision. The Effective Date for any rider adding coverage for an Insured Spouse or Insured Child after this Policy is issued will be as described in that rider.

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 policy anniversary date on or next 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.

This Policy can be continued for any remaining Insured Persons, after coverage has been terminated for an Insured Person. Subsequent premiums will be recalculated to reflect the remaining Insured Persons' current coverage and their original age on the Date of Issue of this Policy. The termination of coverage on an Insured Person will not reduce Our liability for any claim originating prior to the termination.

This Policy will terminate on the earliest 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 the Insured and any Insured Spouse; or

(c) any premium due date requested by You in writing to terminate this Policy; or

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Insured, unless the Insured Spouse, if any, elects to continue this Policy; or

(f) the death of the Insured Spouse who continued this Policy after the death of the Insured; or

(g) the date the Insured Person becomes covered by a separate Critical Illness policy issued by Us; or

(h) the Expiry Date.

GENERAL PROVISIONS

(Continued)

OWNER

The Insured is the Owner of this Policy unless otherwise stated in the application, or later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or

(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office.

BENEFICIARY

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or

(b) Your spouse, child, or parent who We determine is entitled to payment.

CHANGE OF OWNER OR BENEFICIARY

While the Insured Person is living, You may change:

(a) the Owner; or

(b) a Beneficiary designation, if it is not restricted by a previous designation.

We can require that any change be endorsed on Your Policy. Any change will be effective as of the date Your change request was signed, except that it will not apply to any payment We make or any action We take before We record or acknowledge Your request in Our Home Office.

MEDICAID ELIGIBILITY

The Insured Person's current or future eligibility for Medicaid may affect the payment of benefits provided by this Policy. When Medicaid is involved it is possible that the benefits will not be paid directly to You, because of state regulations and/or federal regulations that may require payments to the Medicaid organization or to the medical provider.

CONFORMITY WITH STATE STATUTES

Any provision that conflicts with any laws of the state where You lived, when this Policy was issued, is amended to conform with that law.

NONPARTICIPATION

This Policy does not participate in surplus, and its premiums does not include a charge for participation in surplus.

TAX CONSEQUENCES

Benefits paid under this Policy may be taxable. If so, You or Your Beneficiary may incur tax obligation. As with all tax matters, You should consult Your personal tax advisor for more information about how this may affect You.

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FAMILY COVERAGE

INSURED SPOUSE

If the words "Insured Spouse" are NOT shown as an "Insured Person" in the Policy Data and the Policy Schedule, this provision does not apply and We will pay NO benefits for Your spouse.

An **Insured Spouse** means only the Insured's spouse named in the application for this Policy.

Any coverage on an Insured Spouse will terminate according to the "Termination" provision. The termination of coverage on the Insured Spouse will not reduce any liability We may have under this Policy for any claim originating prior to the termination of such coverage.

If this Policy is in force and the Insured dies, the Insured Spouse may continue this Policy by payment of the required premiums when they are due. The following conditions will apply:

(a) the Insured Spouse will become the Insured under this Policy; and

(b) subsequent premiums will be based on the Insured Spouse's Age on the Date of Issue of this Policy.

If this Policy is in force and the Insured Spouse dies, We will reduce the subsequent premium.

If this Policy is in force and the Insured's marriage to the Insured Spouse is terminated by a divorce decree, the Insured Spouse may obtain a separate Critical Illness policy, subject to the Conversion Privilege provision below.

Coverage provided on any Insured Person by this Policy cannot be continued if the Insured Person is subsequently covered by a separate Critical Illness policy issued by Us. Coverage on any Insured Person provided by this Policy ceases when coverage on such Insured Person becomes effective under a separate Critical Illness policy issued by Us.

INSURED CHILD

If the words "Insured Child" are NOT shown as an "Insured Person" in the Policy Data, and the Policy Schedule, this provision does not apply and We will pay NO benefits for Your child.

An **Insured Child** under this Policy is the Insured's child (biological child, legally adopted child, or stepchild) who is unmarried and dependent on the Insured, and is:

(a) named in the application and is less than 18 years of Age on the date of application; or

(b) born after the Effective Date of this Policy, and the Insured is named as parent on the child's birth certificate; or

(c) legally adopted by the Insured after the Effective Date of this Policy and before the child's 18th birthday.

Any child placed in the Insured's home for adoption will be an Insured Child from the date of the filing of a petition for adoption, or the moment of birth if the petition for adoption is filed within 60 days after the child's birth, until the petition for adoption is dismissed or denied.

Coverage on any Insured Child will terminate on the earlier of:

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

(b) the premium due date following the Insured Child's 18th birthday unless:

  (1) the Insured Child remains an unmarried dependent on the Insured; and

  (2) the Insured Child is either enrolled as a fulltime student in high school or in an institution of higher learning beyond high school, or has been so enrolled for at least five months of each year since his or her 18th birthday, or is eligible to enroll in such an institution but is prevented from enrolling due to illness or injury; or

(c) the premium due date after the Insured Child's 25th birthday if coverage on an Insured Person is continued past the Insured Child's 18th birthday under this provision; or

(d) the Date of Issue of a separate policy, which is issued to the Insured Spouse and provides coverage on the Insured Child; or

(e) the Expiry Date.

The termination of an Insured Child's coverage will not reduce any liability We have under this Policy for any claim originating prior to the termination.

FAMILY COVERAGE

(Continued)

If this Policy is in force when an Insured Child's coverage terminates, such Insured Child may obtain a separate Critical Illness policy, subject to the Conversion Privilege provision below.

The coverage provided on an Insured Child by this Policy may be continued, so long as the Insured Child is:

(a) legally incapable of self-sustained employment due to mental or physical incapacity; and

(b) dependent upon the Insured for support and maintenance.

You must submit satisfactory proof of incapacity and dependency to Us prior to the date on which the coverage on the Insured Child would terminate if he or she were not incapacitated and dependent, and subsequently as We may require, but not more frequently than annually after the two (2) year period following the date coverage on the Insured Child would otherwise have terminated. We may charge an additional premium for continuing the coverage on any Insured Child. We will determine the premium on the basis of the Age, Sex, and premium rate and class in effect for the Insured Child on the date proof of incapacity and dependency is provided.

CONVERSION PRIVILEGE

We will issue a separate Critical Illness Policy to an Insured Spouse or Insured Child as described in this Policy.

Written application with payment of the first premium for such separate policy must be made:

(a) by the Insured Spouse within 31 days following termination of marriage by a divorce decree and prior to the policy anniversary on or following the Insured Spouse's 64th birthday; or

(b) by the Insured Child within 31 days following the termination of his or her coverage under this Policy.

If Critical Illness coverage is still being issued by Us in Your state of residence, a separate policy will be issued:

(a) without evidence of insurability; and

(b) with the same Exclusion and Preexisting Condition Limitation provisions applicable to such Insured Person, if any, provided by this Policy; and

(c) with a current Date of Issue; and

(d) at the premium rate and class in effect for the Insured Person's Age and Sex on the date of application for the separate policy; and

(e) with the same benefits payable, if any, reduced by any benefits previously paid for the Critical Illnesses stated in the Policy Schedule; and

(f) with the same Incontestable provision applicable to such Insured Person provided by this Policy, commencing on the date coverage on the Insured Person becomes effective under this Policy.

(Continued on Back)

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American General Life and Accident Insurance Company

American General Center • Nashville, Tennessee 37250-0001

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY COVERAGE
OUTLINE OF COVERAGE

Policy Form AGLA 91008 S

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of the 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 you have applied for provides a limited benefit for diagnosis of a defined Critical Illness 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 Critical Illness Benefit Amount described in the policy, subject to all applicable policy provisions, if a Critical Illness other than Invasive or In Situ Cancer initially is Incurred or Manifests (if required by the policy) and is initially Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective, or, for Invasive Cancer or In Situ Cancer, such Critical Illness initially Manifests and is initially Diagnosed more than 90 days after the date coverage on the Insured Person becomes effective.

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

Exclusions

For any Insured Person:

(a) We will pay **NO** benefits for a Critical Illness that initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. 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 suicide, while sane or insane, attempted suicide or intentionally self-inflicted injury; or

(2) the Insured Person's mental or emotional disorders, alcoholism or drug addition; or

(3) the Insured Person's participation in a felony, riot or insurrection; or

(4) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(5) the Insured Person's service in the armed forces or units auxiliary thereto.

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 Critical Illnesses that are caused by a Preexisting Condition unless the Critical Illness commences after the policy has been in force two years from the Effective Date or most recent reinstatement date.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	$ _____
Insured Spouse	$ _____
Insured Child(ren)	$ _____

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 initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. There is NO coverage for Loss of Independent Living, if the Insured Person initially Incurred or 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%

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

BENEFITS SCHEDULE

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
❑ 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 Tests (As Limited in the policy)	**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 and any attached rider

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

DEFINITIONS

Critical Illness means ONLY the following illnesses as defined and limited 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;
(k) In-Situ Cancer; or
(l) Loss of Independent Living

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 another 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.

Definitions (Continued)

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:

(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy; and
(b) initially occurs while coverage on an Insured Person under 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 a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:

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

Preexisting Condition means:

(a) any condition misrepresented or not revealed in the application; or
(b) any condition for which symptoms existed prior to becoming covered under the policy that would cause an ordinary prudent person is seek Diagnosis, care, or treatment within the two year period prior to becoming covered under the policy or for which medical advice or treatment was recommended by or received from a physician.

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 Critical Illness that is initially Incurred or Manifests or is Diagnosed 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 earliest of:

(a) the date on which the 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 policy anniversary date on or next 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.

Guaranteed Renewable to The Policy 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 Person's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

Plan: ❑ Individual ❑ Parent & Children ❑ Family

Premium Summary

Premiums: Payable_____Until the Expiry Date
(mode)

Primary..... $ _____

Spouse ..... $ _____

Child(ren) ..... $ _____

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.

American General Life and Accident Insurance Company
A subsidiary of American International Group, Inc.
American General Center
Nashville, Tennessee 37250-0001

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The underwriting risks, financial and contractual obligations and support functions associated with products issued by American General Life and Accident Insurance Company (AGLA) are its responsibility. AIG does not underwrite any insurance policy referenced herein.

NOTICE: Read this outline of coverage carefully. It is **not** the same as the outline of coverage for the policy you applied for. The policy you applied for has not been issued.

American General Life and Accident Insurance Company

DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY COVERAGE OUTLINE OF COVERAGE

Policy Form AGLA 91008 S

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of the 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 you have applied for provides a limited benefit for diagnosis of a defined Critical Illness 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 Critical Illness Benefit Amount described in the policy, subject to all applicable policy provisions, if a Critical Illness, other than Invasive or In Situ Cancer, initially is Incurred or Manifests (if required by the policy) and is initially Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective, or, for Invasive Cancer or In Situ Cancer, such Critical Illness initially Manifests and is initially Diagnosed more than 90 days after the date coverage on the Insured Person becomes effective.

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

Exclusions

For any Insured Person:

(a) We will pay **NO** benefits for a Critical Illness that initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. 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 suicide, while sane or insane, attempted suicide or intentionally self-inflicted injury; or

(2) the Insured Person's mental or emotional disorders, alcoholism or drug addiction; or

(3) the Insured Person's participation in a felony, riot or insurrection; or

(4) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(5) the Insured Person's service in the armed forces or units auxiliary thereto.

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 Critical Illnesses that are caused by a Preexisting Condition unless the Critical Illness commences after the policy has been in force two years from the Effective Date or most recent reinstatement date.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	$ _____
Insured Spouse	$ _____
Insured Child(ren)	$ _____

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 initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if the Insured Person initially Incurred or 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, Speech or Hearing	100%

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

BENEFITS SCHEDULE

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
☐ 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 Tests (As Limited in the policy)	**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 the policy and any attached rider.

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

DEFINITIONS

Critical Illness means ONLY the following illnesses as defined and limited 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;
(k) In-Situ Cancer;or
(l) Loss of Independent Living

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 another 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; and
(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.

Definitions (Continued)

Incurs/Incurred means an event or incident that:

(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy; and
(b) initially occurs while coverage on an Insured Person under 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 a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:

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

Preexisting Condition means:

(a) any condition misrepresented or not revealed in the application; or
(b) any condition for which symptoms existed prior to becoming covered under the policy that would cause an ordinary prudent person to seek Diagnosis, care, or treatment within the two year period prior to becoming covered under the policy or for which medical advice or treatment was recommended by or received from a physician.

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 Critical Illness that is initially Incurred or Manifests or is Diagnosed 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 earliest of:

(a) the date on which the 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 policy anniversary date on or next 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.

Guaranteed Renewable to The Policy 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 Person's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

Plan: ☐ **Individual** ☐ **Family** ☐ **Parent & Child(ren)**

Premium Summary

Premiums: Payable _____ (mode) until the Expiry Date

Primary ..... $ _____

Spouse ..... $ _____

Child(ren) ..... $ _____

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.

American General Life and Accident Insurance Company

A subsidiary of American International Group, Inc.

American General Center
Nashville, Tennessee 37250-0001

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AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER

This Rider is added to and made a part of the Policy to which it is attached.

RIDER SCHEDULE

Insured Person - Insured, [Spouse,] [Child(ren)]

Insured - [John Doe]
Effective Date - [August 1, 2008]
Age/Gender - [35/Male]
Principal Sum Amount - [$25,000]
Expiry Date - [August 1, 2018]
Premium - [$7.34 Monthly; $77.25 Annually]

The Definitions of the Policy to which this Rider is attached will be utilized, along with the terms defined below.

DEFINITIONS

"Accidental Injury" means accidental bodily injury, which is unforeseen and suddenly sustained without the design or intent of an Insured Person that:

(a) is not caused or contributed to, directly or indirectly, by a disease, bodily or mental infirmity, illness, infection, medicine or surgery used to treat an Insured Person, or any cause or physical condition; and

(b) occurs while coverage on that Insured Person under the Policy or Certificate is in force; and

(c) causes loss that is covered by the Policy or Certificate within 90 days following the Accidental Injury.

"Common Carrier" means a taxi, school bus, streetcar, bus, train, ship, ferry, or airplane which is duly licensed by the proper authority for the sole purpose of transporting public passengers for a fee for purposes other than the following activities: hang gliding, bungee jumping, parachuting, sailgliding or parasailing.

"Loss of hand or hands, foot or feet" is the severance at or above the wrist joint or ankle joint, respectively.

"Loss of both eyes" is the permanent and uncorrectable loss of entire sight. The corrected visual acuity must be worse than 20/200 in both eyes or the field of vision must be less than 20 degrees in both eyes.

"Loss of one eye" is the permanent and uncorrectable loss of entire sight in that eye. The corrected visual acuity must be worse than 20/200 or the field of vision must be less than 20 degrees in that eye.

ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

We will pay the Owner the amount shown below for any one listed loss due to an Accidental Injury incurred by the Insured Person. The loss must be incurred within 90 days of the Accidental Injury. This Rider must be in force on the date of the Accidental Injury.

Loss of Life	Principal Sum Amount
Loss of Both Hands	Principal Sum Amount
Loss of Both Feet	Principal Sum Amount
Loss of Both Eyes	Principal Sum Amount
Loss of One Hand and One Foot	Principal Sum Amount
Loss of One Hand and One Eye	Principal Sum Amount
Loss of One Foot and One Eye	Principal Sum Amount
Loss of One Hand	1/3 of Principal Sum Amount
Loss of One Foot	1/3 of Principal Sum Amount
Loss of One Eye	1/3 of Principal Sum Amount

(Continued on Back)

COMMON CARRIER BENEFITS
If We pay any benefit as a result of an Accidental Injury that occurs when riding as a fare-paying passenger inside a Common Carrier, we will pay an additional benefit equal to the benefit amount paid.

EXCLUSIONS AND LIMITATIONS
We will not pay for loss due to any conditions or circumstances excluded in the Policy. If in the same accident, the Insured Person incurs two or more of the losses listed above, We will pay the Owner only ONE benefit amount. The amount We will pay will be the largest shown for the loss incurred.

If a part of the Principal Sum Amount remains unpaid, We will pay the amount for one listed loss due to a subsequent and separate Accident Injury, but not to exceed the remaining part of the Principal Sum Amount.

The loss of both hands, both feet, both eyes, one hand and one eye, and one foot and one eye, is only payable when the double loss occurs as the result of the same accident.

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

(a) the date on which the Policy to which this Rider is attached lapses or terminates; or

(b) the date when an amount equal to the Rider's Principal Sum Amount is paid for that Insured Person; or

(c) the maximum age for an Insured Child; or

(d) the Expiry Date.

The Rider will be continued for any remaining Insured Persons, after coverage has been terminated for an Insured Person, with the exception that if the Rider's Principal Sum Amount is paid for the Insured, coverage under this Rider will terminate.

The Rider will terminate for all Insured Persons on the earliest of:

(a) the date on which the Policy to which this Rider is attached lapses or terminates; or

(b) the date when an amount equal to the Rider's Principal Sum Amount is paid for the Insured; or

(c) the date requested by Owner in writing to terminate the Policy; or

(d) the Expiry Date.

PREMIUM
The premium for this Rider is shown above. Premiums for this Rider are payable in addition to and under the same conditions as premiums for the Policy or Certificate.

GENERAL
This Rider is a part of the Policy or Certificate to which it is attached. Its Benefits are subject to all the terms of this Rider and the Policy or Certificate. If any term of this Rider should conflict with a term or terms of the policy, the terms in this Rider shall control for Benefits provided in this rider.

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

SECRETARY

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

MEDICAL PERSONNEL HIV BENEFIT RIDER

This Rider is added to and made a part of the Policy or Certificate to which it is attached.

THIS IS A LIMITED BENEFIT RIDER...PLEASE READ IT CAREFULLY

RIDER SCHEDULE

Insured Person - Insured, [Spouse]

Insured - [John Doe]
Age/Gender - [35/Male]

Effective Date - [August 1, 2008]
Maximum Benefit Amount - [$10,000]
Expiry Date - [August 1, 2018]

Premium - [$0.74 Monthly; $7.60 Annually]

The Definitions of the Policy or Certificate to which this Rider is attached will be utilized for this Rider, along with the term defined below.

DEFINITION

The term Human Immunodeficiency Virus (HIV) will also include Acquired Immune Deficiency Syndrome (AIDS), and AIDS Related Complex (ARC).

MEDICAL PERSONNEL HIV BENEFITS

If the Insured Person initially Incurs and is Diagnosed with Human Immunodeficiency Virus (HIV) more than 30 days after the rider's Effective Date, We will pay the Maximum Benefit Amount, shown above, if all of the following conditions are met:

(a) the cause of the HIV must be from an accidental needle stick/sharp injury or by accidental mucous membrane exposure to blood or bloodstained bodily fluid which occurred during the 12 months preceding Diagnosis and while the policy is in force; and

(b) the accident must have occurred while the Insured Person was following his or her normal occupational duties and must have been reported in accordance with the established occupational procedures applicable to the Insured Person for such accidents; and

(c) the Insured Person must have undergone a blood test within five days of the accident which indicated the absence of HIV or antibodies to such virus and must have undergone another blood test within 12 months of the accident indicating the presence of HIV or antibodies to such virus.

PREMIUMS

The premium for this Rider is shown in the Rider Schedule. Premiums for this Rider are payable in addition to and under the same conditions as premiums for the policy.

REINSTATEMENT

If the policy is reinstated at the same time, We will reinstate this Rider subject to the Reinstatement provision in the policy. Except for the above and any new provisions We may require for reinstatement, Your rights and Our rights under this Rider will be the same as just before the Rider lapsed.

(Continued on Back)

INCONTESTABLE
Except for nonpayment of premiums, We will not contest this Rider after it has been in force during the lifetime of the Insured Person for two years from the date of application for this Rider.

TERMINATION
Coverage for the Insured Person provided by this Rider will terminate on the earlier of:

(a) the date coverage provided by the Policy terminates;
(b) the Expiry Date, as shown in the Rider Schedule or the policy anniversary on or following the Insured Person's 70th birthday, whichever occurs first;
(c) at the end of the Grace Period, if any premium for this rider or the policy remains unpaid.

GENERAL
This Rider is part of the Policy or Certificate to which it is attached. Its Benefits are subject to all the terms of this Rider and the Policy. If any term of this Rider should conflict with a term or terms of the Policy or Certificate, the terms in this Rider shall control for Benefits provided in this Rider.

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

SECRETARY

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

UNITED NETWORK OF ORGAN SHARING SCIENTIFIC REGISTRY (UNOS) ENDORSEMENT

This Endorsement is added to and made a part of the Policy or Certificate to which it is attached.

If an Insured Person is placed on the UNOS registry as a potential recipient of a Major Organ Transplant, We will pay 25% of the Critical Illness Maximum Benefit Amount multiplied by the applicable Critical Illness Maximum Benefit Amount Percentage for Major Organ Transplant. This obligation is subject to the Policy's Critical Illness Diagnosis and Benefit Payment Conditions provisions.

If a benefit is paid under this Endorsement and the Insured Person later undergoes the Major Organ Transplant for which the Insured Person was placed on the UNOS registry, the Major Organ Transplant Benefit will be reduced. In such a case, the Major Organ Transplant Benefit will be the lesser of:

(a) the Critical Illness Maximum Benefit Amount multiplied by the applicable Critical Illness Maximum Benefit Percentage multiplied by 75%; or

(b) the Critical Illness Maximum Benefit Amount less any previous benefits.

Termination. This Endorsement is optionally renewable. We reserve the right to terminate this Endorsement. Termination will occur on the earliest of the following:

(a) termination of the Policy or Certificate to which this Endorsement is attached; or

(b) thirty (30) days after written notice of termination by Us has been sent to the Insured's last known address; or

(c) the policy anniversary on or following the Insured's 70th birthday.

This Endorsement is effective on the Date of Issue of the Policy or Certificate.

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

SECRETARY

CRITICAL ILLNESS APPLICATION

American General Life and Accident Insurance Company
American General Center • Nashville, Tennessee 37250-0001

1. Primary Proposed Insured Name (Print full name) John Doe

Address 123 4th Street (Street) Little Rock (City) AR (State) 72203 (Zip Code) USA (County)

Birth Date and Place					Age	Gender
Month	Day	Year	State	Country		
01	01	1973	AR	USA	35	☒ M ☐ F

Social Security No. 111-22-3333

Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced Height & Weight: 6 ft 0 ins 190 lbs

Occupation Mechanic Date of Hire 01/01/2000 How long in Occupation 8 yrs

Name of Employer Joe's Garage

Job Duties repairing cars Annual Earned Income $50,000

Driver's License No. 3456789 State of Issue AR

If no license, please explain why. _____

Answer the following questions if premium mode is payroll deduction.

Length of Time Employed by Named Employer _____ Average No. of Hours Worked per Week in Occupation _____

Is Primary Proposed Insured actively at work and able to perform all regular duties? ☐ Yes ☐ No

If "No," please explain why. _____

2. Plan: Critical Illness

Coverage Period	Proposed Insured(s)	Amounts
☒ 10 years	☒ Primary	$ 10,000
☐ 15 years	☒ Spouse	$ 10,000
☐ 20 years	☒ Child(ren)	$ 10,000
☐ 30 years		
☐ Lifetime		

3. Riders:
- ☐ HIV Rider
  - ☐ Primary ☐ Spouse
- ☐ ADD Rider/Amount
  - ☐ Primary $ _____ ☐ Spouse $ _____
  - ☐ Child(ren) $ _____
- ☐ Other Riders _____

4. a. Premium $ 15.25

b. Billing Mode: ☐ A ☐ S ☐ Q ☒ Other Monthly

- ☒ Automatic Bank Check ☐ Payroll Deduction
- ☐ AG Payroll Deduction (AGLA employees only)
- ☐ Add to existing ABC account, policy no. _____
- ☐ Add to existing PD account no. _____

5. Owner Name (If other than Primary Proposed Insured) _____

Address _____ (Street) (City) (State) (Zip Code)

Social Security No. _____ Relationship to Primary Proposed Insured _____

6. Premium Payor Name (If other than Primary Proposed Insured) _____

Address _____ (Street) (City) (State) (Zip Code)

Occupation _____ Date of Hire _____ How long in Occupation _____

Name of Employer _____

Social Security No. _____ Relationship to Primary Proposed Insured _____

Answer the following questions if premium mode is payroll deduction.

Length of Time Employed by Named Employer _____ Average No. of Hours Worked per Week in Occupation _____

Is the Premium Payor actively at work and able to perform all regular duties? ☐ Yes ☐ No

If "No," please explain why. _____

7. First Beneficiary *Jane Doe* | *Wife* | 33
Name | Relationship | Age

Address _____
Street | City | State | Zip Code

Second Beneficiary _____ | _____ | _____
Name | Relationship | Age

Address _____
Street | City | State | Zip Code

8. Spouse (If coverage applied for)

Name	Birth Date and Place: Month	Day	Year	State	Country	Gender
Jane Doe	01	01	1975	*AR*	*USA*	❑ M ☒ F

Social Security No. 444-55-6666 Age 33 Height & Weight: 5 ft 6 ins 135 lbs

Occupation *Homemaker* Date of Hire _____ How long in Occupation _____

Job Duties _____ Annual Earned Income _____

Driver's License No. 9876543 State of Issue *AR*

If no license, please explain why. _____

9. Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

Full Name	Age	Birth Date Month	Day	Year	Gender	Relationship
a. *John Doe, Jr.*	10	01	01	1998	*M*	*Son*
b.						
c.						
d.						
e.						
f.						

Children under age one: Birth Weight _____ lbs. Current Weight _____ lbs.

BACKGROUND/HEALTH QUESTIONS

10. Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following? ..... YES ❑ NO ☒

If "Yes," check applicable boxes below.

- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)
- ❑ stroke, transient ischemia attacks (TIA)
- ❑ kidney failure, polycystic kidneys, abnormal kidney function
- ❑ glaucoma, macular degeneration, optic neuritis
- ❑ familial adenomatous polyposis (Gardener's Syndrome)
- ❑ cancer, malignant tumor or growth
- ❑ leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma
- ❑ diabetes
- ❑ heart disease
- ❑ Multiple Sclerosis, cerebral palsy, paralysis
- ❑ need for an organ transplant

11. Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company? ..... YES ❑ NO ☒

If "Yes," Insured's Name _____ Co. Name _____

Type of Coverage _____ Amt. of Coverage _____ Pol. No. _____

12. Will the policy applied for replace any existing accident or health insurance? ..... ❑ ☒

If "Yes," Insured's Name _____ Co. Name _____

Type of Coverage _____ Pol. No. _____

13. 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 *Cigarettes* Date of Last Use *08/01/2008* Frequency/Amount *daily/1 pack*

Spouse: Type _____ Date of Last Use _____ Frequency/Amount _____

	YES	NO
14. Within the past 10 years, has any proposed insured been diagnosed as having or treated by a member of the medical profession for any of the following?	❑	❑

If "Yes," check applicable boxes below.

- ❑ high blood pressure
- ❑ polycystic ovary
- ❑ breast tumor(s) or cyst(s)
- ❑ disease or disorder of the blood or circulatory system
- ❑ disease or disorder of the spinal cord
- ❑ disease or disorder of the respiratory system
- ❑ disease or disorder of the digestive system
- ❑ disease or disorder of the liver (including hepatitis B or C)
- ❑ disease or disorder of the nervous system
- ❑ disease or disorder of the musculoskeletal system
- ❑ loss of hearing or speech
- ❑ seizures
- ❑ mental illness
- ❑ congenital anomalies
- ❑ colon polyp(s)
- ❑ blindness
- ❑ a condition related to alcohol or drug use
- ❑ disease or disorder of the kidney
- ❑ heart murmur
- ❑ systemic lupus

	YES	NO
15. a. Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis?	❑	❑
b. Within the past 12 months, has any proposed insured been advised by a member of the medical profession 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?	❑	❑
16. Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's license revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured?	❑	❑
17. 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?	❑	❑
18. Has any proposed insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?	❑	❑
19. Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future?	❑	❑
20. Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future?	❑	❑
21. 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?	❑	❑
22. 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?	❑	❑
The following question is NOT required for Payroll Deduction Mode.		
23. Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits?	❑	❑

If "Yes," Name _____ Type _____

24. **REMARKS** (Explain "Yes" answers to Questions 10-23)

Name of Person(s)	Date	Duration	Details	Name and Addresses of Doctor or Hospitals

FOR HOME OFFICE USE ONLY

OWNER'S CERTIFICATION

Under penalties of perjury, I certify that the following number, 3456789, is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:
(a) I am exempt from backup withholding, or
(b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
(c) the IRS has notified me that I am no longer subject to backup withholding, AND

Under penalties of perjury, I certify that I am a U.S. person (including a U.S. resident alien).

You must cross out item (b) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends in your tax return.

X John Doe — Signature of Owner

August 1, 2008 — Date

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING – NOTICE

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter: **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application. **FURTHER AGREE** to the following: (a) All statements and answers in this application are complete and true to the best of my knowledge and belief. (b) 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. **AUTHORIZE:** (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below. **ACKNOWLEDGE** receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; (c) Investigative Consumer Report; and (d) Outline of Coverage, if applicable. **UNDERSTAND** that: (a) I am applying for a critical illness policy and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable. **NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

PRIMARY PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ❑ I elect NOT to be interviewed.

SPOUSE - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ❑ I elect NOT to be interviewed.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ❑ Yes (Explain) ☒ No

Signed at Little Rock (City) AR (State) August 1 (Date), 2008

X John Doe — SIGNATURE OF PRIMARY PROPOSED INSURED

X Jane Doe — SIGNATURE OF SPOUSE (IF INCLUDED AS A PROPOSED INSURED)

X _____ — SIGNATURE OF OWNER AND RELATIONSHIP (IF OTHER THAN PRIMARY PROPOSED INSURED)

X _____ — SIGNATURE OF WITNESS (IF APPLICABLE)

X Sally Shield — SIGNATURE OF LICENSED AGENT

X Sally Shield — PRINTED NAME OF LICENSED AGENT

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642 for hearing impaired). 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.

American General Life and Accident Insurance 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.

NOTICE OF INFORMATION PRACTICES

American General Life and Accident Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

APPLICATION FOR CRITICAL ILLNESS INSURANCE

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Plan Information (as applied)

Plan Name: *CRITICALCARE PLUS - 15 YEAR - PRIMARY*

Max Benefit Amount *$100,000*

Riders/Benefits:
CRITICALCARE PLUS - 15 YEAR - SPOUSE $90,000
CRITICALCARE PLUS - 15 YEAR - CHILDREN $50,000
MEDICAL PERSONNEL HIV RIDER - PRIMARY $100,000
MEDICAL PERSONNEL HIV RIDER - SPOUSE $90,000
ACCIDENTAL DEATH AND DISMEMBERMENT - PRIMARY $150,000
ACCIDENTAL DEATH AND DISMEMBERMENT - SPOUSE $125,000
ACCIDENTAL DEATH AND DISMEMBERMENT - CHILDREN $25,000

Billing Type: *ABC* **Frequency:** *MONTHLY (M)* **Premium Calculation Age:** *40* **Premium:** *$187.23*

Primary Proposed Insured Information

Name: *JOHN Q DOE*
Street/Box: *123 MAIN STREET*
City, State, Zip: *LITTLE ROCK, AR 37250-0001*
Country: *USA*
Home Phone No.: *(615)749-1000*
Work Phone No.: *(615)749-2222*
Best Time to Call: *HOME 07:00 PM*
WORK 12:00 PM
Annual Earned Income: *$45,000.00*
Occupation Category: *FACTORY/INDUSTRIAL*
Current Occupation: *DAIRY WORKER*
Nature of Business: *AGRICULTURAL PRODUCTION LIVESTOCK AND ANIMAL SPECIALTIES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *MILK COWS*

Social Security No.: *123-45-6789*
Sex: *MALE*
Marital Status: *MARRIED*
Driver's License No.: *123456789*
State of Issue: *AR*
Birth Date: *01-01-1968*
Birth State: *AR*
Birth Country: *USA*
Name of Employer: *ACME DAIRY CO*
Owner Duties: *BOTH*
Date of Hire: *01-01-2008*
Length of Time: *LESS THAN ONE YEAR*
Job Status: *FULL TIME*
Height: *6 ft. 0 in.*
Weight: *190 lbs.*

Is the Proposed Insured the Owner? *NO*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
Is the Primary Proposed Insured actively at work and able to perform all regular duties? *NO*
If No, explain: *BROKEN LEG*
No Driver's License Explanation: *MEDICAL CONDITION PREVENTS DRIVING*

Spouse Information

Name: *JANE R DOE*
Annual Earned Income: *$35,000.00*
Occupation Category: *MANAGEMENT/PROFESSIONAL*
Current Occupation: *TEACHER/PROFESSOR*
Nature of Business: *EDUCATIONAL SERVICES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *TEACH ELEMENTARY*

Social Security No.: *321-54-9876*
Sex: *FEMALE*
Driver's License No.: *987654321*
State of Issue: *AR*
Birth Date: *03-21-1969*
Age: *39*
Birth State: *AR*

Job Status:	*FULL TIME*	**Birth Country:**	*USA*
Name of Employer:	*DAVIDSON CO SCHOOL SYSTEM*	**Length of Time:**	*LESS THAN ONE YEAR*
Date of Hire:	*02-15-2008*	**Owner Duties:**	*BOTH*
		Height:	*5 ft. 5 in.*
		Weight:	*140 lbs.*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
No Driver's License Explanation: *NEVER HAD A LICENSE*

Dependent Information

Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

				Children Under Age One	
Name	**Relationship**	**Birth Date**	**Age**	**Birth Weight**	**Current Weight**
JOE S DOE	*SON*	*02-12-1998*	*10*		

Owner Information

Name:	*JAMES T DOE*	**Relationship:**	*FATHER*
Street/Box:	*321 MAIN STREET*	**Social Security No.:**	*444-08-5577*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
		Best Time to Call:	*HOME 07:00 PM*
			WORK 12:00 PM

Payer Information

Name:	*JOHN Q DOE*	**Relationship:**	*PRIMARY PROPOSED INSURED*
Street/Box:	*123 MAIN STREET*	**Social Security No.:**	*123-45-6789*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
Family Group:	*0004*	**Best Time to Call:**	*HOME 07:00 PM*
			WORK 12:00 PM
Name of Employer:	*ACME DAIRY CO*		
Date of Hire:	*04-12-2005*		

Is the Payer actively at work and able to perform all regular duties? *NO*
If NO, explain: *BROKEN LEG*
Average number of hours worked per week in occupation: *30 OR MORE*

Beneficiary Information, with right to change

Name:	*JANE R DOE*	**Relationship:**	*SPOUSE*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*FIRST*
		Age:	*39*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*
Name:	*JOE S DOE*	**Relationship:**	*SON*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*SECOND*
		Age:	*10*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*

Background Information

1. **Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), stroke, transient ischemia attacks (TIA), kidney failure, polycystic kidneys, abnormal kidney function, glaucoma, macular degeneration, optic neuritis, familial adenomatous polyposis (Gardener's Syndrome), cancer, malignant tumor or growth, leukemia, melanoma,**

	Hodgkin's disease, non-Hodgkin's lymphoma, diabetes, heart disease, Multiple Sclerosis, cerebral palsy, paralysis, need for an organ transplant?	*NO*
2.	**Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company?**	*NO*
3.	**Will the policy applied for replace any existing accident or health insurance?**	*NO*
4.	**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?**	*NO*
5.	**Within the past 10 years, has any proposed insured been diagnosed as having or been treated by a member of the medical profession for any of the following: high blood pressure, polycystic ovary, breast tumor(s) or cyst(s), disease or disorder of the blood or circulatory system, disease or disorder of the spinal cord, disease or disorder of the respiratory system, disease or disorder of the digestive system, disease or disorder of the liver (including hepatitis B or C), disease or disorder of the nervous system, disease or disorder of the musculoskeletal system, loss of hearing or speech, seizures, mental illness, congenital anomalies, colon polyp(s), blindness, a condition related to alcohol or drug use, disease or disorder of the kidney, heart murmur, systemic lupus?**	*NO*
6.	**Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis, or within the past 12 months, been advised by a member of the medical profession 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?**	*NO*
7.	**Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's licensed revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured?**	*NO*
8.	**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?**	*NO*
9.	**Has any proposed insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?**	*NO*
10.	**Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future?**	*NO*
11.	**Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future?**	*NO*
12.	**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?**	*NO*
13.	**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?**	*NO*
14.	**Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits?**	*NO*

Agreement - Authorization - Acknowledgement - Understanding - Notice

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter:

» **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application.

» **FURTHER AGREE** to the following:

(a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
(b) 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.

» **AUTHORIZE:**

(a) the Company to obtain an investigative consumer report on me;
(b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below.

» **ACKNOWLEDGE** receipt of the following notices:
(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes;
(b) MIB Pre-Notice;
(c) Investigative Consumer Report; and
(d) Outline of Coverage, if applicable.

» **UNDERSTAND** that:
(a) I am applying for a critical illness policy and not a major medical insurance policy; and
(b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PRIMARY PROPOSED INSURED:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

SPOUSE:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

Signed at: *Little Rock,* *AR* *08/11/2008 3:03:36 PM* X John Q. Doe
City **State** **Date / Time** **JOHN Q DOE, Primary Proposed Insured**

08/11/2008 3:04:08 PM X Jackson Doe
Date / Time **Witness**

08/11/2008 3:05:02 PM X James T. Doe
Date / Time **JAMES T DOE, Owner**

08/11/2008 3:06:39 PM X Jackson Doe
Date / Time **Witness**

08/11/2008 3:07:12 PM X Jane R. Doe
Date / Time **JANE R DOE, Spouse**

08/11/2008 3:08:31 PM X Jackson Doe
Date / Time **Witness**

Name of Minor Child(ren): *JOE S DOE*

Agent's Certification - Confirmation

Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? *YES*

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

» I confirm that any and all signatures of the Primary Proposed Insured, Spouse, Owner and Witness(es) in this application were signed in my presence.

08/11/2008 3:09:27 PM X *Joseph Turner*

Date / Time **JOSEPH TURNER, Licensed Agent**

APPLICATION FOR CRITICAL ILLNESS INSURANCE

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Plan Information (as applied)

Plan Name: *CRITICALCARE PLUS - 15 YEAR - PRIMARY*

Max Benefit Amount *$100,000*

Riders/Benefits:
CRITICALCARE PLUS - 15 YEAR - SPOUSE $90,000
CRITICALCARE PLUS - 15 YEAR - CHILDREN $50,000
MEDICAL PERSONNEL HIV RIDER - PRIMARY $100,000
MEDICAL PERSONNEL HIV RIDER - SPOUSE $90,000
ACCIDENTAL DEATH AND DISMEMBERMENT - PRIMARY $150,000
ACCIDENTAL DEATH AND DISMEMBERMENT - SPOUSE $125,000
ACCIDENTAL DEATH AND DISMEMBERMENT - CHILDREN $25,000

Billing Type: *ABC* **Frequency:** *MONTHLY (M)* **Premium Calculation Age:** *40* **Premium:** *$187.23*

Primary Proposed Insured Information

Name: *JOHN Q DOE*
Street/Box: *123 MAIN STREET*
City, State, Zip: *LITTLE ROCK, AR 37250-0001*
Country: *USA*
Home Phone No.: *(615)749-1000*
Work Phone No.: *(615)749-2222*
Best Time to Call: *HOME 07:00 PM*
WORK 12:00 PM
Annual Earned Income: *$45,000.00*
Occupation Category: *FACTORY/INDUSTRIAL*
Current Occupation: *DAIRY WORKER*
Nature of Business: *AGRICULTURAL PRODUCTION LIVESTOCK AND ANIMAL SPECIALTIES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *MILK COWS*

Social Security No.: *123-45-6789*
Sex: *MALE*
Marital Status: *MARRIED*
Driver's License No.: *123456789*
State of Issue: *AR*
Birth Date: *01-01-1968*
Birth State: *AR*
Birth Country: *USA*
Name of Employer: *ACME DAIRY CO*
Owner Duties: *BOTH*
Date of Hire: *01-01-2008*
Length of Time: *LESS THAN ONE YEAR*
Job Status: *FULL TIME*
Height: *6 ft. 0 in.*
Weight: *190 lbs.*

Is the Proposed Insured the Owner? *NO*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
Is the Primary Proposed Insured actively at work and able to perform all regular duties? *NO*
If No, explain: *BROKEN LEG*
No Driver's License Explanation: *MEDICAL CONDITION PREVENTS DRIVING*

Spouse Information

Name: *JANE R DOE*
Annual Earned Income: *$35,000.00*
Occupation Category: *MANAGEMENT/PROFESSIONAL*
Current Occupation: *TEACHER/PROFESSOR*
Nature of Business: *EDUCATIONAL SERVICES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *TEACH ELEMENTARY*

Social Security No.: *321-54-9876*
Sex: *FEMALE*
Driver's License No.: *987654321*
State of Issue: *AR*
Birth Date: *03-21-1969*
Age: *39*
Birth State: *AR*

Job Status:	*FULL TIME*	**Birth Country:**	*USA*
Name of Employer:	*DAVIDSON CO SCHOOL SYSTEM*	**Length of Time:**	*LESS THAN ONE YEAR*
Date of Hire:	*02-15-2008*	**Owner Duties:**	*BOTH*
		Height:	*5 ft. 5 in.*
		Weight:	*140 lbs.*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
No Driver's License Explanation: *NEVER HAD A LICENSE*

Dependent Information

Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

				Children Under Age One	
Name	**Relationship**	**Birth Date**	**Age**	**Birth Weight**	**Current Weight**
JOE S DOE	*SON*	*02-12-1998*	*10*		

Owner Information

Name:	*JAMES T DOE*	**Relationship:**	*FATHER*
Street/Box:	*321 MAIN STREET*	**Social Security No.:**	*444-08-5577*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
		Best Time to Call:	*HOME 07:00 PM*
			WORK 12:00 PM

Payer Information

Name:	*JOHN Q DOE*	**Relationship:**	*PRIMARY PROPOSED INSURED*
Street/Box:	*123 MAIN STREET*	**Social Security No.:**	*123-45-6789*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
Family Group:	*0004*	**Best Time to Call:**	*HOME 07:00 PM*
			WORK 12:00 PM
Name of Employer:	*ACME DAIRY CO*		
Date of Hire:	*04-12-2005*		

Is the Payer actively at work and able to perform all regular duties? *NO*
If NO, explain: *BROKEN LEG*
Average number of hours worked per week in occupation: *30 OR MORE*

Beneficiary Information, with right to change

Name:	*JANE R DOE*	**Relationship:**	*SPOUSE*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*FIRST*
		Age:	*39*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*
Name:	*JOE S DOE*	**Relationship:**	*SON*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*SECOND*
		Age:	*10*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*

Background Information

1. **Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), stroke, transient ischemia attacks (TIA), kidney failure, polycystic kidneys, abnormal kidney function, glaucoma, macular degeneration, optic neuritis, familial adenomatous polyposis (Gardener's Syndrome), cancer, malignant tumor or growth, leukemia, melanoma,**

Hodgkin's disease, non-Hodgkin's lymphoma, diabetes, heart disease, Multiple Sclerosis, cerebral palsy, paralysis, need for an organ transplant? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JOHN Q DOE	*DIABETES / LOW BLOOD SUGAR*	*06-2002 / 6 YEAR(S)*	*DR RICHARD JONES 777 8TH AVE N LITTLE ROCK AR 37250-0001 (615) 749-0001*

2. Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company? *YES*

Name	Company Name	Amount / Type	Policy No.
JOHN Q DOE	*ACME LIFE INSURANCE CO*	*$100,000 / LIFE*	*55578AV9*

3. Will the policy applied for replace any existing accident or health insurance? *YES*

Name	Company Name	Amount / Type	Policy No.
JOHN Q DOE	*ABC INSURANCE CO*	*$50,000 / HEALTH*	*AB321987*

4. 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? *YES*

Name	Type	Date of Last Use	Frequency / Amount
JOHN Q DOE	*CIGARS*	*06-2008*	*DAILY / 2 CIGARS*
JANE R DOE	*CIGARETTES*	*06-2008*	*DAILY / 40 CIGARETTES*

5. Within the past 10 years, has any proposed insured been diagnosed as having or been treated by a member of the medical profession for any of the following: high blood pressure, polycystic ovary, breast tumor(s) or cyst(s), disease or disorder of the blood or circulatory system, disease or disorder of the spinal cord, disease or disorder of the respiratory system, disease or disorder of the digestive system, disease or disorder of the liver (including hepatitis B or C), disease or disorder of the nervous system, disease or disorder of the musculoskeletal system, loss of hearing or speech, seizures, mental illness, congenital anomalies, colon polyp(s), blindness, a condition related to alcohol or drug use, disease or disorder of the kidney, heart murmur, systemic lupus? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	*SEIZURES / REACTION TO NEW MEDICINE*	*11-2004 / 2 DAY(S)*	*DR FERN DAVIS 321 MAIN ST LITTLE ROCK AR 37025-0001 (615)749-9876*

6. Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis, or within the past 12 months, been advised by a member of the medical profession 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? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JOHN Q DOE	*FATIGUE / COULDN'T STAY AWAKE DURING THE DAY*	*09-2007 / 4 WEEK(S)*	*DR RICHARD JONES 777 8TH AVE N LITTLE ROCK AR 37250-0001 (615)749-0001*

7. Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's licensed revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured? *YES*

Name	Type / Details	State / License #	Date / Duration
JOHN Q DOE	*DUI / .093 BAC*	*AR / 123456789*	*12-2007*

8. 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*

Name	Details	Date / Duration
JOHN Q DOE	*BROKEN LEG*	*05-2008 / 4 WEEK(S)*

9. 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*

Name	Type / Details	Date / Duration
JOHN Q DOE	*POSTPONED / 45 LBS OVERWEIGHT*	*12-1999 / 4 MONTH(S)*

10. Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future? *YES*

Name	Type / Details	Date / Duration
JANE R DOE	*PILOT / OWNS PRIVATE PLANE. OVER 1000 HOURS RECORDED FLIGHT TIME*	*06-2008 / 4 YEARS(S)*

11. Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future? *YES*

Name	Type / Details	Date / Duration
JOHN Q DOE	*UNDERWATER DIVING / CERTIFIED SCUBA DIVER*	*02-2008 / 3 YEAR(S)*

12. 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? *YES*

Name	Type / Details	Date	Disposition
JANE R DOE	*ROBBERY / AR CASE NO 345987*	*02-1992*	*CONVICTED*

13. 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? *YES*

Name	Age at Onset/Living or Deceased/ If Deceased, Age at Death	Type / Details	Relationship
JANE R DOE	*52 / DECEASED / 64*	*CANCER / OVARIAN CANCER*	*MOTHER*

14. Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits? *YES*

Name	Type
JOHN Q DOE	*SUPPLEMENTAL SECURITY INCOME (SSI)*

Agreement - Authorization - Acknowledgement - Understanding - Notice

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter:

» **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application.

» **FURTHER AGREE** to the following:

(a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
(b) 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.

» **AUTHORIZE:**

(a) the Company to obtain an investigative consumer report on me;
(b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below.

» **ACKNOWLEDGE** receipt of the following notices:
(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes;
(b) MIB Pre-Notice;
(c) Investigative Consumer Report; and
(d) Outline of Coverage, if applicable.

» **UNDERSTAND** that:
(a) I am applying for a critical illness policy and not a major medical insurance policy; and
(b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PRIMARY PROPOSED INSURED:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

SPOUSE:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

Signed at: *Little Rock,* *AR* *08/19/2008 3:03:36 PM* X *John Q. Doe*
City **State** **Date / Time** **JOHN Q DOE, Primary Proposed Insured**

08/19/2008 3:04:08 PM X *Jackson Doe*
Date / Time **Witness**

08/19/2008 3:05:02 PM X *James T. Doe*
Date / Time **JAMES T DOE, Owner**

08/19/2008 3:06:39 PM X *Jackson Doe*
Date / Time **Witness**

08/19/2008 3:07:12 PM X *Jane R. Doe*
Date / Time **JANE R DOE, Spouse**

08/19/2008 3:08:31 PM X *Jackson Doe*
Date / Time **Witness**

Name of Minor Child(ren): *JOE S DOE*

Agent's Certification - Confirmation

Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? *YES*

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

» I confirm that any and all signatures of the Primary Proposed Insured, Spouse, Owner and Witness(es) in this application were signed in my presence.

08/19/2008 3:09:27 PM X *Joseph Turner*

Date / Time **JOSEPH TURNER, Licensed Agent**

AGENT'S REPORT

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Contact Source:	*REFERRAL-FRIEND*
Application Origination:	*INSURANCE REVIEW*
Anticipated Effective Date: *Payroll Deduction Mode Only*	*09-15-2008*
What is your relationship to the proposed insured(s)?	*NO RELATIONSHIP*
Is more than one application being submitted at this time or is there any other application pending?	*YES*
LIFE APPLICATION PENDING	
Did you personally see all proposed insured(s) when application was written?	*YES*
Do you have any knowledge of any unfavorable information regarding the proposed insured(s) which has not been fully disclosed in the application?	*YES*
INSURED KNOWN TO ASSOCIATE WITH DRUG DEALERS	
Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance?	*YES*
Are there to be split commissions with another agent?	*YES*
Agent's Name:	*JOHN R ABERCROMBIE*
Agent's ID:	*R005566*
Percentage of split:	*78%*
Agent's Name:	*WANDA G ROBINSON*
Agent's ID:	*R994422*
Percentage of split:	*22%*
Agent's daytime phone number:	*(615)749-3000*
Agent's e-mail address:	*agent01@gmail.com*

Agent's Remarks:
PLEASE ISSUE WITH MAY DATE IF POSSIBLE.

08/19/2008 3:09:27 PM X Joseph Turner
Date / Time **JOSEPH TURNER, Licensed Agent**
AR010097

Rate Information

Rate data does NOT apply to filing.

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 08/27/2008

Comments:

Attachments:

87-1.pdf
AGLA120Z49 REV0807.pdf
ARCERT2.pdf
ARCERT5.pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 08/27/2008

Comments:

These applications are also attached under the Form Schedule Tab for approval.

Attachments:

1000-2C-AR JD.pdf
1000E-2C-AR No.pdf
1000E-2C-AR Yes.pdf

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 08/27/2008

Comments:

These outlines of coverage are also attached under the Form Schedule Tab for approval.

Attachments:

1060CI-AR.pdf
AGLA1060-OCI-AR(0808).pdf

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY
A Member Company of American International Group, Inc.
American General Center • Nashville, Tennessee 37250-0001
(615) 749-1523

Service for the attached policy will be provided by:

The Arkansas Department of Insurance has requested we provide you with the addresses and telephone numbers, as follow:

Customer Services
American General Life and Accident Insurance Company
American General Center - 305N
Nashville, Tennessee 37250
PH: 1-800-888-2452

State of Arkansas
Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904
PH: 1-800-852-5494

LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well-managed and financially stable.

DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health Insurance Guaranty Association
c/o The Liquidation Division
1023 West Capitol
Little Rock, Arkansas 72201

Arkansas Insurance Department
1200 West Third Street
Little Rock, Arkansas 72201-1904

(please turn to back of page)

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or health insurance contract or policy, or if they are insured under a group insurance contract, issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

EXCLUSIONS FROM COVERAGE

However, persons owning such policies are **NOT** protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does **NOT** provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals).
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC")(whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

LIMITS ON AMOUNT OF COVERAGE

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of $300,000 - no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall $300,000 limit, the Association will not pay more than $300,000 in health insurance benefits, $300,000 in present value of annuity benefits, or $300,000 in life insurance death benefits or net cash surrender values - again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a $1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.

American General Life and Accident Insurance Company

A member company of American International Group, Inc.

American General Center • Nashville, Tennessee 37250-0001

AIG® AMERICAN GENERAL

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

ARKANSAS CERTIFICATION

Subject:	AGLA 91008 R	Critical Illness Policy
	AGLA1060-CI-AR (0808)	Outline of Coverage
	AGLA1060-OCI-AR (0808)	Outline of coverage (If Issued Other Than As Applied For)
	AGLA 91208	Accidental Death and Dismemberment Rider
	AGLA 91308	Medical Personnel HIV Benefit Rider
	AGLA 91408	Endorsement
	AGLA 1000-2C-AR (0508)	Critical Illness Application
	AGLA 1000E-2C-AR (0508)	Critical Illness Application

This is to certify that, to the best of my knowledge and belief, the above forms comply with the requirements of Ark. Stat. Ann. 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Leo W. Grace
Vice President

DATE: August 22, 2008

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

ARKANSAS CERTIFICATION

Subject:	AGLA 91008 R	Critical Illness Policy
	AGLA1060-CI-AR (0808)	Outline of Coverage
	AGLA1060-OCI-AR (0808)	Outline of coverage (If Issued Other Than As Applied For)
	AGLA 91208	Accidental Death and Dismemberment Rider
	AGLA 91308	Medical Personnel HIV Benefit Rider
	AGLA 91408	Endorsement
	AGLA 1000-2C-AR (0508)	Critical Illness Application
	AGLA 1000E-2C-AR (0508)	Critical Illness Application

This is to certify that the above form, to the best of my knowledge and belief, meets the provision of Arkansas Rule and Regulation 19 as well as all applicable requirements of the State of Arkansas Department of Insurance.

Leo W. Grace
Vice President

DATE: August 22, 2008

CRITICAL ILLNESS APPLICATION

American General Life and Accident Insurance Company
American General Center • Nashville, Tennessee 37250-0001

1. Primary Proposed Insured Name (Print full name) John Doe

Address 123 4th Street (Street) Little Rock (City) AR (State) 72203 (Zip Code) USA (County)

Birth Date and Place					Age	Gender
Month	Day	Year	State	Country		
01	01	1973	AR	USA	35	☒ M ☐ F

Social Security No. 111-22-3333

Marital Status: ☐ Single ☒ Married ☐ Widowed ☐ Divorced Height & Weight: 6 ft 0 ins 190 lbs

Occupation Mechanic Date of Hire 01/01/2000 How long in Occupation 8 yrs

Name of Employer Joe's Garage

Job Duties repairing cars Annual Earned Income $50,000

Driver's License No. 3456789 State of Issue AR

If no license, please explain why. _____

Answer the following questions if premium mode is payroll deduction.

Length of Time Employed by Named Employer _____ Average No. of Hours Worked per Week in Occupation _____

Is Primary Proposed Insured actively at work and able to perform all regular duties? ☐ Yes ☐ No

If "No," please explain why. _____

2. Plan: Critical Illness

Coverage Period	Proposed Insured(s)	Amounts
☒ 10 years	☒ Primary	$ 10,000
☐ 15 years	☒ Spouse	$ 10,000
☐ 20 years	☒ Child(ren)	$ 10,000
☐ 30 years		
☐ Lifetime		

3. Riders:
- ☐ HIV Rider
  - ☐ Primary ☐ Spouse
- ☐ ADD Rider/Amount
  - ☐ Primary $ _____ ☐ Spouse $ _____
  - ☐ Child(ren) $ _____
- ☐ Other Riders _____

4. a. Premium $ 15.25

b. Billing Mode: ☐ A ☐ S ☐ Q ☒ Other Monthly

- ☒ Automatic Bank Check ☐ Payroll Deduction
- ☐ AG Payroll Deduction (AGLA employees only)
- ☐ Add to existing ABC account, policy no. _____
- ☐ Add to existing PD account no. _____

5. Owner Name (If other than Primary Proposed Insured) _____

Address _____ (Street) (City) (State) (Zip Code)

Social Security No. _____ Relationship to Primary Proposed Insured _____

6. Premium Payor Name (If other than Primary Proposed Insured) _____

Address _____ (Street) (City) (State) (Zip Code)

Occupation _____ Date of Hire _____ How long in Occupation _____

Name of Employer _____

Social Security No. _____ Relationship to Primary Proposed Insured _____

Answer the following questions if premium mode is payroll deduction.

Length of Time Employed by Named Employer _____ Average No. of Hours Worked per Week in Occupation _____

Is the Premium Payor actively at work and able to perform all regular duties? ☐ Yes ☐ No

If "No," please explain why. _____

7. First Beneficiary *Jane Doe* | *Wife* | 33
Name | Relationship | Age

Address _____
Street | City | State | Zip Code

Second Beneficiary _____ | _____ | _____
Name | Relationship | Age

Address _____
Street | City | State | Zip Code

8. Spouse (If coverage applied for)

Name	Birth Date and Place: Month	Day	Year	State	Country	Gender
Jane Doe	01	01	1975	*AR*	*USA*	❑ M ☒ F

Social Security No. 444-55-6666 Age 33 Height & Weight: 5 ft 6 ins 135 lbs

Occupation *Homemaker* Date of Hire _____ How long in Occupation _____

Job Duties _____ Annual Earned Income _____

Driver's License No. 9876543 State of Issue *AR*

If no license, please explain why. _____

9. Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

Full Name	Age	Birth Date Month	Day	Year	Gender	Relationship
a. *John Doe, Jr.*	10	01	01	1998	*M*	*Son*
b.						
c.						
d.						
e.						
f.						

Children under age one: Birth Weight _____ lbs. Current Weight _____ lbs.

BACKGROUND/HEALTH QUESTIONS

10. Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following? ..... YES ❑ NO ☒

If "Yes," check applicable boxes below.

- ❑ Human Immunodeficiency Virus (HIV)
- ❑ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC)
- ❑ stroke, transient ischemia attacks (TIA)
- ❑ kidney failure, polycystic kidneys, abnormal kidney function
- ❑ glaucoma, macular degeneration, optic neuritis
- ❑ familial adenomatous polyposis (Gardener's Syndrome)
- ❑ cancer, malignant tumor or growth
- ❑ leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma
- ❑ diabetes
- ❑ heart disease
- ❑ Multiple Sclerosis, cerebral palsy, paralysis
- ❑ need for an organ transplant

11. Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company? ..... YES ❑ NO ☒

If "Yes," Insured's Name _____ Co. Name _____

Type of Coverage _____ Amt. of Coverage _____ Pol. No. _____

12. Will the policy applied for replace any existing accident or health insurance? ..... ❑ ☒

If "Yes," Insured's Name _____ Co. Name _____

Type of Coverage _____ Pol. No. _____

13. 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 *Cigarettes* Date of Last Use *08/01/2008* Frequency/Amount *daily/1 pack*

Spouse: Type _____ Date of Last Use _____ Frequency/Amount _____

	YES	NO
14. Within the past 10 years, has any proposed insured been diagnosed as having or treated by a member of the medical profession for any of the following?	❑	❑

If "Yes," check applicable boxes below.

- ❑ high blood pressure
- ❑ polycystic ovary
- ❑ breast tumor(s) or cyst(s)
- ❑ disease or disorder of the blood or circulatory system
- ❑ disease or disorder of the spinal cord
- ❑ disease or disorder of the respiratory system
- ❑ disease or disorder of the digestive system
- ❑ disease or disorder of the liver (including hepatitis B or C)
- ❑ disease or disorder of the nervous system
- ❑ disease or disorder of the musculoskeletal system
- ❑ loss of hearing or speech
- ❑ seizures
- ❑ mental illness
- ❑ congenital anomalies
- ❑ colon polyp(s)
- ❑ blindness
- ❑ a condition related to alcohol or drug use
- ❑ disease or disorder of the kidney
- ❑ heart murmur
- ❑ systemic lupus

	YES	NO
15. a. Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis?	❑	❑
b. Within the past 12 months, has any proposed insured been advised by a member of the medical profession 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?	❑	❑
16. Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's license revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured?	❑	❑
17. 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?	❑	❑
18. Has any proposed insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?	❑	❑
19. Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future?	❑	❑
20. Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future?	❑	❑
21. 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?	❑	❑
22. 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?	❑	❑
The following question is NOT required for Payroll Deduction Mode.		
23. Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits?	❑	❑

If "Yes," Name _____ Type _____

24. **REMARKS** (Explain "Yes" answers to Questions 10-23)

Name of Person(s)	Date	Duration	Details	Name and Addresses of Doctor or Hospitals

FOR HOME OFFICE USE ONLY

OWNER'S CERTIFICATION

Under penalties of perjury, I certify that the following number, 3456789, is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:
(a) I am exempt from backup withholding, or
(b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
(c) the IRS has notified me that I am no longer subject to backup withholding, AND

Under penalties of perjury, I certify that I am a U.S. person (including a U.S. resident alien).

You must cross out item (b) above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends in your tax return.

X John Doe — Signature of Owner

August 1, 2008 — Date

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING – NOTICE

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter: **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application. **FURTHER AGREE** to the following: (a) All statements and answers in this application are complete and true to the best of my knowledge and belief. (b) 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. **AUTHORIZE:** (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below. **ACKNOWLEDGE** receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; (c) Investigative Consumer Report; and (d) Outline of Coverage, if applicable. **UNDERSTAND** that: (a) I am applying for a critical illness policy and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable. **NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

PRIMARY PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ❑ I elect NOT to be interviewed.

SPOUSE - If an investigative consumer report is prepared in connection with this application:
☒ I elect to be interviewed. ❑ I elect NOT to be interviewed.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ❑ Yes (Explain) ☒ No

Signed at Little Rock (City) AR (State) August 1 (Date), 2008

X John Doe — SIGNATURE OF PRIMARY PROPOSED INSURED

X Jane Doe — SIGNATURE OF SPOUSE (IF INCLUDED AS A PROPOSED INSURED)

X _____ — SIGNATURE OF OWNER AND RELATIONSHIP (IF OTHER THAN PRIMARY PROPOSED INSURED)

X _____ — SIGNATURE OF WITNESS (IF APPLICABLE)

X Sally Shield — SIGNATURE OF LICENSED AGENT

X Sally Shield — PRINTED NAME OF LICENSED AGENT

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life and Accident Insurance Company, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642 for hearing impaired). 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.

American General Life and Accident Insurance 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.

NOTICE OF INFORMATION PRACTICES

American General Life and Accident Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes)

APPLICATION FOR CRITICAL ILLNESS INSURANCE

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Plan Information (as applied)

Plan Name: *CRITICALCARE PLUS - 15 YEAR - PRIMARY*

Max Benefit Amount *$100,000*

Riders/Benefits:
CRITICALCARE PLUS - 15 YEAR - SPOUSE $90,000
CRITICALCARE PLUS - 15 YEAR - CHILDREN $50,000
MEDICAL PERSONNEL HIV RIDER - PRIMARY $100,000
MEDICAL PERSONNEL HIV RIDER - SPOUSE $90,000
ACCIDENTAL DEATH AND DISMEMBERMENT - PRIMARY $150,000
ACCIDENTAL DEATH AND DISMEMBERMENT - SPOUSE $125,000
ACCIDENTAL DEATH AND DISMEMBERMENT - CHILDREN $25,000

Billing Type: *ABC* **Frequency:** *MONTHLY (M)* **Premium Calculation Age:** *40* **Premium:** *$187.23*

Primary Proposed Insured Information

Name: *JOHN Q DOE*
Street/Box: *123 MAIN STREET*
City, State, Zip: *LITTLE ROCK, AR 37250-0001*
Country: *USA*
Home Phone No.: *(615)749-1000*
Work Phone No.: *(615)749-2222*
Best Time to Call: *HOME 07:00 PM*
WORK 12:00 PM
Annual Earned Income: *$45,000.00*
Occupation Category: *FACTORY/INDUSTRIAL*
Current Occupation: *DAIRY WORKER*
Nature of Business: *AGRICULTURAL PRODUCTION LIVESTOCK AND ANIMAL SPECIALTIES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *MILK COWS*

Social Security No.: *123-45-6789*
Sex: *MALE*
Marital Status: *MARRIED*
Driver's License No.: *123456789*
State of Issue: *AR*
Birth Date: *01-01-1968*
Birth State: *AR*
Birth Country: *USA*
Name of Employer: *ACME DAIRY CO*
Owner Duties: *BOTH*
Date of Hire: *01-01-2008*
Length of Time: *LESS THAN ONE YEAR*
Job Status: *FULL TIME*
Height: *6 ft. 0 in.*
Weight: *190 lbs.*

Is the Proposed Insured the Owner? *NO*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
Is the Primary Proposed Insured actively at work and able to perform all regular duties? *NO*
If No, explain: *BROKEN LEG*
No Driver's License Explanation: *MEDICAL CONDITION PREVENTS DRIVING*

Spouse Information

Name: *JANE R DOE*
Annual Earned Income: *$35,000.00*
Occupation Category: *MANAGEMENT/PROFESSIONAL*
Current Occupation: *TEACHER/PROFESSOR*
Nature of Business: *EDUCATIONAL SERVICES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *TEACH ELEMENTARY*

Social Security No.: *321-54-9876*
Sex: *FEMALE*
Driver's License No.: *987654321*
State of Issue: *AR*
Birth Date: *03-21-1969*
Age: *39*
Birth State: *AR*

Job Status:	*FULL TIME*	**Birth Country:**	*USA*
Name of Employer:	*DAVIDSON CO SCHOOL SYSTEM*	**Length of Time:**	*LESS THAN ONE YEAR*
Date of Hire:	*02-15-2008*	**Owner Duties:**	*BOTH*
		Height:	*5 ft. 5 in.*
		Weight:	*140 lbs.*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
No Driver's License Explanation: *NEVER HAD A LICENSE*

Dependent Information

Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

				Children Under Age One	
Name	**Relationship**	**Birth Date**	**Age**	**Birth Weight**	**Current Weight**
JOE S DOE	*SON*	*02-12-1998*	*10*		

Owner Information

Name:	*JAMES T DOE*	**Relationship:**	*FATHER*
Street/Box:	*321 MAIN STREET*	**Social Security No.:**	*444-08-5577*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
		Best Time to Call:	*HOME 07:00 PM*
			WORK 12:00 PM

Payer Information

Name:	*JOHN Q DOE*	**Relationship:**	*PRIMARY PROPOSED INSURED*
Street/Box:	*123 MAIN STREET*	**Social Security No.:**	*123-45-6789*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
Family Group:	*0004*	**Best Time to Call:**	*HOME 07:00 PM*
			WORK 12:00 PM
Name of Employer:	*ACME DAIRY CO*		
Date of Hire:	*04-12-2005*		

Is the Payer actively at work and able to perform all regular duties? *NO*
If NO, explain: *BROKEN LEG*
Average number of hours worked per week in occupation: *30 OR MORE*

Beneficiary Information, with right to change

Name:	*JANE R DOE*	**Relationship:**	*SPOUSE*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*FIRST*
		Age:	*39*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*
Name:	*JOE S DOE*	**Relationship:**	*SON*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*SECOND*
		Age:	*10*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*

Background Information

1. **Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), stroke, transient ischemia attacks (TIA), kidney failure, polycystic kidneys, abnormal kidney function, glaucoma, macular degeneration, optic neuritis, familial adenomatous polyposis (Gardener's Syndrome), cancer, malignant tumor or growth, leukemia, melanoma,**

	Hodgkin's disease, non-Hodgkin's lymphoma, diabetes, heart disease, Multiple Sclerosis, cerebral palsy, paralysis, need for an organ transplant?	*NO*
2.	**Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company?**	*NO*
3.	**Will the policy applied for replace any existing accident or health insurance?**	*NO*
4.	**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?**	*NO*
5.	**Within the past 10 years, has any proposed insured been diagnosed as having or been treated by a member of the medical profession for any of the following: high blood pressure, polycystic ovary, breast tumor(s) or cyst(s), disease or disorder of the blood or circulatory system, disease or disorder of the spinal cord, disease or disorder of the respiratory system, disease or disorder of the digestive system, disease or disorder of the liver (including hepatitis B or C), disease or disorder of the nervous system, disease or disorder of the musculoskeletal system, loss of hearing or speech, seizures, mental illness, congenital anomalies, colon polyp(s), blindness, a condition related to alcohol or drug use, disease or disorder of the kidney, heart murmur, systemic lupus?**	*NO*
6.	**Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis, or within the past 12 months, been advised by a member of the medical profession 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?**	*NO*
7.	**Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's licensed revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured?**	*NO*
8.	**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?**	*NO*
9.	**Has any proposed insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?**	*NO*
10.	**Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future?**	*NO*
11.	**Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future?**	*NO*
12.	**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?**	*NO*
13.	**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?**	*NO*
14.	**Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits?**	*NO*

Agreement - Authorization - Acknowledgement - Understanding - Notice

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter:

» **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application.

» **FURTHER AGREE** to the following:

(a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
(b) 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.

» **AUTHORIZE:**

(a) the Company to obtain an investigative consumer report on me;
(b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below.

» **ACKNOWLEDGE** receipt of the following notices:
(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes;
(b) MIB Pre-Notice;
(c) Investigative Consumer Report; and
(d) Outline of Coverage, if applicable.

» **UNDERSTAND** that:
(a) I am applying for a critical illness policy and not a major medical insurance policy; and
(b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

PRIMARY PROPOSED INSURED:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

SPOUSE:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

Signed at: *Little Rock,* *AR* *08/11/2008 3:03:36 PM* X John Q. Doe
City **State** **Date / Time** **JOHN Q DOE, Primary Proposed Insured**

08/11/2008 3:04:08 PM X Jackson Doe
Date / Time **Witness**

08/11/2008 3:05:02 PM X James T. Doe
Date / Time **JAMES T DOE, Owner**

08/11/2008 3:06:39 PM X Jackson Doe
Date / Time **Witness**

08/11/2008 3:07:12 PM X Jane R. Doe
Date / Time **JANE R DOE, Spouse**

08/11/2008 3:08:31 PM X Jackson Doe
Date / Time **Witness**

Name of Minor Child(ren): *JOE S DOE*

Agent's Certification - Confirmation

Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? *YES*

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

» I confirm that any and all signatures of the Primary Proposed Insured, Spouse, Owner and Witness(es) in this application were signed in my presence.

08/11/2008 3:09:27 PM X *Joseph Turner*

Date / Time **JOSEPH TURNER, Licensed Agent**

APPLICATION FOR CRITICAL ILLNESS INSURANCE

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Plan Information (as applied)

Plan Name: *CRITICALCARE PLUS - 15 YEAR - PRIMARY*

Max Benefit Amount *$100,000*

Riders/Benefits:
CRITICALCARE PLUS - 15 YEAR - SPOUSE $90,000
CRITICALCARE PLUS - 15 YEAR - CHILDREN $50,000
MEDICAL PERSONNEL HIV RIDER - PRIMARY $100,000
MEDICAL PERSONNEL HIV RIDER - SPOUSE $90,000
ACCIDENTAL DEATH AND DISMEMBERMENT - PRIMARY $150,000
ACCIDENTAL DEATH AND DISMEMBERMENT - SPOUSE $125,000
ACCIDENTAL DEATH AND DISMEMBERMENT - CHILDREN $25,000

Billing Type: *ABC* **Frequency:** *MONTHLY (M)* **Premium Calculation Age:** *40* **Premium:** *$187.23*

Primary Proposed Insured Information

Name: *JOHN Q DOE*
Street/Box: *123 MAIN STREET*
City, State, Zip: *LITTLE ROCK, AR 37250-0001*
Country: *USA*
Home Phone No.: *(615)749-1000*
Work Phone No.: *(615)749-2222*
Best Time to Call: *HOME 07:00 PM*
WORK 12:00 PM
Annual Earned Income: *$45,000.00*
Occupation Category: *FACTORY/INDUSTRIAL*
Current Occupation: *DAIRY WORKER*
Nature of Business: *AGRICULTURAL PRODUCTION LIVESTOCK AND ANIMAL SPECIALTIES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *MILK COWS*

Social Security No.: *123-45-6789*
Sex: *MALE*
Marital Status: *MARRIED*
Driver's License No.: *123456789*
State of Issue: *AR*
Birth Date: *01-01-1968*
Birth State: *AR*
Birth Country: *USA*
Name of Employer: *ACME DAIRY CO*
Owner Duties: *BOTH*
Date of Hire: *01-01-2008*
Length of Time: *LESS THAN ONE YEAR*
Job Status: *FULL TIME*
Height: *6 ft. 0 in.*
Weight: *190 lbs.*

Is the Proposed Insured the Owner? *NO*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
Is the Primary Proposed Insured actively at work and able to perform all regular duties? *NO*
If No, explain: *BROKEN LEG*
No Driver's License Explanation: *MEDICAL CONDITION PREVENTS DRIVING*

Spouse Information

Name: *JANE R DOE*
Annual Earned Income: *$35,000.00*
Occupation Category: *MANAGEMENT/PROFESSIONAL*
Current Occupation: *TEACHER/PROFESSOR*
Nature of Business: *EDUCATIONAL SERVICES*
Most Recent Occupation: *COMPUTER PROGRAMMER*
Job Duties: *TEACH ELEMENTARY*

Social Security No.: *321-54-9876*
Sex: *FEMALE*
Driver's License No.: *987654321*
State of Issue: *AR*
Birth Date: *03-21-1969*
Age: *39*
Birth State: *AR*

Job Status:	*FULL TIME*	**Birth Country:**	*USA*
Name of Employer:	*DAVIDSON CO SCHOOL SYSTEM*	**Length of Time:**	*LESS THAN ONE YEAR*
Date of Hire:	*02-15-2008*	**Owner Duties:**	*BOTH*
		Height:	*5 ft. 5 in.*
		Weight:	*140 lbs.*

Length of time employed for named Employer: *LESS THAN ONE YEAR*
Average number of hours worked per week in occupation: *30 OR MORE*
No Driver's License Explanation: *NEVER HAD A LICENSE*

Dependent Information

Enter names of unmarried, dependent child(ren), legally adopted child(ren) and stepchild(ren) under age 18 for whom insurance coverage is being requested in this application. Note: The biological/adoptive parent must also be proposed for coverage.

				Children Under Age One	
Name	**Relationship**	**Birth Date**	**Age**	**Birth Weight**	**Current Weight**
JOE S DOE	*SON*	*02-12-1998*	*10*		

Owner Information

Name:	*JAMES T DOE*	**Relationship:**	*FATHER*
Street/Box:	*321 MAIN STREET*	**Social Security No.:**	*444-08-5577*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
		Best Time to Call:	*HOME 07:00 PM*
			WORK 12:00 PM

Payer Information

Name:	*JOHN Q DOE*	**Relationship:**	*PRIMARY PROPOSED INSURED*
Street/Box:	*123 MAIN STREET*	**Social Security No.:**	*123-45-6789*
		Home Phone:	*(615)749-1000*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Work Phone:**	*(615)749-2222*
Family Group:	*0004*	**Best Time to Call:**	*HOME 07:00 PM*
			WORK 12:00 PM
Name of Employer:	*ACME DAIRY CO*		
Date of Hire:	*04-12-2005*		

Is the Payer actively at work and able to perform all regular duties? *NO*
If NO, explain: *BROKEN LEG*
Average number of hours worked per week in occupation: *30 OR MORE*

Beneficiary Information, with right to change

Name:	*JANE R DOE*	**Relationship:**	*SPOUSE*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*FIRST*
		Age:	*39*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*
Name:	*JOE S DOE*	**Relationship:**	*SON*
Street/Box:	*123 MAIN STREET*	**Beneficiary Class:**	*SECOND*
		Age:	*10*
City, State, Zip:	*LITTLE ROCK, AR 37250-0001*	**Beneficiary Type:**	*INDIVIDUAL*

Background Information

1. **Has any proposed insured ever been diagnosed as having or been treated by a member of the medical profession for any of the following: Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), stroke, transient ischemia attacks (TIA), kidney failure, polycystic kidneys, abnormal kidney function, glaucoma, macular degeneration, optic neuritis, familial adenomatous polyposis (Gardener's Syndrome), cancer, malignant tumor or growth, leukemia, melanoma,**

Hodgkin's disease, non-Hodgkin's lymphoma, diabetes, heart disease, Multiple Sclerosis, cerebral palsy, paralysis, need for an organ transplant? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JOHN Q DOE	*DIABETES / LOW BLOOD SUGAR*	*06-2002 / 6 YEAR(S)*	*DR RICHARD JONES 777 8TH AVE N LITTLE ROCK AR 37250-0001 (615) 749-0001*

2. Does any proposed insured have any life or health insurance in force or currently applied for with this Company or any other company? *YES*

Name	Company Name	Amount / Type	Policy No.
JOHN Q DOE	*ACME LIFE INSURANCE CO*	*$100,000 / LIFE*	*55578AV9*

3. Will the policy applied for replace any existing accident or health insurance? *YES*

Name	Company Name	Amount / Type	Policy No.
JOHN Q DOE	*ABC INSURANCE CO*	*$50,000 / HEALTH*	*AB321987*

4. 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? *YES*

Name	Type	Date of Last Use	Frequency / Amount
JOHN Q DOE	*CIGARS*	*06-2008*	*DAILY / 2 CIGARS*
JANE R DOE	*CIGARETTES*	*06-2008*	*DAILY / 40 CIGARETTES*

5. Within the past 10 years, has any proposed insured been diagnosed as having or been treated by a member of the medical profession for any of the following: high blood pressure, polycystic ovary, breast tumor(s) or cyst(s), disease or disorder of the blood or circulatory system, disease or disorder of the spinal cord, disease or disorder of the respiratory system, disease or disorder of the digestive system, disease or disorder of the liver (including hepatitis B or C), disease or disorder of the nervous system, disease or disorder of the musculoskeletal system, loss of hearing or speech, seizures, mental illness, congenital anomalies, colon polyp(s), blindness, a condition related to alcohol or drug use, disease or disorder of the kidney, heart murmur, systemic lupus? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	*SEIZURES / REACTION TO NEW MEDICINE*	*11-2004 / 2 DAY(S)*	*DR FERN DAVIS 321 MAIN ST LITTLE ROCK AR 37025-0001 (615)749-9876*

6. Within the past 24 months, has any proposed insured experienced unexplained weight loss, dizziness, fatigue, numbness, or paralysis, or within the past 12 months, been advised by a member of the medical profession 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? *YES*

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JOHN Q DOE	*FATIGUE / COULDN'T STAY AWAKE DURING THE DAY*	*09-2007 / 4 WEEK(S)*	*DR RICHARD JONES 777 8TH AVE N LITTLE ROCK AR 37250-0001 (615)749-0001*

7. Within the past 24 months, has any proposed insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's licensed revoked or suspended, or within the past 3 years, had multiple moving violations in any vehicle(s) operated by the proposed insured? *YES*

Name	Type / Details	State / License #	Date / Duration
JOHN Q DOE	*DUI / .093 BAC*	*AR / 123456789*	*12-2007*

8. 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*

Name	Details	Date / Duration
JOHN Q DOE	*BROKEN LEG*	*05-2008 / 4 WEEK(S)*

9. 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*

Name	Type / Details	Date / Duration
JOHN Q DOE	*POSTPONED / 45 LBS OVERWEIGHT*	*12-1999 / 4 MONTH(S)*

10. Within the past 24 months, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the future? *YES*

Name	Type / Details	Date / Duration
JANE R DOE	*PILOT / OWNS PRIVATE PLANE. OVER 1000 HOURS RECORDED FLIGHT TIME*	*06-2008 / 4 YEARS(S)*

11. Within the past 12 months, has any proposed insured engaged in parachuting, hang gliding, underwater diving, the racing of any motor powered land vehicle or watercraft, or avocation generally considered dangerous or does any proposed insured have any intentions to do so in the future? *YES*

Name	Type / Details	Date / Duration
JOHN Q DOE	*UNDERWATER DIVING / CERTIFIED SCUBA DIVER*	*02-2008 / 3 YEAR(S)*

12. 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? *YES*

Name	Type / Details	Date	Disposition
JANE R DOE	*ROBBERY / AR CASE NO 345987*	*02-1992*	*CONVICTED*

13. 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? *YES*

Name	Age at Onset/Living or Deceased/ If Deceased, Age at Death	Type / Details	Relationship
JANE R DOE	*52 / DECEASED / 64*	*CANCER / OVARIAN CANCER*	*MOTHER*

14. Has any proposed insured applied for or does any proposed insured currently receive Temporary Assistance for Needy Families (TANF) or Supplemental Security Income (SSI) benefits? *YES*

Name	Type
JOHN Q DOE	*SUPPLEMENTAL SECURITY INCOME (SSI)*

Agreement - Authorization - Acknowledgement - Understanding - Notice

I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter:

» **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 and Accident Insurance Company ("The Company") will have no further liability regarding this application.

» **FURTHER AGREE** to the following:

(a) All statements and answers in this application are complete and true to the best of my knowledge and belief.
(b) 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.

» **AUTHORIZE:**

(a) the Company to obtain an investigative consumer report on me;
(b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for 24 months from the date shown below.

» **ACKNOWLEDGE** receipt of the following notices:
(a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes;
(b) MIB Pre-Notice;
(c) Investigative Consumer Report; and
(d) Outline of Coverage, if applicable.

» **UNDERSTAND** that:
(a) I am applying for a critical illness policy and not a major medical insurance policy; and
(b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

NOTICE: Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

SPOUSE:
» If an investigative consumer report is prepared in connection with this application: I elect to be interviewed.

Signed at: *Little Rock,* *AR* *08/19/2008 3:03:36 PM* X *John Q. Doe*
City **State** **Date / Time** **JOHN Q DOE, Primary Proposed Insured**

08/19/2008 3:04:08 PM X *Jackson Doe*
Date / Time **Witness**

08/19/2008 3:05:02 PM X *James T. Doe*
Date / Time **JAMES T DOE, Owner**

08/19/2008 3:06:39 PM X *Jackson Doe*
Date / Time **Witness**

08/19/2008 3:07:12 PM X *Jane R. Doe*
Date / Time **JANE R DOE, Spouse**

08/19/2008 3:08:31 PM X *Jackson Doe*
Date / Time **Witness**

Name of Minor Child(ren): *JOE S DOE*

Agent's Certification - Confirmation

Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? *YES*

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

» I confirm that any and all signatures of the Primary Proposed Insured, Spouse, Owner and Witness(es) in this application were signed in my presence.

08/19/2008 3:09:27 PM X *Joseph Turner*

Date / Time **JOSEPH TURNER, Licensed Agent**

AGENT'S REPORT

American General Life and Accident Insurance Company
American General Center, Nashville, Tennessee 37250-0001

Contact Source:	*REFERRAL-FRIEND*
Application Origination:	*INSURANCE REVIEW*
Anticipated Effective Date: *Payroll Deduction Mode Only*	*09-15-2008*
What is your relationship to the proposed insured(s)?	*NO RELATIONSHIP*
Is more than one application being submitted at this time or is there any other application pending?	*YES*
LIFE APPLICATION PENDING	
Did you personally see all proposed insured(s) when application was written?	*YES*
Do you have any knowledge of any unfavorable information regarding the proposed insured(s) which has not been fully disclosed in the application?	*YES*
INSURED KNOWN TO ASSOCIATE WITH DRUG DEALERS	
Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance?	*YES*
Are there to be split commissions with another agent?	*YES*
Agent's Name:	*JOHN R ABERCROMBIE*
Agent's ID:	*R005566*
Percentage of split:	*78%*
Agent's Name:	*WANDA G ROBINSON*
Agent's ID:	*R994422*
Percentage of split:	*22%*
Agent's daytime phone number:	*(615)749-3000*
Agent's e-mail address:	*agent01@gmail.com*

Agent's Remarks:
PLEASE ISSUE WITH MAY DATE IF POSSIBLE.

08/19/2008 3:09:27 PM X Joseph Turner
Date / Time **JOSEPH TURNER, Licensed Agent**
AR010097

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY COVERAGE
OUTLINE OF COVERAGE

Policy Form AGLA 91008 R

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of the 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 you have applied for provides a limited benefit for diagnosis of a defined Critical Illness 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 Critical Illness Benefit Amount described in the policy, subject to all applicable policy provisions, if a Critical Illness initially is Incurred or Manifests (if required by the policy) and is initially Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective.

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

Exclusions

For any Insured Person:

(a) We will pay **NO** benefits for a Critical Illness that initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. 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) 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; or

(2) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic or other drug or intoxicant, including those prescribed by a physician that are misused by the Insured Person; or

(3) the Insured Person's commission of or attempt to commit an assault or felony; or

(4) the Insured Person engaging in an illegal activity or occupation; or

(5) the Insured Person's voluntary participation in a riot or civil insurrection; or

(6) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(7) war, or any act of war, whether declared or not; or

(8) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedures; or

(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; or

(10) injury incurred while the Insured Person was operating any type of land, water or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the injury occurred.

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 Critical Illnesses that are caused by a Preexisting Condition unless the Critical Illness commences after the policy has been in force two years from the Effective Date or most recent reinstatement date.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	$ _____
Insured Spouse	$ _____
Insured Child(ren)	$ _____

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 initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. There is NO coverage for Loss of Independent Living, if the Insured Person initially Incurred or 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**

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
❑ Invasive Cancer If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective	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%

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

BENEFITS SCHEDULE

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
❑ Severe Burn	100%
❑ Loss of Sight, Hearing or Speech	100%
❑ In-Situ Cancer If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective ***Any Benefits for In Situ Cancer are payable only once per lifetime, per Insured Person.***	25% of the Maximum Benefit Amount, or $25,000 whichever is less
❑ Loss of Independent Living Elimination Period – 180 days	100%

PREVENTIVE CARE BENEFIT

Health Screening Tests (As Limited in the policy)	**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 and any attached rider

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

DEFINITIONS

Critical Illness means ONLY the following illnesses as defined and limited 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;
(k) In-Situ Cancer; or
(l) Loss of Independent Living

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 another 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.

Definitions (Continued)

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:

(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy; and
(b) initially occurs while coverage on an Insured Person under 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 a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:

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

Preexisting Condition means:

(a) the existence of a condition or symptom that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment within the two year period before the date coverage on the Insured Person becomes effective under the policy; or
(b) a condition or symptom for which medical advice, care, attention or treatment was recommended by a physician or received from a physician within the two year period before the date coverage on the Insured Person 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 Critical Illness that is initially Incurred or Manifests or is Diagnosed 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 earliest of:

(a) the date on which the 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 policy anniversary date on or next 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.

Guaranteed Renewable to The Policy 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 Person's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

Plan: ❑ Individual ❑ Parent & Children ❑ Family

Premium Summary

Premiums: Payable_____Until the Expiry Date
(mode)

Primary..... $ _____

Spouse ..... $ _____

Child(ren) ..... $ _____

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.

American General Life and Accident Insurance Company
A subsidiary of American International Group, Inc.
American General Center
Nashville, Tennessee 37250-0001

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The underwriting risks, financial and contractual obligations and support functions associated with products issued by American General Life and Accident Insurance Company (AGLA) are its responsibility. AIG does not underwrite any insurance policy referenced herein.

NOTICE: Read this outline of coverage carefully. It is **not** the same as the outline of coverage for the policy you applied for. The policy you applied for has not been issued.

American General Life and Accident Insurance Company

DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY COVERAGE OUTLINE OF COVERAGE

Policy Form AGLA 91008 R

Read Your Policy Carefully

This outline of coverage provides a very brief description of the important features of the 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 you have applied for provides a limited benefit for diagnosis of a defined Critical Illness 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 Critical Illness Benefit Amount described in the policy, subject to all applicable policy provisions, if a Critical Illness initially is Incurred or Manifests (if required by the policy) and is initially Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective.

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

Exclusions

For any Insured Person:

(a) We will pay **NO** benefits for a Critical Illness that initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. 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) 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; or

(2) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic or other drug or intoxicant, including those prescribed by a physician that are misused by the Insured Person; or

(3) the Insured Person's commission of or attempt to commit an assault or felony; or

(4) the Insured Person engaging in an illegal activity or occupation; or

(5) the Insured Person's voluntary participation in a riot or civil insurrection; or

(6) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(7) war, or any act of war, whether declared or not; or

(8) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedures; or

(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; or

(10) injury incurred while the Insured Person was operating any type of land, water or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the injury occurred.

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 Critical Illnesses that are caused by a Preexisting Condition unless the Critical Illness commences after the policy has been in force two years from the Effective Date or most recent reinstatement date.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	$ _____
Insured Spouse	$ _____
Insured Child(ren)	$ _____

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 initially is Incurred or Manifests or is Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if the Insured Person initially Incurred or 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.**

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
☐ Invasive Cancer	
If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective	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%

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

BENEFITS SCHEDULE

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
☐ Loss of Sight, Speech or Hearing	100%
☐ In Situ Cancer If Manifested or Diagnosed during the first 30 days after the date coverage on an Insured Person becomes effective	0%
If Manifested and Diagnosed on the 31st day or later after the date coverage on an Insured Person becomes effective	25% of the Maximum Benefit Amount, or $25,00, whichever is less
Any Benefits for In Situ Cancer are payable only once per lifetime, per Insured Person	
☐ Loss of Independent Living Elimination Period - 180 days	100%

PREVENTIVE CARE BENEFIT

Health Screening Tests (As Limited in the policy)	**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 the policy and any attached rider.

***The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.**

DEFINITIONS

Critical Illness means ONLY the following illnesses as defined and limited 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;
(k) In-Situ Cancer; or
(l) Loss of Independent Living

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 another 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; and
(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.

Definitions (Continued)

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:
(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy; and
(b) initially occurs while coverage on an Insured Person under 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 a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:
(a) on or after the date coverage on an Insured Person becomes effective under the policy; and
(b) while coverage on an Insured Person under the policy is in force; and
(c) that is not excluded by any specific description or exclusion stated in the policy.

Preexisting Condition means:
(a) the existence of a condition or symptom that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment within the two year period before the date coverage on the Insured Person becomes effective under the policy; or
(b) a condition or symptom for which medical advice, care, attention or treatment was recommended by a physician or received from a physician within the two year period before the date coverage on the Insured Person 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 Critical Illness that is initially Incurred or Manifests or is Diagnosed 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 earliest of:
(a) the date on which the 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 policy anniversary date on or next 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.

Guaranteed Renewable to The Policy 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 Person's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

Plan: ☐ **Individual** ☐ **Family** ☐ **Parent & Child(ren)**

Premium Summary

Premiums: Payable _____ (mode) until the Expiry Date

Primary ..... $ _____

Spouse ..... $ _____

Child(ren) ..... $ _____

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.

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American General Center
Nashville, Tennessee 37250-0001

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