

SERFF Tracking Number: LTCG-125673815 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 39428
Company Tracking Number: AR AIG IND LTC FILING
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: AR AIG Ind LTC Filing
Project Name/Number: AR AIG Ind LTC Filing/SM9

Filing at a Glance

Company: American General Life Insurance Company

Product Name: AR AIG Ind LTC Filing SERFF Tr Num: LTCG-125673815 State: ArkansasLH
TOI: LTC03I Individual Long Term Care SERFF Status: Closed State Tr Num: 39428
Sub-TOI: LTC03I.001 Qualified Co Tr Num: AR AIG IND LTC State Status: Approved-Closed
FILING

Filing Type: Form/Rate Co Status: Reviewer(s): Marie Bennett, Harris Shearer

Author: Sheryll Mantle Disposition Date: 08/14/2008

Date Submitted: 06/26/2008 Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: AR AIG Ind LTC Filing
Project Number: SM9
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments: Substantially similar forms were submitted to the domiciliary state of Texas on May 21, 2008

Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Market Type: Individual
Group Market Size:
Group Market Type:

Filing Status Changed: 08/14/2008

State Status Changed: 08/14/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

On behalf of American General Life Insurance Company (Company), we at Long Term Care Group, Inc. (LTCG) are submitting the attached long term care insurance forms for your review and approval. A letter of filing authorization from the Company is attached.

These forms provide individual long term care insurance and are filed for general use in accordance with the applicable

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statutes and regulations of your jurisdiction. The policy is guaranteed renewable and intended to provide federally tax qualified long term care insurance under the Health Insurance Portability and Accountability Act of 1996.

In addition, the policy is intended to be Partnership Qualified if the appropriate inflation protection rider is elected to meet Partnership requirements. Otherwise, the policy will be issued as a non-Partnership policy. A completed Partnership Certification form is attached.

Substantially similar forms were submitted to the domiciliary state of Texas on May 21, 2008.

The filing fee of \$100.00 is provided through the SERFF system via electronic funds transfer, as required. This is the required retaliatory fee for companies domiciled in Texas, the Company's home state.

The enclosed Explanation of Variability form addresses the purpose of any bracketed fields found in the policy and related forms.

We reserve the right to change the lines in the applications and related forms from conventional, flat lines to three-sided Optical Character Recognition (OCR) boxes or another similar format to support the technology selected at that time to expedite application data entry functionality.

Each policy will be issued with the following benefits: Facility Care Benefit, Home and Community Care Benefit, Flexible Care Benefit, International Benefit, Stay At Home Support Benefit (includes Respite Care, Hospice Care, Caregiver Training, Home Modification and Durable Medical Equipment), and Future Care Benefit.

Applicants will choose from Lifetime Maximums of \$100,000, \$250,000, \$400,000, \$500,000, \$600,000, \$750,000 and \$1,000,000 and from Monthly Maximums ranging from \$2,000 through \$12,000 in \$1,000 increments. Benefits will be paid on a monthly basis and there is no daily benefit amount. Only combinations of Lifetime Maximums and Monthly Maximums that meet your state's minimum benefit requirements will be available. For instance, an applicant may not elect a \$100,000 Lifetime Maximum with a \$12,000 Monthly Benefit, as selection of that combination could result (if the maximum benefit was paid every month) in a coverage duration of between eight and nine months, which is a shorter duration than your state requires. In addition, combinations of Lifetime Maximums and Monthly Maximums that exceed 13.89 years in benefit duration are not available.

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Applicants may elect from elimination periods of 30, 90, 180 and 365 days. The elimination period does not apply to the Stay At Home Support Benefit.

The following riders are available only at the time of policy issue: Paid-Up Premium Rider; Nonforfeiture Benefit – Shortened Benefit Period Rider; Return of Premium at Death Benefit Rider; Automatic Inflation Protection – [3%/5%] Compound for Life Funded With Graded Premium Increases Rider; and Automatic Inflation Protection – [3%/5%] Compound for Life Funded With Graded Premium Increases to Age 65 Rider. If an applicant purchases the Paid-Up Premium Rider, no riders may be added to the policy after the policy effective date. The applicant must be younger than age 65 in order to purchase the inflation protection riders that are funded with graded premium increases to age 65.

The following optional riders are available on the date of policy issue or may be added later (subject to underwriting): Shared Care Benefit Rider; Restoration of Benefits Rider; Automatic Inflation Protection – [3%/5%] Compound for Life Rider ; Joint Survivor Benefit Rider; Joint Waiver of Premium Rider; and Waiver of Elimination Period for Home and Community Care Benefit Rider.

The following are restrictions in terms of purchasing rider combinations:

- Only one inflation protection rider may be purchased;
- Inflation protection riders with graded premium increases may not be purchased with the Paid-Up Premium Rider; and
- An individual who has reached his or her 55th birthday may not be issued the Paid-Up Premium Rider in combination with the Joint Survivor Benefit Rider.

Individuals ranging from 21 through 84 years of age may apply for coverage under the policy. Application for Long Term Care Insurance AGLC102851-AR must be completed by members of the general population to apply for coverage. Multi-Life Short Form Long Term Care Insurance Application AGLC102854-AR must be completed when the individual is a member of an eligible sponsoring employer. Executive Carve Out Short Form Long Term Care Insurance Application AGLC102990-AR must be completed by members of an eligible sponsoring employer seeking to cover key employees. The dependents of eligible employees of sponsoring employers must complete Application AGLC102851-AR to apply for coverage. The applications may, in some instances, be completed electronically which may also include the use of electronic signatures.

Coverage is medically underwritten based on information provided in the application and from other sources, such as attending physician statements, copies of medical records and assessments of functional capacity.

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The submitted policy form will be marketed through agents.

We trust that you will find our filing to be in order and hope that you will be able to grant your Department's approval to this submission. If you have any questions or would like to discuss any of the materials included in this filing submission, please feel free to call me toll free at 1-888-312-5824. You may also send an email to smantle@ltcg.com.

Company and Contact

Filing Contact Information

(This filing was made by a third party - longtermcaregroup)

Sheryll Mantle, Consultant smantle@LTCG.com
 5 Commonwealth Road (508) 651-8800 [Phone]
 Natick, MA 01760 (508) 651-8804[FAX]

Filing Company Information

American General Life Insurance Company	CoCode: 60488	State of Domicile: Texas
2727-A Allen Parkway	Group Code: 11	Company Type: Life and Health
Houston, TX 77019	Group Name:	State ID Number:
(713) 831-3150 ext. [Phone]	FEIN Number: 25-0598210	

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: Per Arkansas regulations
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life Insurance Company	\$100.00	06/26/2008	21107636

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Marie Bennett	08/14/2008	08/14/2008

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
Referenced Filing	Note To Reviewer	Marie Bohrer	08/11/2008	08/11/2008

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Disposition

Disposition Date: 08/14/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Health - Actuarial Justification		No
Supporting Document	Outline of Coverage		Yes
Supporting Document	Authorization to File		Yes
Supporting Document	Partnership Certification		Yes
Supporting Document	Explanation of Variability		Yes
Supporting Document	Cover Letter		Yes
Form	Individual LTC Policy		Yes
Form	Individual LTC Policy Schedule		Yes
Form	Separate Premium Payer Endorsement		Yes
Form	Automatic Inflation Protection – [3%/5%] Compound for Life Rider		Yes
Form	Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums		Yes
Form	Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums to Age 65		Yes
Form	Joint Survivor Benefit Rider		Yes
Form	Joint Waiver of Premium Rider		Yes
Form	Nonforfeiture Benefit – Shortened Benefit Period Rider		Yes
Form	Paid-Up Premium Rider		Yes
Form	Restoration of Benefits Rider		Yes
Form	Return of Premium At Death Benefit Rider		Yes
Form	Shared Care Benefit Rider		Yes
Form	Waiver of Elimination Period for Home and Community Care Benefits Rider		Yes
Form	Long Term Care Insurance Potential Rate Increase Disclosure Form		Yes
Form	Outline of Coverage		Yes
Form	Application for Long Term Care Insurance		Yes

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Form	Multi-Life Short Form Long Term Care Insurance Application	Yes
Form	Executive Carve Out Short Form Long Term Care Insurance Application	Yes
Form	Statement of Good Health and Insurability	Yes
Form	Long Term Care Insurance Personal Worksheet	Yes
Form	Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance	Yes
Form	Things You Should Know Before You Buy Long Term Care Insurance	Yes
Form	Contact Notice	Yes
Rate	Actuarial Certification and Rate Sheets	No

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Note To Reviewer

Created By:

Marie Bohrer on 08/11/2008 03:02 PM

Subject:

Referenced Filing

Comments:

We are writing at this time to inquire as to the current status of the referenced filing.

Thank you in advance for your assistance.

Marie E. Bohrer, HIA AIRC
Long Term Care Group
Compliance Consultant

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Form Schedule

Lead Form Number: 08000-AR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	08000-AR	Policy/Cont	Individual LTC Policy	Initial			08000-AR Policy.pdf
			act/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider				
	08000-AR	Schedule	Individual LTC Policy	Initial			08000-AR Policy Schedule.pdf
			Pages Schedule				
	08001	Policy/Cont	Separate Premium	Initial			08001 Separate Premium Payer Endorsement.pdf
			act/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider				
	08002	Policy/Cont	Automatic Inflation	Initial			08002 3%/5% Compound Inflation Rider For Life.pdf
			act/Fraternal Protection – [3%/5%] Compound for Life Certificate: Rider Amendment, Insert Page, Endorsement or Rider				
	08003	Policy/Cont	Automatic Inflation	Initial			08003 3%/5% Age Graded
			act/Fraternal Protection – [3%/5%]				

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	al	Compound for Life		Compound
	Certificate:	Rider Funded With		Inflation Rider
	Amendmen	Age Graded		For Life.pdf
	t, Insert	Premiums		
	Page,			
	Endorseme			
	nt or Rider			
08004	Policy/Cont	Automatic Inflation	Initial	08004 3%/5%
	ract/Fratern	Protection – [3%/5%]		Age Graded
	al	Compound for Life		Prem to 65
	Certificate:	Rider Funded With		Compound
	Amendmen	Age Graded		Inflation Rider
	t, Insert	Premiums to Age 65		For Life.pdf
	Page,			
	Endorseme			
	nt or Rider			
08005	Policy/Cont	Joint Survivor Benefit	Initial	08005 Joint
	ract/Fratern	Rider		Survivor
	al			Benefit
	Certificate:			Rider.pdf
	Amendmen			
	t, Insert			
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08006	Policy/Cont	Joint Waiver of	Initial	08006 Joint
	ract/Fratern	Premium Rider		Waiver of
	al			Premium
	Certificate:			Rider.pdf
	Amendmen			
	t, Insert			
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08007	Policy/Cont	Nonforfeiture Benefit	Initial	08007
	ract/Fratern	– Shortened Benefit		Nonforfeiture
	al	Period Rider		Benefit
	Certificate:			Rider.pdf

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	Amendmen t, Insert Page, Endorseme nt or Rider		
08008	Policy/Cont Paid-Up Premium Initial ract/Fratern Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		08008 Paid- Up Premium Rider.pdf
08009	Policy/Cont Restoration of Initial ract/Fratern Benefits Rider al Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		08009 Restoration of Benefits Rider.pdf
08010	Policy/Cont Return of Premium Initial ract/Fratern At Death Benefit al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider		08010 Return of Premium At Death Benefit Rider.pdf
08011	Policy/Cont Shared Care Benefit Initial ract/Fratern Rider al Certificate: Amendmen t, Insert		08011 Shared Benefit Rider.pdf

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08012	Policy/Cont Waiver of Elimination Initial ract/Fratern Period for Home and al Community Care Certificate: Benefits Rider Amendmen t, Insert Page, Endorseme nt or Rider	08012 Waiver Of EP for HHC Benefit.pdf
08013	Policy/Cont Long Term Care Initial ract/Fratern Insurance Potential al Rate Increase Certificate: Disclosure Form Amendmen t, Insert Page, Endorseme nt or Rider	08013.pdf
08014-AR	Outline of Outline of Coverage Initial Coverage	08014-AR OOC.pdf
AGLC1028 51-AR	Application/ Application for Long Initial Enrollment Term Care Insurance Form	AGLC102851 -AR.pdf
AGLC1028 54-AR	Application/Multi-Life Short Form Initial Enrollment Long Term Care Form Insurance Application	AGLC102854 -AR.pdf
AGLC1029 90-AR	Application/Executive Carve Out Initial Enrollment Short Form Long Form Term Care Insurance Application	AGLC102990 -AR.pdf
AGLC1029 86	Policy/Cont Statement of Good Initial ract/Fratern Health and al Insurability Certificate: Amendmen	AGLC102986. pdf

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AGLC1029 87	Policy/Cont Long Term Care ract/Fratern Insurance Personal al Worksheet Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial	AGLC102987. pdf
AGLC1029 88	Policy/Cont Notice to Applicant ract/Fratern Regarding al Replacement of Certificate: Individual Accident Amendmen and Sickness or t, Insert Long Term Care Page, Insurance Endorseme nt or Rider	Initial	AGLC102988. pdf
AGLC1029 89	Policy/Cont Things You Should ract/Fratern Know Before You al Buy Long Term Care Certificate: Insurance Amendmen t, Insert Page, Endorseme nt or Rider	Initial	AGLC102989. pdf
08020-AR	Other Contact Notice	Initial	08020-AR Contact Information.p df

AMERICAN GENERAL LIFE INSURANCE COMPANY
Home Office: 2727-A Allen Parkway, Houston, Texas 77019
[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

LONG TERM CARE INSURANCE POLICY
NONPARTICIPATING

We at American General Life Insurance Company are pleased to issue this insurance Policy. It has many important features. Please read it carefully.

CAUTION: The issuance of this long term care insurance Policy is based upon the responses to questions on Your Application. A copy of that Application is enclosed. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind this Policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of Your answers are incorrect, contact Us at the [Long Term Care Correspondence] address shown above.

NOTICE TO BUYER. This Policy may not cover all of the costs associated with long term care that You may incur during the period of coverage. You are advised to review carefully all Policy limitations.

THIS POLICY IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither American General Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

THIS IS A TAX QUALIFIED CONTRACT. This Policy is intended to be a tax qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

GUARANTEED RENEWABLE FOR LIFE. You have the right, subject to the terms of this Policy, to continue it as long as You pay the required premiums on time. We cannot change any of the terms of this Policy on Our own, except that, in the future, We may increase the premiums.

OUR LIMITED RIGHT TO CHANGE PREMIUMS. Premiums will not increase due to a change in Your age or health. We can, however, change premiums on a premium class basis; but only if We change the premiums for all similar policies issued in the same state and on the same form as this Policy. Any premium changes will be effective on the next Premium Due Date following Our notice to You. We must give You at least 45 days written notice before We change premiums.

30-DAY RIGHT TO EXAMINE YOUR POLICY. You have 30 days from the day You receive this Policy to examine and return it to Us if You decide not to keep it. You do not have to tell Us Your reason for returning this Policy. Simply return it to Us at the [Long Term Care Correspondence] address shown above or to the agent or office through which it was bought. We will refund the full amount of any premium paid within 30 days of such a Policy return; and the Policy will be void from the start.

Signed for American General Life Insurance Company.


Secretary


President

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These are the major provisions of this Policy in the order in which they appear.

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 A copy of the Application for this Policy	 Attached
 Any appropriate Riders, Endorsements, Notices and other papers.....	 Attached

Refer to the Policy Schedule to determine the Benefits, options and applicable coverage details

DEFINITIONS

This section provides the definitions of words used in this Policy that have a special meaning when applied to Your coverage. To help You recognize these special words and phrases, the first letter of each word is capitalized wherever it appears.

Activities of Daily Living (ADLs) means the following self-care functions:

Bathing: Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Adult Day Care means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it operates on less than a 24 hour basis;
- it keeps written record of services for each person; and
- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Application means the written application form provided by Us and completed by You when You apply for initial coverage, any increase in coverage, reinstatement or exchange.

Assessment means an evaluation done by a Licensed Health Care Practitioner to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

DEFINITIONS (Continued)

Assisted Living Facility means a facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets all of the following requirements:

- it provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- it has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- it makes and keeps records of all care and services provided to each resident;
- it provides at least three meals a day and accommodates special dietary needs;
- it provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- it has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- it has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorder; a Nursing Home; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordinator means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill.

Care Coordination means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- the performance of comprehensive individualized Assessments, including reassessments as needed;
- the development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in Your condition;
- the coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by You or Your Representative and determined necessary by the Care Coordinator.

Care Coordination Provider means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

DEFINITIONS (Continued)

Chronically Ill means that You have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect Yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that You meet such requirements.

Confinement or Confined means You are a resident in a Nursing Home, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses means costs You incur for Qualified Long Term Care Services and for which a benefit is payable under this Policy. Each benefit section defines its own Covered Expenses.

Domestic Partner means a person who lives with You in a domestic partner relationship, provided that You have completed and returned to Us a Declaration of Domestic Partnership in a form and manner required by Us.

Durable Medical Equipment means equipment included in Your Plan of Care which:

- can enhance Your abilities to perform Activities of Daily Living;
- is functionally necessary and not just for Your convenience;
- is designed for repeated and prolonged use; and
- is suited for use in the home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in Your body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period means the total number of days that You are Chronically Ill before benefits are payable. You need not receive covered services on a day in order for that day to count towards meeting the Elimination Period. The Elimination Period begins on the first day You contact Us if We verify that You are Chronically Ill. Each day on which You are Chronically Ill will count towards the Elimination Period. The days do not have to be consecutive.

The start of the Elimination Period will be no earlier than the date You contact Us, unless We can reasonably establish that You were Chronically Ill before the filing of a claim. We may require that You provide Us with proof that You received covered services prior to the date You contacted Us. However, in no case will the Elimination Period start date be more than:

- 90 days prior to Your contacting Us for a loss related to the inability to perform Activities of Daily Living; or
- 365 days prior to Your contacting Us for a loss due to Severe Cognitive Impairment.

The Elimination Period need only be met once during Your lifetime. The Elimination Period does not apply to the Stay At Home Support Benefit or Care Coordination.

DEFINITIONS (Continued)

Flexible Care Monthly Benefit means the total amount of monthly benefits payable under this Policy for the Flexible Care Benefit. It is equal to 40% of the Monthly Maximum. Your Flexible Care Monthly Benefit is shown on Your Policy Schedule.

Home means Your domicile. Home does not include:

- a Nursing Home, Assisted Living Facility or Hospice Care Facility;
- a hospital; or
- any other institutional setting.

Home Health Care Services means the following services provided in Your Home:

- part-time or intermittent skilled services provided by licensed nursing personnel;
- home health aide services; and
- physical therapy, respiratory therapy, occupational therapy, or speech therapy or medical social services.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;
- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- have the appropriate state licensure or certification, where required or available.

Home Modification means the labor, equipment, and supplies used to make changes in Your Home. These changes must be designed to:

- enhance Your ability to perform Activities of Daily Living; and
- allow You to live safely and independently in Your Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Hospice Care means services designed to provide palliative care and alleviate Your physical, emotional and social discomforts if You are Terminally Ill and in the last phases of life.

Hospice Care Facility means a facility which provides a formal hospice care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

DEFINITIONS (Continued)

Immediate Family means Your Spouse, Your parents, Your brothers and sisters and Your children by blood, adoption or marriage.

Informal Caregiver means the person who has responsibility for providing nonprofessional care on an unpaid basis for You in Your Home. With the exception of an Informal Caregiver You choose to compensate under the Flexible Care Benefit, a person who is paid to care for You cannot be an Informal Caregiver.

International Lifetime Maximum means the maximum benefit payable under this Policy for the International Benefit. Your International Lifetime Maximum is shown on Your Policy Schedule.

International Monthly Benefit means the total amount of monthly benefits payable under this Policy for the International Benefit. It is equal to 40% of the Monthly Maximum. Your International Monthly Benefit is shown on Your Policy Schedule.

Licensed Health Care Practitioner means any of the following who is not an Immediate Family Member: a Physician (as defined in this section); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Lifetime Maximum means the total amount of lifetime benefits payable under this Policy as shown on the Policy Schedule. The Lifetime Maximum will increase in accordance with the terms of any Inflation Protection Rider in force and shown as the Inflated Lifetime Maximum on the Policy Schedule. The Lifetime Maximum is current as of the Current Coverage Effective Date on the Policy Schedule.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which You are a Chronically Ill individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare means title XVIII of the Social Security Act.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of Your illness will be used.

Monthly Maximum means the total amount of monthly benefits payable under this Policy for either the Facility Care Benefit or the Home and Community Care Benefit. Your Monthly Maximum is shown on Your Policy Schedule. The Monthly Maximum will increase in accordance with the terms of any Inflation Protection Rider in force.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.

DEFINITIONS (Continued)

Nursing Home means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. It also:

- provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (R.N.) or a Physician;
- maintains a daily medical record of each inpatient; and
- provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home also means a facility that is licensed as a specialized Alzheimer's Unit in all states where such licensure exists.

A Nursing Home is not: a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorder; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or Your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home only if it: meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner. It specifies Your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- Your functional or cognitive abilities;
- Your social situation; and
- Your care service needs.

Policy means the contract between You and Us.

Policy Anniversary Date means the annually recurring date when coverage began under this Policy.

Policy Effective Date means the date coverage is effective under this Policy as shown on the Policy Schedule, and is the date which determines the Policy Anniversary.

Policy Renewal Date means the date Your Policy's premium payment is due. The frequency of the policy renewal date can vary depending on whether the premiums are paid on a monthly, quarterly, semiannual, annual or some other basis.

Premium Due Date means each date a premium is due, after the initial premium, in accordance with the terms of this Policy.

DEFINITIONS (Continued)

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative means a person or entity legally empowered to represent You.

Respite Care means supervision and care You receive while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Rider Effective Date means the date a rider becomes effective under this Policy. A Rider Effective Date is the Policy Effective Date unless otherwise shown on the rider.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

- short-term or long-term memory;
- orientation as to people, places or time; and
- deductive or abstract reasoning.

Spouse means the person to whom You are legally married or Your Domestic Partner.

Stay At Home Support Lifetime Maximum means the maximum benefit payable under the Stay at Home Support Benefit, which is not to exceed ten percent of either the Lifetime Maximum or, if an inflation protection rider applies, the Inflated Lifetime Maximum as shown on Your Policy Schedule.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which You would be unable to perform the Activities of Daily Living. Standby Assistance means the presence of another person, within Your arm's reach, that is necessary to prevent, by physical intervention, Your injury while You are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect You from threats to Your health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill means having six months or less to live, as certified by a Physician.

We, Us, Our means American General Life Insurance Company or the administrator it designates.

You, Your or Yourself means the Policyholder named on Your Policy Schedule.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

Eligibility for the Payment of Benefits

Subject to all the terms and provisions of this Policy, benefits are payable as described in this Policy when We verify that You meet all of the following conditions:

- You are Chronically Ill;
- A Licensed Health Care Practitioner certifies You as being Chronically Ill;
- The service, if applicable, is covered under this Policy and is provided pursuant to a written Plan of Care for You that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill;
- Coverage under this Policy is in force on the date(s) the care is received;
- You have satisfied the applicable Elimination Period;
- You have not exhausted the applicable limits on the specific benefits claimed, or the Lifetime Maximum for this Policy; and
- You meet the additional requirements for the specific Policy benefits You claim.

If You are Chronically Ill due to a Severe Cognitive Impairment, Your need for Substantial Supervision must be such that:

- You do not continue to operate a motor vehicle;
- You require assistance to take medication;
- You are not left alone for substantial portions of the day; and
- If You are a resident in a Nursing Home or Assisted Living Facility, You are not able to leave that facility without competent adult supervision.

Elimination Period

You must complete the applicable Elimination Period before benefits are payable. Your Policy Schedule shows the number of days for Your Elimination Period. You do not need to satisfy an Elimination Period to receive the Stay At Home Support Benefit or Care Coordination.

Any days for which benefits have been paid by Medicare or other insurance for covered Qualified Long Term Care Services otherwise covered by this Policy will count towards the applicable Elimination Period.

The Elimination Period need only be met once during Your lifetime.

Benefits Paid Reduce the Amount Available Under Your Policy

Expenses paid under any benefit reduce the amount available under Your Policy's applicable maximums by the amount of benefits paid. Expenses for Care Coordination do not reduce Your Lifetime Maximum.

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS (Continued)

Timely Notification

It is important that You notify Us as soon as possible if it appears that You may need benefits covered by this Policy. This enables Us to better help You and Your family plan for the financial obligations of Your care. Care Coordination can help You identify the services You might need. It is more useful to You if it is provided as soon as You need care.

Certain Exclusions Apply

There are certain conditions under which benefits will not be paid under this Policy even if You otherwise meet the Eligibility for the Payment of Benefits requirements. These exclusions are stated in the Exclusions and Limitations Section.

Multiple Benefits Per Day

Although the benefits of this Policy are expressed in terms of monthly units, Covered Expenses are typically incurred on a daily basis. If You are eligible for more than one of the following benefits, benefits are payable for only one of the following which would provide the greatest benefit on a single day:

- Facility Care Benefit;
- Home and Community Care Benefit; and
- Future Care Benefit.

CARE COORDINATION

CARE COORDINATION	Care Coordination helps You identify Your specific care needs and the long term care services and programs in Your area which can best meet those needs. You may use a Care Coordinator to help You make the most informed decision regarding Your care.
About Care Coordination	Care Coordination provides You with the knowledge and training of a Care Coordinator who will review Your unique situation and develop Plans of Care to meet Your needs. The Care Coordinator will: <ul style="list-style-type: none">• assess Your functional, cognitive and personal needs for care and services on an ongoing basis;• work with You to determine the specific services You require;• develop and suggest initial and subsequent Plans of Care to assist You in meeting Your needs;• coordinate and monitor Your care needs on an ongoing basis to help You receive appropriate care; and• help You arrange for care, if You desire.
Care Coordination is Voluntary	Care Coordination is advisory only. You are not required to use Care Coordination to arrange for Your care providers or to use the specific care providers identified in the Plan of Care. However, all Your Policy benefits must be provided in accordance with an approved Plan of Care.
Limited Availability Outside United States and Canada	Care Coordination other than development of an initial Plan of Care is not available outside the United States and Canada.
Elimination Period Does Not Apply	You are not required to complete the Elimination Period in order to receive Care Coordination.
Transition Planning	If You desire, the Care Coordination Provider will recommend a transition plan which specifies how Your care needs may be met once: <ul style="list-style-type: none">• You have exhausted the benefits under Your Policy; or• You are no longer Chronically Ill but need some continued level of assistance.

FACILITY CARE BENEFIT

FACILITY CARE BENEFIT

Benefits are payable for Covered Expenses during Your Confinement in a Nursing Home or Assisted Living Facility. The Covered Expenses and the amount of the benefit We will pay are described below.

Covered Expenses

Covered Expenses for Facility Care means expenses You incur during Your Confinement in a Nursing Home or Assisted Living Facility for:

- Room and board, provided You are receiving Qualified Long Term Care Services from employees of the facility;
- Ancillary services such as therapy services;
- Patient supplies provided by the Nursing Home or Assisted Living Facility for care of its residents; and
- Bed reservation to keep your bed in the facility while You are absent for any reason (except discharge), for up to 30 days per calendar year.

Covered Expenses do not include the cost of drugs. We will not pay for any charges for comfort and convenience items such as televisions, telephones, beauty care and entertainment, or for expenses or charges incurred by or for individuals other than You (e.g., guest meals or spouse charges).

How Much We Will Pay

Benefits are payable for the Covered Expenses You incur for Facility Care during the calendar month up to the Monthly Maximum shown on Your Policy Schedule. However, if You are not Chronically Ill each day of the calendar month, Your benefit for the month will be pro-rated. It will consist of Your Covered Expenses incurred during the month for each day You were Chronically Ill, subject to a maximum of 1/30 of Your Monthly Maximum times the number of days You are Chronically Ill during the month.

HOME AND COMMUNITY CARE BENEFIT

HOME AND COMMUNITY CARE BENEFIT Benefits are payable for Covered Expenses You incur for Home and Community Care. The Covered Expenses and the amount of the benefit We will pay are described below.

Covered Expenses Covered Expenses for Home and Community Care means fees charged for the following services when provided to You by a Home Health Care Agency or by an Independent Provider who meets the Criteria for Receiving Care from an Independent Provider:

- Home Health Care Services; and
- Maintenance or Personal Care Services.

Covered Expenses also include care in an Adult Day Care Center.

Criteria for Receiving Care from an Independent Provider The Independent Provider must be licensed or certified in the state where the care will be provided, if licensing or certification is required or available for the services provided. A home health aide or certified nursing assistant must present written proof of completion of an established training course or written proof of certification. The education must include training in safely assisting persons with Activities of Daily Living. We will accept as proper credentials the home health aide's or certified nursing assistant's inclusion in the government-sponsored nurse aide registry. If the state in which You live does not require or accept licensure or certification for Independent Providers, then We may approve benefits for an Independent Provider if We can determine that the individual is qualified by training and experience to provide Maintenance or Personal Care Services.

How Much We Will Pay Benefits are payable for the Covered Expenses You incur for Home and Community Care during the calendar month up to the Monthly Maximum shown on Your Policy Schedule. However, if You are not Chronically Ill each day of the calendar month, Your benefit for the month will be pro-rated. It will consist of Your Covered Expenses incurred during the month for each day You were Chronically Ill, subject to a maximum of 1/30 of Your Monthly Maximum times the number of days You are Chronically Ill during the month.

FLEXIBLE CARE BENEFIT

FLEXIBLE CARE BENEFIT

You are eligible to receive cash benefits instead of the Facility Care Benefit or the Home and Community Care Benefit. If You choose to receive the Flexible Care Benefit, no other benefit is payable under this Policy for any calendar month except for the Stay At Home Support Benefit. Additionally, this cash benefit might be used to pay for care not otherwise covered under the Policy, such as care provided by an Immediate Family member. The conditions under which We will pay this benefit and the amount of benefit We will pay are described below.

Conditions for Flexible Care Benefits

This cash benefit will be available beginning on the day You first satisfy the Eligibility for the Payment of Benefits requirements. You are not required to incur any Covered Expenses in order to receive this benefit. However, You must be in compliance with the written individualized plan of services in Your Plan of Care.

You must notify Us in advance to receive benefits under this provision. The notice must be made in writing.

Flexible Care Benefits will end at the earliest of the date on which:

- You have received the Lifetime Maximum;
- You are no longer Chronically Ill; or
- You elect to receive Facility Care Benefits, Home and Community Care Benefits or Future Care Benefits in lieu of this benefit.

No other benefit under this Policy, except for the Stay At Home Support Benefit, is payable during a calendar month for which You receive a Flexible Care Benefit.

How Much We Will Pay

Benefits are payable for each month that You meet the Conditions for Flexible Care Benefits. We will pay the Flexible Care Monthly Benefit shown on Your Policy Schedule. However, if You are not Chronically Ill each day of the calendar month, Your benefit for the month will be pro-rated. It will consist of 1/30 of Your Flexible Care Monthly Benefit times the number of days You are Chronically Ill during the month.

INTERNATIONAL BENEFIT

INTERNATIONAL BENEFIT

You are eligible to receive cash benefits when You are outside the United States, its territories and possessions and Canada. The conditions under which We will pay this International Benefit and the amount of benefit payable are described below.

Conditions for International Benefits

This cash benefit will be available beginning on the day You first satisfy the Eligibility for the Payment of Benefits requirements. This benefit is in lieu of all other benefits under this Policy.

You are not required to incur any Covered Expenses in order to receive this benefit. However, You must be in compliance with the written individualized plan of services in Your Plan of Care. You must provide written proof, in English, that You are Chronically Ill.

You must notify Us in advance to receive benefits under this provision. The notice must be made in writing and in English.

The International Benefit will end at the earliest of the date on which:

- You have received the Lifetime Maximum;
- You have received the International Lifetime Maximum;
- You are no longer Chronically Ill; or
- You return to the United States, its territories or possessions or Canada.

No other benefit under this Policy is payable during a calendar month for which You receive the International Benefit.

How Much We Will Pay

Benefits are payable for each month that You meet the Conditions for International Benefits. We will pay the International Monthly Benefit shown on Your Policy Schedule. However, if You are not Chronically Ill each day of the calendar month, Your benefit for the month will be pro-rated. It will consist of 1/30 of Your International Monthly Benefit times the number of days You are Chronically Ill during the month. This benefit is subject to the International Lifetime Maximum, also shown on Your Policy Schedule.

All benefit payments will be made in U.S. dollars.

STAY AT HOME SUPPORT BENEFIT

STAY AT HOME SUPPORT BENEFIT

Benefits are payable for Covered Expenses You incur for Stay At Home Support. The amount of the benefit We will pay and the conditions under which We will pay this benefit are described below.

Covered Expenses

Covered Expenses for the Stay At Home Support Benefit means Covered Expenses You incur for the following, as described below:

- Respite Care;
- Hospice Care;
- Caregiver Training;
- Home Modification; and
- Durable Medical Equipment.

How Much We Will Pay

Benefits are payable for Covered Expenses You incur for Stay At Home Support. This benefit is subject to the Stay At Home Support Lifetime Maximum shown on Your Policy Schedule.

Elimination Period Does Not Apply

You are not required to complete the Elimination Period before We will pay Stay At Home Support Benefits.

RESPITE CARE

Stay At Home Support Benefits are payable for Covered Expenses for Respite Care. Respite Care provides temporary relief for those persons who ordinarily care for You on a regular basis.

Covered Expenses

Covered Expenses for Respite Care means:

- Covered Expenses for care in a Nursing Home or an Assisted Living Facility; or
- Covered Expenses for Home Health Care Services.

HOSPICE CARE

Stay At Home Support Benefits are payable for Covered Expenses when We verify that You are Chronically Ill and You are Terminally Ill.

STAY AT HOME SUPPORT BENEFIT (Continued)

Covered Expenses

Covered Expenses for Hospice Care means:

- Expenses You incur during Your Confinement in a Hospice Care Facility or a Nursing Home for:
 - Room and board;
 - Ancillary services provided by the Hospice Care Facility or Nursing Home; and
 - Patient supplies provided by the Hospice Care Facility or Nursing Home for care of their residents; or
- Expenses for Home Health Care Services.

Covered Expenses for Hospice Care do not include the cost of drugs, supplies, equipment or physician visits. We will not pay for any charges for Your comfort and convenience such as television, telephone, beauty care and entertainment.

Subject to the other terms and conditions of this Policy, this benefit will be paid as long as Your Physician continues to certify You as being Terminally Ill and You are not receiving preventive or curative treatment.

CAREGIVER TRAINING

Stay At Home Support Benefits are payable for Covered Expenses You incur for training an Informal Caregiver (family or friend) to provide care for You in Your Home.

Covered Expenses

Covered Expenses for Caregiver Training means expenses You incur for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for You. The training cannot be received when You are Confined in a hospital, Assisted Living Facility or Nursing Home, unless it is reasonably expected that the training will make it possible for You to return to Your Home where You can be cared for by the person receiving the training.

HOME MODIFICATION

The Stay At Home Support Benefit is payable if Home Modification is recommended by a Care Coordinator in a Plan of Care and is mutually agreeable to You and Us as a cost-effective alternative to benefits otherwise provided by this Policy. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Home Modification under the Stay At Home Support Benefit will not waive any of the rights You or We have under this Policy. This benefit may not be used solely to increase the value of the Home. We determine what shall be considered Home Modification under this Policy.

STAY AT HOME SUPPORT BENEFIT (Continued)

Covered Expenses

Covered Expenses for Home Modification means the cost of Home Modification if Your Care Coordinator finds that modification to Your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to Your Home that will enhance Your ability to perform the Activities of Daily Living and allow You to remain in Your Home safely. Home does not include an Assisted Living Facility.

DURABLE MEDICAL EQUIPMENT

The Stay At Home Support Benefit is payable if the use of Durable Medical Equipment is specified in Your Plan of Care and is mutually agreeable to You and Us as a cost-effective alternative to benefits otherwise provided by this Policy. Benefits are not payable for any expenses incurred prior to the date of mutual agreement. Agreement to participate in Durable Medical Equipment under the Stay At Home Support Benefit will not waive any of the rights You or We have under this Policy. The Durable Medical Equipment must be located in Your Home.

Covered Expenses

Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in Your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

FUTURE CARE BENEFIT

FUTURE CARE BENEFIT We reserve the right to authorize benefits for providers, treatments, or services not otherwise specified in this Policy.

(For expenses not otherwise covered, but authorized by Us.)

Benefits and services can be authorized if We determine that they:

- are cost-effective;
- are appropriate to Your needs;
- are consistent with general standards of care;
- provide You with an equal or greater quality of care; and
- are for and constitute Qualified Long Term Care Services.

Any benefits, treatments, or services We authorize must also be agreed to by You or Your Representative and, if appropriate, Your Physician.

We reserve the right to decline to authorize benefits and services.

Benefits are not payable for any expenses incurred either: prior to the date of mutual agreement; or once You have exhausted the benefits under Your Policy. Agreement to participate in Future Care Benefits will not waive any of the rights You or We have under this Policy.

Future Care Benefits may be discontinued at any time without affecting Your right to the benefits otherwise available under this Policy.

WAIVER OF PREMIUM

WAIVER OF PREMIUM

We will waive the payment of premium which becomes due when the coverage is in force and You are receiving benefits under this Policy, except for benefits payable during the Elimination Period. We will waive premiums beginning the first day You receive benefits. We will refund or credit the pro-rata amount paid for periods after the premium waiver begins.

As long as You continue to receive benefits, additional premiums will not be required. If You cease to receive benefits, premium payment will again be required. You must pay future premiums, beginning within 30 days of the date You last receive a benefit.

CONTINGENT NONFORFEITURE BENEFIT

This benefit is available to You if You have not elected the Nonforfeiture Benefit Rider. Your Policy Schedule shows whether or not You are covered by this benefit. The benefit will apply to You if, and only if, there is a substantial increase in the premium rates for Your coverage, as described below.

How This Benefit Works

If there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the schedule specified below, We will do all of the following on or before the date the substantial increase in premium rates is effective:

- We will offer to reduce Your current level of coverage without evidence of insurability so that the required premium rates for Your coverage are not increased.
- We will offer to convert coverage to a paid-up status with a shortened benefit period as described below. This option may be elected at any time during the 120-day period following the date of the premium rate increase.
- We will notify You that a default or lapse at any time during the 120-day period following the date of the premium increase will be deemed to be the election of the preceding offer to convert. A default or lapse is Your failure to pay the required premiums within the grace period.

If Your coverage is converted to paid-up status in accordance with the provisions above, We will continue to pay benefits, subject to all of the terms and conditions of this Policy in effect at the time of lapse. Benefits for covered services will be paid up to the applicable monthly and lifetime benefit maximums in effect at the time Your Policy terminated due to non-payment of premium, until the Shortened Benefit Period Allowance has been reached or You no longer meet the Eligibility for the Payment of Benefits requirements of this Policy.

Shortened Benefit Period Allowance

The Shortened Benefit Period Allowance We will pay will be the greater of :

- one hundred percent (100%) of the sum of all premiums paid for Your coverage, excluding any waived premiums; or
- Your Monthly Maximum in effect at the time of lapse.

The Shortened Benefit Period Allowance is reduced by the sum of all benefits previously paid to You.

In no event will the total of benefits payable under this Policy exceed the Lifetime Maximum.

Inflation Protection Will Not Apply to this Benefit

If You have elected an Inflation Protection Rider, any benefit paid on or after Your Policy lapses will be the benefit amount in effect on that date and no further increases in benefit amounts will occur.

CONTINGENT NONFORFEITURE BENEFIT (Continued)

When Coverage Ends

Your coverage under this option ends when the Shortened Benefit Period Allowance has been reached or the Lifetime Maximum has been exhausted.

The following table determines what constitutes a substantial premium increase.

Triggers for a Substantial Premium Increase

Cumulative premium increase over original premium that will allow Contingent Nonforfeiture to be initiated. (Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Issue Age	Percentage of Increase Over Initial Annual Premium	Issue Age	Percentage of Increase Over Initial Annual Premium
29 and under	200%	72	36%
30 – 34	190%	73	34%
35 – 39	170%	74	32%
40 – 44	150%	75	30%
45 – 49	130%	76	28%
50 – 54	110%	77	26%
55 – 59	90%	78	24%
60	70%	79	22%
61	66%	80	20%
62	62%	81	19%
63	58%	82	18%
64	54%	83	17%
65	50%	84	16%
66	48%	85	15%
67	46%	86	14%
68	44%	87	13%
69	42%	88	12%
70	40%	89	11%
71	38%	90 and Older	10%

EXCLUSIONS AND LIMITATIONS

This Section states the conditions under which payment will be limited, or not made at all, even if You otherwise qualify for benefits. These conditions apply to all benefits provided by this Policy.

Exclusions

This Policy will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- care or services provided by Your Immediate Family unless:
 - he or she is a regular employee of an organization which is providing the treatment, service or care; and
 - the organization receives the payment for the treatment, service or care; or
- care or services provided by Your Immediate Family member unless You are compensating him/her through proceeds from Your Flexible Care Benefit; or
- care or services for which no charge is made in the absence of insurance; or
- care or services provided outside the United States of America, its territories and possessions and Canada, except as provided for under the International Benefit; or
- care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury; or
- care or services that result from war or any act of war (whether declared or undeclared); or
- treatment provided in a government facility (unless otherwise required by law); or services for which benefits are available under Medicare or other governmental program (except Medicaid); or
- services received while this Policy is not in force, except as provided in the Extension of Benefits provision.

No Pre-Existing Conditions Exclusion

We will not reduce or deny any claim under this Policy because of a sickness or physical or medical condition disclosed on Your Application.

Non-Duplication With Other Plans

We will not pay benefits for services or items for which benefits are payable by Medicare (including amounts that would be reimbursable but for the application of a deductible or coinsurance amount). We will pay the difference between Your actual expense and the benefits payable by Medicaid or private insurance, but Our payment will not exceed the amount We would have paid in the absence of such other insurance. However, if Your Medicaid or private insurance denies payment to You for a service that We cover, We will pay the benefit as outlined in this Policy. The Care Coordinator can assist You in identifying other insurance benefits to which You are entitled that can be applied to meet Your actual expenses.

COVERAGE CHANGES PROVISIONS

This Section describes the coverage change rules of this Policy.

You May Request an Increase in Your Coverage

You have the right to request to increase Your coverage at any time (if this policy form is still being offered in Your state.) The increase must be to an amount offered by Us. We reserve the right to determine what represents an increase in coverage. You will be required to provide an Application and evidence of insurability in a form and manner specified by Us. The premium for the increased coverage will be based on Your age as of the date the increase in coverage becomes effective. Premium for any previously purchased coverage will not be affected.

When Increases in Coverage Become Effective

If, within 60 days of the Policy Effective Date, You submit a written Application, including evidence of insurability, to increase coverage and the request is approved by Us, the change is effective as of the Policy Effective Date. If You submit a written Application, including evidence of insurability, to increase coverage after that time and the request is approved by Us, the change is effective as of the date Your next premium is due and paid.

You May Elect to Decrease Coverage

You have the right to request Us to reduce Your future premiums by reducing Your Policy's applicable maximum benefits, reducing the applicable monthly benefit amount or changing to a coverage amount offered by Us which we determine to be a decrease in coverage. The premium for the reduced coverage will be based on the current premium rate table in effect and the age used to determine the coverage currently in force.

We will notify You of this right to reduce coverage if Your coverage is about to lapse and in the event that premiums are increased.

If You request a change in coverage to a coverage amount that represents a decrease in coverage, You will not be required to provide evidence of insurability.

CLAIMS PROVISIONS

This Section describes: when We must be notified of a claim; what to send Us; how We evaluate and pay claims; and other rights and responsibilities under the contract.

Your Role in the Claims Process

Early awareness by Us will facilitate a timely claim review. You can help Us in this process by letting Us know immediately when You think You are eligible for benefits under this Policy. To file a claim, You or Your Representative may call Us, notify Us in writing or submit a completed claim form We provide.

Notify Us as Soon As Possible

We can handle Your claim request more efficiently if We are notified within 30 days after You are eligible for benefits or as soon as reasonably possible. We prefer that You notify Us as soon as You first become disabled to the extent that You may soon need care covered by this Policy. Notify Us even if You are unsure, and We can help You determine whether or not You are eligible for benefits.

How Claims Are Evaluated

When notice of claim is received, We will collect the information We need to verify whether You meet the Eligibility for the Payment of Benefits requirements. We may need to contact Your Physician or other care provider and to review Your medical records. Based on Our evaluation of this information, We will verify Your eligibility for benefits. We will not pay benefits until We verify Your eligibility for benefits. If You are determined to be eligible for benefits, We will arrange for a Plan of Care to be developed by a Licensed Health Care Practitioner or Care Coordination Provider.

Claim Forms

We will contact You and provide claim forms for the filing of proofs of loss when We receive Your notice of claim. If You or Your Representative do not get the necessary claim forms within 15 days, Proofs of Loss can be filed without them by sending Us a letter which describes the occurrence, the character and the extent of the loss for which Your claim is made. That letter must be sent to Us at the location designated for [Long Term Care Correspondence] on the first page of this Policy within the time noted below under Proof of Loss.

Proof of Loss

In the case of a claim for continuing loss for which this Policy provides any periodic benefits, written proof of loss must be given to Us within 90 days after the end of each 30-day period for which Covered Expenses are incurred. In the case of a claim for any other loss, written proof must be given to Us within 90 days after the date of such loss. However, a claim will still be considered if it was not possible for You to furnish proof within this time and the proof was furnished as soon as reasonably possible. Except in the absence of legal capacity, in no event will an expense be considered if proof for that expense is furnished more than one year after the date the proof is otherwise required.

CLAIMS PROVISIONS (Continued)

Written Notification

You will be notified in writing whether or not You are eligible for benefits. We will notify You within ten days of receiving all the required information. If You want to receive information related to such denial, that information will be sent to You within 60 days of receipt of Your written request.

When Benefit Payments Will Be Made

Once You have completed the applicable Elimination Period, benefit payments will be made upon Our receipt of Your required written claims and evidence of Your continued eligibility. Benefit payments will be made as long as Your loss and Our liability continue. When a claim is paid You will receive an Explanation of Benefits that will show the unused balance of Your lifetime maximums.

To Whom We Will Pay Benefits

All benefits will be payable to You unless otherwise assigned. Any benefits to which You are entitled that are unpaid at Your death will be payable to Your estate. If benefits are payable to an estate, We may pay a portion of those benefits, up to \$1,000, directly to Your Spouse or someone related to You by blood or marriage who is deemed by Us to be justly entitled to the benefits. We will be discharged to the extent of any such payment made in good faith.

Physical Examination

At Our expense, We have the right to require an examination of Your functional or cognitive status when a claim is made, and at reasonable intervals while benefits are being claimed.

How You Can Appeal a Claim Decision

If You disagree with Our decision regarding Your claim, You may request in writing within 60 days of that decision that We reconsider Your claim. You should submit any additional information that You feel We need to review Our decision. You should include the names, addresses, and phone numbers of any care providers You think We should contact to learn more about Your loss. You are responsible for the expense of securing additional information, if applicable, for each instance of reconsideration. We will reconsider Our decision and send You written notification of the results. If We deny Your appeal request and You want to receive written information related to such denial, that information will be sent to You within 60 days of receipt of Your written appeal request.

Legal Actions

No action may be brought to recover under this Policy until 60 days after proof of loss has been given. No action can be brought more than three years from the date written proof of loss was required to be given.

CLAIMS PROVISIONS (Continued)

Direct Payment of Benefits to Care Provider (Assignment of Benefits)

You may instruct Us to pay benefits due You under this coverage directly to a Nursing Home, Assisted Living Facility, Hospice Care Facility or Home Health Agency providing the care for which We are reimbursing expenses. The care provider must also agree to the assignment of benefits. You must notify Us in writing. No assignment shall be binding upon Us unless a copy is on file at the location designated for Long Term Care Correspondence on the first page of this Policy. We do not assume any responsibility for the validity or effect of an assignment.

PREMIUMS AND RENEWAL PROVISIONS

This section describes such things as: the importance of paying premiums on time; what happens if premiums are not paid on time; and protection available in the event of unintentional lapse of this Policy.

- Guaranteed Renewable** Each premium paid continues insurance in force until the date the next premium is due, except as stated in the Grace Period provision. We cannot terminate or refuse to renew Your coverage under this Policy before benefits have been exhausted, as long as premiums for Your coverage are paid on time.
- Paying Premiums** You will pay premiums to Us. Your first premium is due on the Policy Effective Date. The modal premium for ongoing payments is reflected on the Policy Schedule. Please note that a Grace Period applies. You chose Your mode of premium payment and frequency on Your Application. You may change Your mode or frequency of premium payment with Our approval.
- Protection Against Unintentional Lapse** In order to protect Yourself against unintentional lapse, You must either designate at least one person in addition to You to receive notice of lapse or termination of the Policy for non-payment of premium or You must sign a waiver electing not to designate an additional person to receive notice. You may change this designation at any time. To do so, You must notify Us in writing. We will remind You in writing every two years of this opportunity.
- Changes In Premium Rates** Your premiums will not increase due solely to a change in Your age or health. However, if Your coverage includes an Inflation Protection with Graded Premiums Rider, the premiums for the annual benefit increases provided by that rider increase annually with Your age as Your benefits increase. Premium changes other than those for an Inflation Protection with Graded Premiums Rider will be made only if We change premiums for all similar policies in the same state and on the same form as this Policy. Any premium changes will be effective on the next Premium Due Date following the effective date of the rate increase. We must give You at least 45 days written notice before We change Your premiums.
- Your Options If Premium Rates Change** If the premium rates are increased for all similar policies in Your same state on the same Policy form, You will have the option of: maintaining Your current benefits at the increased premium rate; or electing a decrease in coverage to a coverage amount We offer that maintains or reduces Your current premium. The procedure for decreasing coverage is described under the Coverage Changes Section.
- Unless You notify Us within 30 days after receiving Our notice, You will be considered to have elected to maintain Your current benefit amount at the increased premium rate.

PREMIUMS AND RENEWAL PROVISIONS (Continued)

Refund of Premiums Paid Beyond Your Death

If You die while covered under this Policy, We will refund the pro-rata part of any premium paid for the period after Your death. The refund will be made within 30 days of Our receipt of written notice and proof of Your death. Your beneficiary will be as shown in Your Application unless later changed by You. If there is no named or living beneficiary on the date of Your death, the refund will be paid to Your Spouse, if living, or to Your estate.

Grace Period

There is a 31-day Grace Period. This means that if a premium is not paid on or before the date it is due, it may be paid during the following 31 days. We will continue coverage during the Grace Period. Your insurance under this Policy will remain in force during the Grace Period, unless We have been advised in writing by You that You want to cancel Your coverage prior to the end of the Grace Period.

Notification of Non-Payment

If Your premium is due and unpaid at the end of 30 days, We will give notice of termination to You and to the person(s) You have designated to receive notice. The notice of termination will be sent at least 35 days in advance of termination and will state the amount of unpaid premium, the date by which premium must be paid, the date the coverage is to terminate and will remind You of Your right to reduce coverage and premiums. Our notice will be sent prepaid by United States first class mail. We will consider You and Your designee(s) notified as of five calendar days after the date the notice is mailed. If Your premium is not paid by the end of the Grace Period, Your coverage will terminate as of the last date through which premiums were paid. Any benefits payable for covered services You received after the last date for which Your premium was paid will be reduced by the premium due from the date the last premium was paid to the date Your coverage under this Policy terminated.

Reinstatement

If Your coverage is terminated for non-payment of premium, You may apply for reinstatement by writing to Us. You will be asked to complete an Application for reinstatement. Completed reinstatement Applications must be received by Us within one year after the end of the Grace Period. We have the right to require evidence of insurability. You will be required to pay the cost of any records that may be necessary to provide this evidence. If approved, the premium due from the date of the first unpaid premium must be paid, and coverage will be reinstated retroactive to the date of termination of coverage. We have the right to decline a request for reinstatement of coverage. Any premium accepted in connection with a reinstatement will be applied to the period for which premium was not previously paid. Acceptance of premium by Our agent does not mean Your reinstatement Application has been accepted. In all other respects, You will have the same rights under this Policy as You had prior to the Premium Due Date of the defaulted premium.

PREMIUMS AND RENEWAL PROVISIONS (Continued)

Unpaid Premiums

When a claim is paid, any premium due and unpaid will be deducted from the claim payment.

Added Protection Against Lapse

If Your coverage terminates due to non-payment of premiums, We will provide a reinstatement of coverage as specified on the previous page, if certain conditions are met. To be eligible for this reinstatement, You must provide Us proof that You were Chronically Ill, beginning on or before the date of termination.

The proof must be in the form of a certification and Assessment from a Licensed Health Care Practitioner which demonstrates that You were Chronically Ill. The proof must be provided to Us within five months of the termination date. You must pay all past due premiums that would not become subject to Waiver of Premium for the coverage that was in force immediately prior to the date of lapse. In that event, Your insurance will be reinstated as of the date of that termination without interruption of insurance for that period.

EFFECTIVE DATE AND TERMINATION OF INSURANCE PROVISIONS

This Section describes when this Policy becomes effective and when coverage ends.

- Evidence Of Insurability** You are required to provide evidence of insurability in a form and manner specified by Us.
- Policy Effective Date** You will become covered under this Policy on the Policy Effective Date shown on Your Policy Schedule, provided the required premium has been received.
- Your Right to Cancel Coverage at Any Time** You may cancel Your coverage at any time by sending Us written notice. We must receive Your request to cancel 30 days prior to Your requested cancellation date. Termination of Your coverage will be effective within 30 days of the date We receive the request, unless Your requested termination date is later. We will promptly return the unearned portion of any premium paid. The cancellation will not prejudice any claim for care received before the effective date of the cancellation.
- When Insurance Ends** Your coverage terminates on the first to occur of:
- the date of Your death;
 - the date coverage is cancelled pursuant to Your request;
 - the date You have received the Lifetime Maximum allowed under this Policy; or
 - the last date through which premiums have been paid if the amount due is not received by the date stated in notice of termination of coverage as provided by the terms of the Notification of Non-Payment provision.
- Extension of Benefits** If Your Policy terminates due to failure to pay premium, We will recognize Your basis for a claim for Your Confinement in a Nursing Home or an Assisted Living Facility before the date Your Policy ended in the same manner as if Your insurance was in force. Extension of Benefits stops on the earlier of:
- the date when You no longer meet the Eligibility for the Payment of Benefits requirements; or
 - the date You are no longer Confined in a Nursing Home or an Assisted Living Facility.

BASIC CONTRACT PROVISIONS

This Section describes: the documents that state all the contractual agreements; the importance of completing the application truthfully and correctly; and other basic rights, obligations and features.

Entire Contract; Changes The entire contract consists of: this Policy; the Policy Schedule; any riders or endorsements to the Policy that are issued by Us; and Your Application. All statements made by You for the purpose of effecting insurance are considered true and complete to the best of the knowledge and belief of the persons making them. These statements are representations and not warranties. No statement will be used in any contest unless: the statement is in writing; and a copy of that statement is given to You.

Agreements All agreements made by Us must be signed by one of Our executive officers. No agent may modify or waive any of the terms of this Policy. An endorsement or amendment changing this Policy must be signed by an executive officer of Ours.

Changes To This Policy No change in this Policy is effective until You accept the change in writing, with the following exceptions: a change in the premiums; a change which is required by law or regulation; or a change which does not reduce or eliminate benefits or coverage. This exception does not include an increase in benefits or coverage with a like increase in premium when requested by You and approved by Us; or when offered by Us and accepted by You.

Any change will be without prejudice to any claim incurred for benefits prior to the date of the change.

**Misstatements/
Incontestability** In issuing this Policy, We have relied upon the information presented by You in Your Application. We may rescind Your Policy or deny a claim due to a misrepresentation that is material to Your acceptance for coverage if Your Policy has been in force for less than six months. The Policy Effective Date is shown on the Policy Schedule.

If Your coverage has been in force for at least six months but less than two years, We may rescind Your Policy or deny a claim due to a showing of misrepresentation in Your Application that is both material to Your acceptance for coverage and which pertains to the conditions for which benefits are sought.

After Your coverage has been in force for two years, We may rescind Your Policy and deny a claim for benefits that began after the two-year period if You knowingly and intentionally misrepresented relevant facts in Your Application relating to Your health.

BASIC CONTRACT PROVISIONS (Continued)

Misstatement of Age	If Your age was misstated in Your Application, We will adjust Your premium to the correct amount for Your insurance at Your correct age as of the Policy Effective Date. The amount of the insurance shall not be affected, provided that any necessary adjustment in premium is made and collected. If based on Your correct age Your Application would not have been accepted and a policy not issued, We will cancel Your Policy and will only be liable for the refund of all premiums paid for this Policy.
Conformity With State Statutes	Any provision of Your Policy which, on the Policy Effective Date, is contrary to the applicable laws of the State where this Policy is delivered is amended to conform to the minimum requirements of such laws.
Conformity With Internal Revenue Code	If on its Effective Date, this Policy does not comply with the requirements of Section 7702B(b) of the Internal Revenue Code of 1986, it will be treated as if it had been changed to comply with those requirements. Because this Policy is guaranteed renewable, We will inform You in writing of any required change in the provisions of this Policy; and You will be given the choice of accepting the change, or retaining this Policy without that change.
Time Periods	All time periods start and end at 12:01 a.m. in the time zone in which You reside.
Clerical Error	Clerical error or delays in making entries on the records by Us or Our designees will not void Your coverage if Your coverage would otherwise have been in effect. Such clerical error will not cause You to become insured if You are otherwise not eligible. Such clerical error will also not extend Your coverage if Your coverage would otherwise have ended or been reduced as provided by this Policy. If a clerical error is found, premiums and benefits will be adjusted based on the true facts and the provisions of the Policy.
Nonparticipation	This Policy does not participate in surplus, it has no cash value and its premiums do not include a charge for participation in surplus.
No Cash Values, Borrowing, or Use as Collateral	This Policy does not provide for a cash surrender value, or other money that can be: borrowed; or paid, assigned or pledged as collateral for a loan.

**American General Life Insurance Company Long Term Care Insurance
Policy Schedule
Toll Free Phone # [888.565.3769]**

Policyholder: [John Q. Doe] Policy Number: [123456]
Address: [1234 Main Street]
[Anytown, USA 99999]

Age At Issue: [45]

Policy Effective Date: [01/01/2008]

Current Coverage Effective Date: [06/01/2008]

[Insured Spouse:] [Jane Q. Buck]

COVERAGE AMOUNTS AND MAXIMUMS

Lifetime Maximum: [\$100,000; \$250,000; \$400,000; \$500,000;
\$600,000; \$750,000; \$1,000,000]

Inflated Lifetime Maximum: [\$XXX,XXX]

Monthly Maximum: [\$2,000 - \$12,000 in \$1,000 increments]

Flexible Care
Monthly Benefit: [40% of Monthly Maximum – Dollar Amount
Will Appear Here]

International Lifetime
Maximum: [24 times the International Monthly Maximum –
Dollar Amount Will Appear Here]

International Monthly
Benefit: [40% of Monthly Maximum – Dollar Amount
Will Appear Here]

Stay at Home Support
Lifetime Maximum: [10% of Lifetime Maximum – Dollar Amount
Will Appear Here]

[Shared Care
Lifetime Maximum:] [Amount equal to Lifetime Maximum Will
Appear Here]

BASE POLICY BENEFITS
 Facility Care Benefit
 Home and Community Care Benefit
 Flexible Care Benefit
 International Benefit
 Stay At Home Support Benefit
 Future Care Benefit
 Contingent Nonforfeiture Benefit

Elimination Period: [30, 90 or 180 or 365 calendar days]

PREMIUM INFORMATION

Rate Classification: [Preferred/Standard/Substandard] [with Spousal Discount] [with Marital Discount] [with Discount for Executive Carve Out]

ADDITIONAL COVERAGES AND ANNUAL PREMIUMS

Base Policy Coverage	[\$xx.xx]
[Automatic Inflation Protection – 3%/5% Compound For Life Rider]	[\$xx.xx]
[Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases]	[\$xx.xx]
[Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases to Age 65]	[\$xx.xx]
[Joint Survivor Benefit Rider]	[\$xx.xx]
[Joint Waiver of Premium Rider]	[\$xx.xx]
[Nonforfeiture Benefit – Shortened Benefit Period Rider]	[\$xx.xx]
[Paid-Up Premium Rider]	[\$xx.xx]
[Restoration of Benefits Rider]	[\$xx.xx]
[Return of Premium at Death Benefit Rider]	[\$xx.xx]
[Shared Care Benefit Rider]	[\$xx.xx]
[Waiver of Elimination Period for Home and Community Care Benefits Rider]	[\$xx.xx]
ANNUAL TOTAL	[\$xx.xx]

Modal Premium Amount: [Monthly] [\$xx.xx]

Premiums payable other than annually are equal to a percentage of the annual premium and include additional premium charges. You will save money by paying the premium on an annual basis.

Policy Schedule Print Date: [01/01/01]

SEPARATE PREMIUM PAYER ENDORSEMENT

This endorsement takes effect on the Policy Effective Date shown on Your Policy Schedule.

Separate Premium Payer If someone other than You has been designated the Premium Payer in Your Application, this endorsement applies to Your Policy.

Rights and Responsibilities If a Premium Payer other than You has been designated in Your Application, the following applies:

The Premium Payer designated in Your Application is responsible for paying premium. All sections of the Policy pertaining to the payment of premiums apply to the Premium Payer. If the Premium Payer stops paying the premiums for any reason, You will be given the opportunity to pay the premiums required to continue the Policy. If You elect to assume responsibility for paying the required premiums for the Policy, We will bill You directly and all sections of the Policy pertaining to the payment of premiums will apply to You and cease to apply to the individual or entity designated as Premium Payer in Your Application.

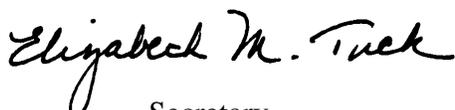
Termination

This endorsement will end if:

- You revoke the designation of a Premium Payer other than Yourself (if You do that, You will be able to continue Your coverage as described above); or
- The Premium Payer ceases to pay the required premium (in this case, You will be able to continue Your coverage as described above).

This endorsement will also end if Your Policy terminates.

Signed for American General Life Insurance Company.


Secretary


President

AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Rider Works

We will increase Your Inflated Lifetime Maximum and Your Monthly Maximum by the percentage shown on Your Policy Schedule, compounded annually on the anniversary of the Rider Effective Date as long as this rider and Your Policy remain in force. The amount available under this rider is equal to Your Inflated Lifetime Maximum reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.

Your premium rate will not change as a result of these annual benefit increases. **However, Your premium may change subject to the other terms of the Policy. See the Our Limited Right to Change Premiums section of the Policy.**

When Increases Become Effective

The increase will be effective on each anniversary of this rider even if You are receiving benefits.

Inflated Lifetime Maximum

Inflated Lifetime Maximum means the new total amount of lifetime benefits payable to You after We apply any inflation protection increase under this rider. Prior to the first inflation protection increase, the Inflated Lifetime Maximum will be the same amount as the Lifetime Maximum. Your Inflated Lifetime Maximum is shown on Your Policy Schedule.

Termination

If You request that We remove this benefit from Your Policy, then on the date We receive Your request:

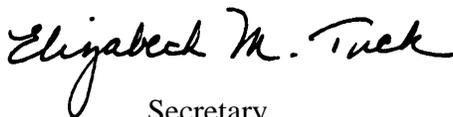
- Your benefit maximums will remain at the level they were as of the date We received Your request; and
- Your premium will be changed to equal the amount that would be charged for the current benefit maximums based on Your original issue age and the rate schedule in effect at the time We receive Your request. However, if this rider was added to Your Policy after the Policy Effective Date, Your premium will be based on Your current benefit maximums and Your age at the time this rider was added to Your Policy.

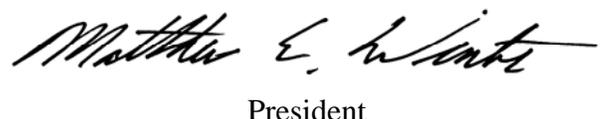
Annual inflation protection increases will terminate if Your coverage is continuing in effect under:

- the Nonforfeiture Benefit – Shortened Benefit Period Rider, if any; or
- the Contingent Nonforfeiture Benefit.

This rider will also end if Your Policy terminates.

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]

**AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER
FUNDED WITH GRADED PREMIUM INCREASES**

This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Rider Works	We will increase Your Inflated Lifetime Maximum and Your Monthly Maximum by the percentage shown on Your Policy Schedule, compounded annually on the Policy Anniversary Date as long as this rider and Your Policy remain in force. The amount available under this rider is equal to Your Inflated Lifetime Maximum reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.
When Increases Become Effective	The increase will be effective on each Policy Anniversary Date even if You are receiving benefits.
Premiums Increase As Benefits Increase	Your premium rate will also increase by the inflation protection percentage shown on Your Policy Schedule, compounded annually, on Your Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will continue as long as this rider and Your Policy remain in force. Your premium may also change subject to the other terms of the Policy. See the Our Limited Right to Change Premiums section of the Policy.
Inflated Lifetime Maximum	Inflated Lifetime Maximum means the new total amount of lifetime benefits payable to You after We apply any inflation protection increase under this rider. Prior to the first inflation protection increase, the Inflated Lifetime Maximum will be the same amount as the Lifetime Maximum. Your Inflated Lifetime Maximum is shown on Your Policy Schedule.
Termination	If You request that We remove this benefit from Your Policy, then on the date We receive Your request: <ul style="list-style-type: none">• Your benefit maximums will remain at the level they were as of the date We received Your request; and• Your premium will be changed to equal the amount that would be charged for the current benefit maximums based on Your original issue age and the rate schedule in effect at the time We receive Your request. Annual inflation protection increases will terminate if Your coverage is continuing in effect under: <ul style="list-style-type: none">• the Nonforfeiture Benefit – Shortened Benefit Period Rider, if any; or• the Contingent Nonforfeiture Benefit. This rider will also end if Your Policy terminates.

Signed for American General Life Insurance Company.


Secretary


President

**AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER
FUNDED WITH GRADED PREMIUM INCREASES TO AGE 65**

This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

- How This Rider Works** We will increase Your Inflated Lifetime Maximum and Your Monthly Maximum by the percentage shown on Your Policy Schedule, compounded annually on the Policy Anniversary Date as long as this rider and Your Policy remain in force. The amount available under this rider is equal to Your Inflated Lifetime Maximum reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.
- When Increases Become Effective** The increase will be effective on each Policy Anniversary Date even if You are receiving benefits.
- Premiums Increase As Benefits Increase** Your premium rate will also increase by the inflation protection percentage shown on Your Policy Schedule, compounded annually, on Your Policy Anniversary Date, as a result of these annual benefit increases. While You will continue to pay premium for these benefit increases as long as this rider and Your Policy remain in force, the premium rate increases will cease once You reach 65 years of age.
- Your premium may also change subject to the other terms of the Policy. See the Our Limited Right to Change Premiums section of the Policy.
- Inflated Lifetime Maximum** Inflated Lifetime Maximum means the new total amount of lifetime benefits payable to You after We apply any inflation protection increase under this rider. Prior to the first inflation protection increase, the Inflated Lifetime Maximum will be the same amount as the Lifetime Maximum. Your Inflated Lifetime Maximum is shown on Your Policy Schedule.
- Termination** If You request that We remove this benefit from Your Policy, then on the date We receive Your request:
- Your benefit maximums will remain at the level they were as of the date We received Your request; and
 - Your premium will be changed to equal the amount that would be charged for the current benefit maximums based on Your original issue age and the rate schedule in effect at the time We receive Your request.
- Annual inflation protection increases will terminate if Your coverage is continuing in effect under:
- the Nonforfeiture Benefit – Shortened Benefit Period Rider, if any; or
 - the Contingent Nonforfeiture Benefit.
- This rider will also end if Your Policy terminates.

Signed for American General Life Insurance Company.


Secretary


President

JOINT SURVIVOR BENEFIT RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Eligibility For Benefits Under This Rider

In order to be eligible for benefits under this rider, You and Your Spouse must both have been insured under the same policy form number and the same Joint Survivor Benefit Rider form, for a minimum of ten years and benefits cannot have been paid under either policy during this minimum period. If You and Your Insured Spouse are covered under the Joint Survivor Benefit Rider, Your Policy Schedule will show Your Insured Spouse's name and indicate that You and Your Spouse are covered by the Joint Survivor Benefit Rider.

How This Rider Works

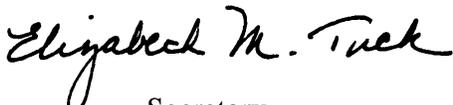
If either You or Your Spouse die while this rider is in force, We will waive premiums for the policy and any riders in force for the surviving spouse.

Termination

This rider ends on the earliest of the following:

- The date Your Policy or Your Spouse's policy described above terminates;
- The date either this rider terminates or the date Your Spouse's Joint Survivor Benefit Rider described above terminates; or
- The date either Your coverage or that of Your Spouse is continued in accordance with the terms of the Contingent Nonforfeiture Benefit; or, if purchased by You, the Nonforfeiture Benefit – Shortened Benefit Period Rider; or if purchased by You, the Paid-Up Premium Rider, including the Contingent Nonforfeiture Benefit in that rider.

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]

JOINT WAIVER OF PREMIUM RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Eligibility For This Rider

In order to be eligible for this rider, You and Your Spouse must both be insured under the same policy form number and both You and Your Spouse must elect the same Joint Waiver of Premium Rider form. If:

- You are covered under this rider; and
- Your Insured Spouse is covered under the same Joint Waiver of Premium Rider form;

Your Policy Schedule will show Your Insured Spouse's name and indicate that You and Your Spouse are covered by the Joint Waiver of Premium Rider.

How This Rider Works

If either You or Your Spouse become eligible for and begin to receive benefits while this rider is in effect, We will waive the premiums for the other spouse while the spouse receiving benefits continues to receive benefits. As long as You or Your Spouse continue to receive benefits, additional premiums will not be required. If You or Your Spouse cease to receive benefits, premium payments will again be required. You must pay such premiums beginning within 30 days of the date You or Your Spouse last receive a benefit.

Premiums will not be waived under this rider while the spouse receiving benefits is in the Elimination Period.

Termination

This rider ends on the earliest of the following:

- The date Your Policy or Your Spouse's policy terminates;
- The date either You or Your Spouse's Joint Waiver of Premium Rider terminates; or
- The date either Your coverage or that of Your Spouse is continued in accordance with the terms of the Contingent Nonforfeiture Benefit; or if purchased by You, the Nonforfeiture Benefit – Shortened Benefit Period Rider; or if purchased by You, the Paid-Up Premium Rider including the Contingent Nonforfeiture Benefit provided in that rider.

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]

NONFORFEITURE BENEFIT – SHORTENED BENEFIT PERIOD RIDER

This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works

This benefit provides a continuation of Your coverage, but on a reduced basis, in the event that Your coverage terminates due to non-payment of premium.

This Nonforfeiture benefit provides a continuation of Your coverage up to a specified dollar amount (called the Shortened Benefit Period Allowance) if Your coverage terminates due to non-payment of premium before the Lifetime Maximum has been exhausted. The conditions under which We will pay benefits under this provision are described below.

If Your coverage terminates due to non-payment of premium on or after the third anniversary of Your Policy Effective Date, We will pay benefits, subject to all of the terms and conditions of the Policy, until the Shortened Benefit Period Allowance has been reached. Benefits You receive will be payable up to the applicable monthly and lifetime benefit maximums in effect at the time Your coverage terminated due to non-payment of premium.

The Shortened Benefit Period Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for Your coverage, excluding any waived premiums; or (b) Your Monthly Maximum in effect at the time of lapse. The Shortened Benefit Period Allowance is reduced by the sum of all benefits previously paid to You.

Inflation Protection Will Not Apply To This Benefit

If You have elected an inflation protection rider, any benefit paid will be the benefit amount in effect on the date Your Policy lapses and no further increases in benefit amounts will occur.

Termination

Your coverage under this provision will end when the Shortened Benefit Period Allowance has been reached or Your Lifetime Maximum has been exhausted. In no event will the total of benefits payable under the Policy and this provision exceed the Lifetime Maximum.

Signed for American General Life Insurance Company.


Secretary


President

PAID-UP PREMIUM RIDER

This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works

This rider allows You to discontinue paying premiums after the later of:

- the first anniversary of the Policy Effective Date following Your 65th birthday; or
- the tenth anniversary of Your Policy Effective Date.

After the later of the above dates has occurred, no additional premiums will be due.

Prior to the date on which You may discontinue paying premiums pursuant to the paragraph above, We have the right to change Your premium, but only if We change premiums for all policies issued to persons in Your premium class, as specified in Our Limited Right to Change Premiums section of the Policy. We will not change premiums solely due to a change in Your age or health. Any change in premiums is subject to the other terms of the Policy.

No Other Riders May Be Added

Because You have elected this Paid-Up Premium Rider, no other riders may be added to Your coverage after the Policy Effective Date.

Termination

This rider will end on the earliest of:

- The date We receive Your request to change the premium payment period of Your Policy;
- The date Your Policy terminates; or
- The date Nonforfeiture coverage or Contingent Nonforfeiture coverage becomes effective under Your Policy.

Contingent Nonforfeiture Benefit

The following Contingent Nonforfeiture Benefit is in addition to the Contingent Nonforfeiture Benefit in Your Policy. If You are eligible for the Contingent Nonforfeiture Benefit in Your Policy and as described in this rider, You must choose between the one in Your Policy and the one in this rider, as only one of the benefits will apply. If You are not eligible for the Contingent Nonforfeiture Benefit in Your Policy, the Contingent Nonforfeiture Benefit in this rider will automatically apply.

The Contingent Nonforfeiture Benefit described in this rider is available to You regardless of whether or not You have purchased the Nonforfeiture Benefit Rider. Your Policy Schedule shows whether or not You are covered by this Paid- Up Premium Rider, which includes the Contingent Nonforfeiture Benefit described in this rider. The Contingent Nonforfeiture Benefit described in this rider will apply to You if, and only if, there is a Substantial Increase in the premium rates for Your coverage, as described below.

Definition of Substantial Increase

- A Substantial Increase in premium rates occurs if all of the following apply:
- there is an increase in premium rates so that the cumulative amount of all premium rate increases is considered to be a substantial increase in premium rates, as determined by the Schedule in this rider;
 - Your Policy lapses within 120 days of the due date for the payment of premiums; and
 - The ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period is 40%;

How This Benefit Works

- We will do all of the following on or before a Substantial Increase in premium rates is effective:
- We will offer to convert coverage to a paid-up status with the Reduced Benefit Allowance described in this rider. As long as the events described in the paragraph above occur, this option may be elected at any time during the 120-day period following the Premium Due Date.
 - We will offer to reduce Your current level of coverage without evidence of insurability so that the required premium rates for Your coverage are not increased.
 - If the ratio described in the Reduced Benefit Allowance definition is 40% or more, We will notify You that a default or lapse at any time during the 120-day period following the Premium Due Date will be deemed to be the election of the option to convert to a paid-up status with a Reduced Benefit Allowance. A default or lapse is Your failure to pay the required premiums within the grace period.

If You convert Your coverage to paid-up status in accordance with the provisions above, We will continue to pay benefits, subject to all of the terms and conditions of this Policy in effect at the time of lapse. Benefits for covered services will be paid up to the applicable monthly and lifetime benefit maximums in effect at the time Your Policy terminated due to non-payment of premium, until the Reduced Benefit Allowance has been reached or You no longer meet the Eligibility for the Payment of Benefits requirements of Your Policy.

Reduced Benefit Allowance

The Reduced Benefit Allowance will be an amount equal to 90% of the benefit maximums in effect immediately prior to the lapse multiplied by the ratio of the number of completed months of paid premiums divided by the number of months in the premium paying period.

Inflation Protection Will Not Apply to this Benefit

If You have elected an Inflation Protection Rider, any benefit paid on or after Your Policy lapses will be the benefit amount in effect on that date and no further increases in benefit amounts will occur.

When Coverage Ends

Your coverage under this Contingent Nonforfeiture Benefit ends when Your Reduced Benefit Allowance has been reached or the Lifetime Maximum has been exhausted.

Triggers for a Substantial Premium Increase

Cumulative premium increase over original premium that will allow this Contingent Nonforfeiture Benefit to be initiated. (Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

THE FOLLOWING TABLE DETERMINES WHAT CONSTITUTES A SUBSTANTIAL PREMIUM INCREASE FOR PURPOSES OF THE CONTINGENT NONFORFEITURE BENEFIT DESCRIBED IN THIS RIDER.

SCHEDULE	
Issue Age	Percentage of Increase Over Initial Annual Premium
Under 65	50%
65-80	30%
Over 80	10%

Signed for American General Life Insurance Company.


Secretary


President

RESTORATION OF BENEFITS RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

How This Benefit Works

Following a period during which We had been paying benefits but You did not exhaust:

- Your Lifetime Maximum; or
- Your Inflated Lifetime Maximum if an inflation protection rider increased Your coverage;

We will restore Your Lifetime Maximum or Your Inflated Lifetime Maximum after You meet the Qualification Free Period.

Your Lifetime Maximum or Inflated Lifetime Maximum may be restored an unlimited number of times, provided the Qualification Free Period is met each time.

Qualification Free Period is defined on the next page of this rider.

How Increases and Decreases are Handled

The benefits described above will be adjusted to reflect any voluntary increases or decreases in coverage You have elected. The benefits described above will be restored to the lesser of:

- The most recent amount in force just prior to the last time You began to receive benefits; or
- The new reduced amount of coverage You have elected.

When Benefits Are Restored

If all of the conditions of the Qualification Free Period are met, Your Lifetime Maximum or Your Inflated Lifetime Maximum amount will be restored on the 181st day after the start date of the Qualification Free Period, which is the last date for which You incurred Covered Expenses or received covered services. No Restoration of Benefits will be available if Your Lifetime Maximum or Your Inflated Lifetime Maximum has been exhausted, which automatically terminates Your Policy.

Qualification Free Period

Qualification Free Period means a period of 180 consecutive days during which a Licensed Health Care Practitioner certifies, and We verify, that You meet the following:

- You are able to perform, without Substantial Assistance from another individual, all six Activities of Daily Living (ADLs); and
- You do not require Substantial Supervision by another person to protect Yourself from threats to health and safety due to Severe Cognitive Impairment.

Termination

This rider ends on the earliest of the following:

- The date Your Policy terminates;
- The date this rider terminates pursuant to Your request or failure to pay premium; or
- The date Your coverage is continued in accordance with the terms of the Contingent Nonforfeiture Benefit; or, if purchased by You, the Paid-Up Premium Rider, including the Contingent Nonforfeiture Benefit provided in that rider.

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]
08009

RETURN OF PREMIUM AT DEATH BENEFIT RIDER

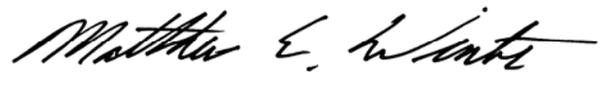
This rider is attached to and made part of Your Policy as of the Policy Effective Date shown on Your Policy Schedule. Your Application and premium put this rider in force as of the Policy Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

- How This Benefit Works** A Return of Premium At Death Benefit will be paid if You die while Your Policy and this rider are in force.
- How Much We Will Pay** The Return of Premium At Death Benefit is the total premium paid less claims. We will pay the total amount of premiums paid for the Policy and any applicable riders, from the Policy Effective Date up to the date of Your death. The amount of claims paid under Your Policy, including claims paid prior to a restoration of benefits pursuant to a Restoration of Benefits Rider, if applicable, will be deducted from the premiums paid.
- To Whom We Will Pay This Benefit** Payment of this benefit will be made in one lump sum to Your beneficiary. Your beneficiary will be as shown in Your Application unless later changed by You. If there is no named or living beneficiary on the date of Your death, the benefit will be paid to Your Spouse, if living, or to Your estate. You may change Your beneficiary at any time by giving written notice to Us. The effective date of the beneficiary change will be the date the change is received and recorded by Us.
- Termination** This rider terminates on the earliest of the following:
- The date this rider terminates pursuant to Your request or failure to pay premium; or
 - The date Your coverage is continued in accordance with the terms of the Nonforfeiture Benefit – Shortened Benefit Period Rider or Contingent Nonforfeiture Benefit.

This rider will also end if Your Policy terminates.

Signed for American General Life Insurance Company.


Secretary


President

SHARED CARE BENEFIT RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Eligibility For This Rider

In order to be eligible for this rider, You and Your Spouse must be insured under the same policy form number and maintain identical coverage. Your Policy Effective Dates must be the same. If You and Your Spouse have inflation protection riders, the riders must have become effective on the same date. If You are covered under this rider, Your Policy Schedule will show Your Insured Spouse's name and indicate that You and Your Spouse are covered by the Shared Care Benefit Rider.

How This Benefit Works

This rider establishes a separate fund, called the Shared Care Lifetime Maximum, shown on Your Policy Schedule. The Shared Care Lifetime Maximum is available to You upon exhaustion of Your Lifetime Maximum. The Shared Care Lifetime Maximum is available to Your Insured Spouse upon the exhaustion of Your Insured Spouse's Lifetime Maximum. You and Your Insured Spouse may access the Shared Care Lifetime Maximum at the same time, provided You both meet the Eligibility for the Payment of Benefits requirements and have exhausted Your own Lifetime Maximums.

If Your coverage or Your Insured Spouse's coverage under your respective policies or this rider terminates, please take note of the different treatment of the remaining Shared Care Lifetime Maximum, depending on the reason for the termination, as described below.

How Much We Will Pay

We will pay Covered Expenses subject to the limitations and conditions of the Policy, up to the Shared Care Lifetime Maximum. The Shared Care Lifetime Maximum is equal to Your Lifetime Maximum, which is also equal to Your Insured Spouse's Lifetime Maximum. The Shared Care Lifetime Maximum is one additional pool of benefits available to both You and Your Insured Spouse. The amount available under the Shared Care Lifetime Maximum is reduced by the amount of benefits paid under this rider to You and/or Your Insured Spouse.

Shared Care Lifetime Maximum

Shared Care Lifetime Maximum means the maximum benefit available under the Shared Care Benefit, as described in this rider. If an Inflation Protection Rider is in force under the Policy, the calculation of the Shared Care Lifetime Maximum is based upon the Inflated Lifetime Maximum.

No Reduction If One Policy Terminates Due to Death

If either You or Your Insured Spouse dies, the surviving spouse can choose to continue this rider by continuing to pay the required premiums for this rider. The entire amount of remaining benefits available under the Shared Care Lifetime Maximum in effect at the time of the spouse's death will remain in effect under the surviving spouse's coverage.

Coverage Reduction If One Policy Terminates Due to Reason Other Than Death

If, while neither You nor Your Insured Spouse is in claim status, one spouse's policy or this rider terminates for any reason other than death, this rider can be continued for the spouse whose coverage remains in force so long as the

required premium payments for this rider are made. The amount of coverage will equal one-half the benefits remaining under the Shared Care Lifetime Maximum amount in effect at the time of such termination or change.

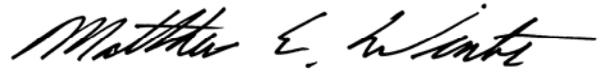
Termination

This benefit will terminate at the earliest of:

- the date of the termination of Your Policy or Your Insured Spouse's policy (unless You or Your Insured Spouse have continued coverage as described above);
- the date either You or Your Insured Spouse changes coverage under your policy so that Your coverage and Your Insured Spouse's coverage is no longer identical;
- the date Your Shared Care Lifetime Maximum has been exhausted;
- the last date for which premiums have been paid for this rider.

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]

WAIVER OF ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE BENEFITS RIDER

This rider is attached to and made part of Your Policy as of the Rider Effective Date shown below. Your Application and premium put this rider in force as of the Rider Effective Date. A copy of Your Application is attached. If the provisions of this rider and those of the Policy do not agree, the provisions of this rider will apply.

Waiver of Elimination Period For Home and Community Care Benefits

If You meet the Eligibility for the Payment of Benefits requirements and You incur Covered Expenses for Home and Community Care, We will waive the requirement that You must meet the Elimination Period before receiving Home and Community Care Benefits.

This rider does not waive the Elimination Period for any other benefit for which it is required, even if You receive the Home and Community Care Benefit first and then apply for another benefit.

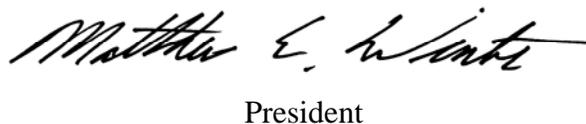
Termination

This rider ends on the earliest of the following:

- The date Your Policy terminates;
- The date this rider terminates pursuant to Your request or failure to pay premium; or
- The date Your coverage is continued in accordance with the terms of the Nonforfeiture Benefit – Shortened Benefit Period Rider or Contingent Nonforfeiture Benefit

Signed for American General Life Insurance Company.


Secretary


President

Rider Effective Date: [01/01/2008]

American General Life Insurance Company

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

1. **Premium Rate:** Premium rate that is applicable to you and that will be in effect until a request is made and approved for an increase is \$_____.

2. **The premium for this policy will be shown on the schedule page of your policy.**

3. **Rate Schedule Adjustments:**

The premium rates for this policy may change. Such change will be applied only when the same change is made on all policies of this Form issued to persons of the same classification in your state. We must give you at least 45 days written notice before we change premiums. The changed premium becomes effective on the premium due date to which the change in premium applies.

4. **Potential Rate Revisions:**

This policy is Guaranteed Renewable. This means that the rates for this product may be increased in the future. Your rate can NOT be increased due to your increasing age or declining health, but your rates may go up based on the experience of all policyholders with a policy similar to yours.

If you receive a premium rate or premium rate schedule increase in the future, you will be notified of the new premium amount and you will be able to exercise at least one of the following options:

- Pay the increased premium and continue your policy in force as is.
- Reduce your policy benefits to a level such that your premiums will not increase. (Subject to state law minimum standards.)
- Exercise your nonforfeiture option if purchased. (This option is available for purchase for an additional premium.)
- Exercise your contingent nonforfeiture rights.* (This option may be available if you do not purchase a nonforfeiture benefit rider.)

***Contingent Nonforfeiture**

If the premium rate for your policy goes up in the future and you didn't buy a nonforfeiture benefit rider, you may be eligible for contingent nonforfeiture. Here's how to tell if you are eligible:

You will keep some long-term care insurance coverage, if:

- Your premium after the increase exceeds your original premium by the percentage shown (or more) in the following table; and
- You lapse (not pay more premiums) within 120 days of the increase.

The amount of coverage (i.e., new lifetime maximum benefit amount) you will keep will equal the total amount of premiums you've paid since your policy was first issued. If you have already received benefits under the policy, so that the remaining maximum benefit amount is less than the total amount of premiums you've paid, the amount of coverage will be that remaining amount.

Except for this reduced lifetime maximum benefit amount, all other policy benefits will remain at the levels attained at the time of the lapse and will not increase thereafter. Should you choose this Contingent Nonforfeiture option, your policy, with this reduced maximum benefit amount, will be considered "paid-up" with no further premiums due.

Example:

- You bought the policy at age 65 and paid the \$1,000 annual premium for 10 years, so you have paid a total of \$10,000 in premium.
- In the eleventh year, you receive a rate increase of 50%, or \$500 for a new annual premium of \$1,500, and you decide to lapse the policy (not pay any more premiums).
- Your "paid-up" policy benefits are \$10,000 (provided you have at least \$10,000 of benefits remaining under your policy.)

**Contingent Nonforfeiture
Cumulative Premium Increase over Initial Premium
That Qualifies for Contingent Nonforfeiture**

(Percentage increase is cumulative from date of original issue. It does NOT represent a one time increase.)

Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium	Issue Age	Percent Increase Over Initial Premium
29 and under	200%	66	48%	79	22%
30-34	190%	67	46%	80	20%
35-39	170%	68	44%	81	19%
40-44	150%	69	42%	82	18%
45-49	130%	70	40%	83	17%
50-54	110%	71	38%	84	16%
55-59	90%	72	36%	85	15%
60	70%	73	34%	86	14%
61	66%	74	32%	87	13%
62	62%	75	30%	88	12%
63	58%	76	28%	89	11%
64	54%	77	26%	90 and over	10%
65	50%	78	24%		

The following contingent nonforfeiture disclosure applies only to those who have elected the Paid-Up Premium Rider.

In addition to the contingent nonforfeiture benefits described above, the following reduced “paid-up” contingent nonforfeiture benefit is an option in all policies that have a fixed or limited premium payment period, even if you selected a nonforfeiture benefit rider when you bought your policy. If both the reduced “paid-up” benefit AND the contingent benefit described above are triggered by the same rate increases, you can choose either of the two benefits.

You are eligible for the reduced “paid-up” contingent nonforfeiture benefit when all three conditions shown below are met:

1. The premium you are required to pay after the increase exceeds your original premium by the same percentage or more shown in the chart below;

Triggers for a Substantial Premium Increase

Issue Age	Percent Increase Over Initial Premium
Under 65	50%
65-80	30%
Over 80	10%

2. You stop paying your premiums within 120 days of when the premium increase took effect; AND
3. The ratio of the number of months you already paid premiums for is 40% or more than the number of months you originally agreed to pay.

If you exercise this option your coverage will be converted to reduced “paid-up” status. That means there will be no additional premiums required. Your benefits will change in the following ways:

- a. The total lifetime amount of benefits your reduced paid-up policy will provide can be determined by multiplying 90% of the lifetime benefit amount at the time the policy becomes paid-up by the ratio of the number of months you already paid premiums to the number of months you agreed to pay them.
- b. The monthly benefit amounts you purchased will also be adjusted by the same ratio.

Example:

- You bought the policy at age 65 with an annual premium payable for 10 years.
- In the sixth year, you receive a rate increase of 35% and you decide to stop paying premiums.
- Because you have already paid 50% of your total premium payments and that is more than the 40% ratio, your “paid-up” policy benefits are .45 (.90 times .50) times the total benefit amount that was in effect when you stopped paying your premiums. If you purchased inflation protection, it will not continue to apply to the benefits in the reduced “paid-up” policy.

AMERICAN GENERAL LIFE INSURANCE COMPANY

(herein called We, Us and Our)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, MN 55164-0889

Phone Number 888.565.3769]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

Policy Form Series 08000

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. You are advised to review carefully all limitations.

CAUTION: The issuance of this long term care insurance policy is based upon the responses to questions on your application. A copy of your application will be attached to your policy. If your answers are incorrect or untrue, We have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Us at this address: American General Life Insurance Company, [Long Term Care Correspondence, P.O. Box 64889, St. Paul, MN 55164-0889].

1. POLICY DESIGNATION

The policy is an individual policy of insurance issued in the state of residence.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

Renewability: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue your policy as long as premiums for your policy are paid on time. We cannot change any of the terms of your policy on Our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium: We will waive your premium payments that become due when you are receiving benefits under the policy, except for benefits payable during the Elimination Period.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We have a limited right to change the premium rates for your coverage. The premium rates for your coverage will not increase due to a change in your age or health. Premium rates may change on a premium class basis if We change the premiums for all similar policies issued in the same state and on the same policy form. We will give you at least 45 days written notice before We change the premiums for your coverage.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

You may return your policy for any reason within 30 days after you receive it. To do so, mail it to Us at the [Long Term Care Correspondence] address shown at the top of Page 1 in this Outline of Coverage; or return it to the agent or office through which it was bought. We will refund the full amount of any premium paid within 30 days of such a return; and the policy will be considered void from the start.

You may purchase an optional Return of Premium at Death Benefit Rider with the policy. See the Optional Riders section of this Outline of Coverage for details.

We will return unearned premium in the event your coverage terminates due to death, surrender or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We nor our agents represent Medicare, the federal government, or any state government.

8. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the Home.

This coverage includes two types of benefits, reimbursement and indemnity. Reimbursement benefits reimburse you for covered long term care expenses you incur. Indemnity benefits pay a fixed dollar amount regardless of expenses incurred. Both types of benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE POLICY – BENEFIT ELIGIBILITY

BENEFITS

Benefits are available up to the monthly and lifetime maximums until your Lifetime Maximum is exhausted. You must meet the Limitations or Conditions On Eligibility for Benefits requirements in order to receive benefits. The maximums are based on your coverage selections as shown on the solicitation materials and stated in the policy schedule you will receive if you become insured.

BASE POLICY BENEFITS

The following benefits are included in the base policy:

FACILITY CARE BENEFIT

Monthly benefits are payable for Covered Expenses you incur during your Confinement in a Nursing Home or Assisted Living Facility. Covered Expenses for Facility Care means expenses you incur during your Confinement for: room and board; ancillary services such as therapy services; patient supplies; and bed reservation to keep your bed in the facility while you are absent for any reason except discharge. Covered Expenses do not include expenses you incur for drugs or any charges for your comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. We will pay up to the Monthly Maximum for Covered Expenses you incur during your Confinement. The Facility Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. There is a maximum benefit for bed reservation of 30 days per calendar year. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

HOME AND COMMUNITY CARE BENEFIT

Monthly benefits are payable for Covered Expenses you incur for Home and Community Care. Covered Expenses for Home and Community Care means fees charged for the following services when provided to you by a Home Health Care Agency or by an Independent Provider: Home Health Care Services; and Maintenance or Personal Care Services. Covered Expenses also include care in an Adult Day Care Center. We will pay up to the Monthly Maximum for Covered Expenses you incur. The Home and Community Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

FLEXIBLE CARE BENEFIT

You are eligible to receive monthly cash benefits instead of the Facility Care Benefit or the Home and Community Care Benefit. If you choose to receive the Flexible Care Benefit, no other benefit is payable under the policy for any calendar month except for the Stay At Home Support Benefit. Additionally, this cash benefit might be used to pay for care not otherwise covered by the policy, such as care provided by an Immediate Family member. This cash benefit will be available beginning on the date you first satisfy the Limitations or Conditions On Eligibility for Benefits requirements. You are not required to incur any Covered Expenses in order to receive this benefit. However, you must be in compliance with the written individualized plan of services in your Plan of Care. You must notify Us in advance to receive Flexible Care Benefits. The Flexible Care Monthly Benefit is equal to 40% of the Monthly Maximum. The Flexible Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

INTERNATIONAL BENEFIT

You are eligible to receive monthly cash benefits when you are outside the United States, its territories, possessions and Canada. No other benefit is payable under the policy during any calendar month for which you receive the International Benefit. This cash benefit will be available beginning on the date you first satisfy the Limitations or Conditions On Eligibility for Benefits requirements. You are not required to incur any Covered Expenses in order to receive this benefit. However, you must be in compliance with the written individualized plan of services in your Plan of Care. You must provide written proof, in English, that you are Chronically Ill. You must also notify Us in advance to receive International Benefits. The notice must be made in writing and in English. The International Monthly Benefit is equal to 40% of the Monthly Maximum. The International Benefit is subject to the International Lifetime Maximum, which is 24 times the International Monthly Maximum. The International Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

STAY AT HOME SUPPORT BENEFIT

Benefits are payable for Covered Expenses you incur for Stay At Home Support. Covered Expenses for Stay At Home Support means Covered Expenses you incur for: Respite Care; Hospice Care; Caregiver Training; Home Modification; and Durable Medical Equipment. The Stay At Home Support Benefit is subject to the Stay At Home Support Lifetime Maximum and the Lifetime Maximum. It is not subject to the Elimination Period.

RESPITE CARE. Respite Care provides temporary relief for those persons who ordinarily care for you on a regular basis. Covered Expenses for Respite Care means: Covered Expenses for care in a Nursing Home or an Assisted Living Facility; or Covered Expenses for Home Health Care Services.

HOSPICE CARE. We must verify that you are Chronically Ill and Terminally Ill in order for Stay At Home Support Benefits to be payable for Hospice Care. Covered Expenses for Hospice Care means expenses you incur during your Confinement in a Hospice Care Facility or a Nursing Home for room and board, ancillary services provided by the facility and patient supplies; or expenses for Home Health Care Services.

CAREGIVER TRAINING. Stay At Home Support Benefits are payable for Covered Expenses you incur for training an Informal Caregiver (family or friend) to provide care for you in your Home. Covered Expenses for Caregiver Training means expenses you incur for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for you. The training cannot be received when you are confined in a hospital, Assisted Living Facility or Nursing Home, unless it is reasonably expected that the training will make it possible for you to return to your Home where you can be cared for by the person receiving the training.

HOME MODIFICATION. The Stay At Home Support Benefit is payable if Home Modification is recommended by a Care Coordinator in your Plan of Care and is mutually agreeable to you and Us as a cost-effective alternative to benefits otherwise provided by the policy. Covered Expenses for Home Modification means the cost of Home Modification if your Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to your Home that will enhance your ability to perform the Activities of Daily Living and allow you to remain in your Home safely.

DURABLE MEDICAL EQUIPMENT. The Stay At Home Support Benefit is payable if the use of Durable Medical Equipment is specified in your Plan of Care and is mutually agreeable to you and Us as a cost-effective alternative to benefits otherwise provided by the policy. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

FUTURE CARE BENEFIT

We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the policy. Benefits and services can be authorized if We determine that they: are cost-effective; are appropriate to your needs; are consistent with general standards of care; provide you with an equal or greater quality of care; and are for and constitute Qualified Long Term Care Services. Any benefits, treatments or services We authorize must also be agreed to by you or your Representative and, if appropriate, your Physician. We reserve the right to decline to authorize benefits and services.

CONTINGENT NONFORFEITURE BENEFIT

You will receive coverage under this benefit if you do not elect the Nonforfeiture Benefit Rider. If there is a substantial increase in premium rates, you will be given the right to reduce coverage or convert to a paid-up status with a reduced Lifetime Maximum called the Shortened Benefit Period Allowance. The Shortened Benefit Period Allowance is equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) your Monthly Maximum in effect at the time of lapse. In no event will the total of benefits payable under the policy exceed the Lifetime Maximum.

OPTIONAL RIDERS

The following are optional benefit riders that may be purchased:

OPTIONAL JOINT SURVIVOR BENEFIT RIDER

In order to be eligible for benefits under this rider, you and your Spouse must both have been insured under the same policy form number and the same Joint Survivor Benefit Rider form, for a minimum of ten years

and benefits cannot have been paid under either policy during this minimum period. If either you or your Spouse die while this rider is in force, We will waive premiums for the policy and any riders in force for the surviving spouse.

OPTIONAL JOINT WAIVER OF PREMIUM BENEFIT RIDER

In order to be eligible for this rider, you and your Spouse must both be insured under the same policy form number and both You and Your Spouse must elect the same Joint Waiver of Premium Rider form. If either you or your Spouse become eligible for and begin to receive benefits while this rider is in effect, We will waive the premiums for the other spouse while the spouse receiving benefits continues to receive benefits. As long as you or your Spouse continue to receive benefits, additional premiums will not be required. If you or your Spouse cease to receive benefits, premium payments will again be required.

OPTIONAL NONFORFEITURE BENEFIT RIDER

If you are covered by the Nonforfeiture Benefit Rider, it will provide a continuation of your coverage up to a specified dollar amount, called the Shortened Benefit Period Allowance, if your coverage terminates due to non-payment of premium before your Lifetime Maximum has been paid. If your coverage terminates due to non-payment of premium on or after the third anniversary of your Policy Effective Date, We will pay benefits, subject to all of the terms and conditions of your policy: until the Shortened Benefit Period Allowance has been reached; or the date you no longer meet the Limitations or Conditions On Eligibility for Benefits requirements; whichever occurs first. The Shortened Benefit Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) your Monthly Maximum in effect at the time of lapse. In no event will the total of benefits payable under the policy exceed the Lifetime Maximum.

OPTIONAL PAID-UP PREMIUM RIDER

This rider allows you to discontinue paying premiums after the later of: the first anniversary of the Policy Effective Date following your 65th birthday; or the tenth anniversary of your Policy Effective Date. After the later of these dates has occurred, no additional premiums will be due. If you elect this rider and are eligible for the Contingent Nonforfeiture Benefit in the policy, should that benefit activate you may choose between the Contingent Nonforfeiture Benefit in the policy and a different one available only to those who have the Paid-Up Premium Rider. If you are not eligible for the Contingent Nonforfeiture Benefit in the policy, the one available to those who have the Paid-Up Premium Rider will automatically activate should it be triggered.

OPTIONAL RESTORATION OF BENEFITS RIDER

Following a period during which We had been paying benefits but you did not exhaust: your Lifetime Maximum; or your Inflated Lifetime Maximum if an inflation protection rider increased your coverage; We will restore your Lifetime Maximum or your Inflated Lifetime Maximum after you meet the Qualification Free Period. Your Lifetime Maximum or Inflated Lifetime Maximum may be restored an unlimited number of times, provided the Qualification Free Period is met each time.

OPTIONAL RETURN OF PREMIUM AT DEATH BENEFIT RIDER

A Return of Premium At Death Benefit will be paid if you die while your policy and this rider are in force. We will pay the total amount of premiums paid for the policy and any applicable riders, from the Policy Effective Date up to the date of your death. The amount of claims paid under your policy, including claims paid prior to a restoration of benefits pursuant to a Restoration of Benefits Rider, if applicable, will be deducted from the premiums paid.

OPTIONAL SHARED CARE BENEFIT RIDER

In order to be eligible for this rider, you and your Spouse must be insured under the same policy form number and maintain identical coverage. Your Policy Effective Dates must be the same. If you and your

Spouse have inflation protection riders, the riders must have become effective on the same date. This rider establishes a separate fund, called the Shared Care Lifetime Maximum. The Shared Care Lifetime Maximum is available to you upon exhaustion of your Lifetime Maximum. The Shared Care Lifetime Maximum is available to your insured Spouse upon the exhaustion of your insured Spouse's Lifetime Maximum. You and your insured Spouse may access the Shared Care Lifetime Maximum at the same time, provided you both meet the Limitations or Conditions On Eligibility for Benefits requirements and have exhausted your own Lifetime Maximums.

OPTIONAL WAIVER OF ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE BENEFIT RIDER

If you meet the Limitations or Conditions On Eligibility for Benefits requirements and you incur Covered Expenses for Home and Community Care, We will waive the requirement that you must meet the Elimination Period before receiving Home and Community Care Benefits. This rider does not waive the Elimination Period for any other benefit for which it is required, even if you receive the Home and Community Care Benefit first and then apply for another benefit.

AUTOMATIC INFLATION PROTECTION RIDERS - SEE RELATIONSHIP OF COST OF CARE AND BENEFITS

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

For you to be eligible for benefits provided by your coverage, We must verify that you are Chronically Ill and that you have been certified as Chronically Ill within the past 12 months by a Licensed Health Care Practitioner. In addition:

- The service, if applicable, must be covered under the policy and provided pursuant to a written Plan of Care for you that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill;
- Coverage under the policy must be in force on the date(s) the care is received;
- You must satisfy the applicable Elimination Period;
- You must not have exhausted the applicable limits on the specific benefits claimed, or the Lifetime Maximum for the policy; and
- You must meet the additional requirements for the specific benefits you claim.

Benefit payments cease when your Lifetime Maximum is exhausted and are subject to: the Elimination Period; and all other limits determined from the specific benefits.

Those limits are based on your coverage selections as shown on the application and stated in the policy schedule you will receive if you become insured.

10. EXCLUSIONS AND LIMITATIONS

There are no pre-existing conditions exclusions or limitations for conditions disclosed on your application.

Non-eligible Facilities/Providers: Any facility or provider for a given benefit that does not fall within the "Definitions" section would be a non-eligible facility/provider for that benefit.

Non-eligible Levels of Care: Coverage is not based on the specific level of care. Rather, coverage is for care furnished for a specific covered reason, by or through the covered facilities and providers. Care from family members is covered only when specifically indicated.

Exclusions/Exceptions and Limitations: We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by your Immediate Family unless he or she is a regular employee of an organization which is providing the treatment, service or care and the organization receives the payment for such treatment, service or care;
- Care or services provided by your Immediate Family member unless you are compensating him or her through proceeds from your Flexible Care Benefit;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, its territories and possessions and Canada, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Care or services that result from war or any act of war (whether declared or undeclared);
- Treatment provided in a government facility (unless otherwise required by law); or services for which benefits are available under Medicare or other governmental program (except Medicaid); or
- Services received while the policy is not in force.

Non-Duplication: We will not pay benefits for services or items for which benefits are payable by Medicare. We will pay the difference between your actual expense and the benefits payable by Medicaid or private insurance.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of the policy may be adjusted. You may purchase one of the inflation protection riders to increase your coverage. Only increases taken in accordance with one of the inflation protection riders do not require proof of insurability.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the anniversary of the Rider Effective Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.

AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the anniversary of the Rider Effective Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 5%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will continue as long as this rider and your policy remain in effect.

AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 3%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will continue as long as this rider and your policy remain in effect.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES TO AGE 65

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 5%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will cease once you reach 65 years of age.

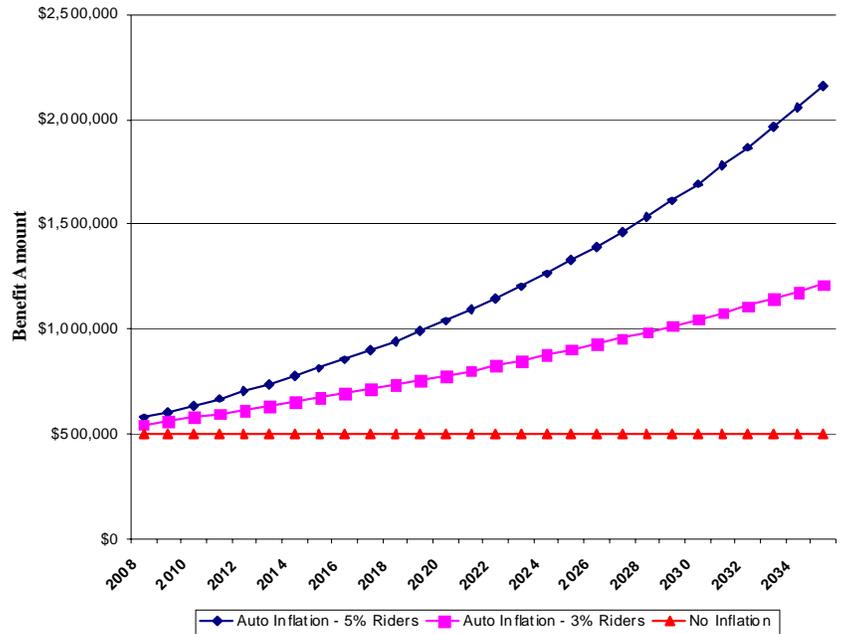
AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES TO 65

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 3%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will cease once you reach 65 years of age.

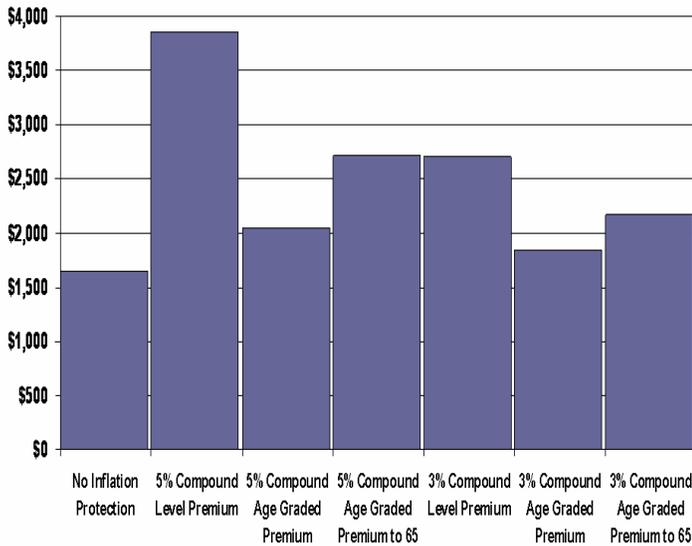
Inflation Protection – Graphic Comparisons

Benefit Levels

The chart to the right compares and contrasts benefit levels for a policy with no inflation protection rider and policies with the 5% compound and 3% compound automatic inflation protection riders offered with the policy. The chart assumes that the insured starts with a Lifetime Maximum of \$500,000.



Inflation Protection Initial Annual Premium Illustration



The chart to the left compares the initial annual premium paid by an insured, whose policy was issued when he was 52, for one policy with no inflation protection rider and one policy with each of the following automatic inflation protection riders available under the policy:

- 5% Compound For Life
- 3% Compound For Life
- 5% Compound For Life Funded With Graded Premium Increases
- 3% Compound For Life Funded With Graded Premium Increases
- 5% Compound For Life Funded With Graded Premium Increases To Age 65
- 3% Compound For Life Funded With Graded Premium Increases To Age 65

It assumes the following: a Lifetime Maximum of \$500,000; a Monthly Maximum of \$6,000; and no other riders in force under the policy.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application for coverage is approved, the policy provides coverage for those who are Chronically Ill as a result of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

13. PREMIUM

The initial premium for your coverage will be determined based on the amount of coverage and riders selected and your issue age as described in your application. The chart below can be completed to show your annual premiums.

PREMIUM	
Premium Payment Mode* (Adjustment Factor)	Base Policy Coverage: [\$XX.XX]
<ul style="list-style-type: none"> ○ Annual = 1.00 ○ Semi-Annual = .52 ○ Quarterly = .265 ○ Monthly = .090 	Automatic Inflation Protection – 3%/5% Compound For Life Rider: [\$XX.XX] Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases: [\$XX.XX] Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases to Age 65: [\$XX.XX] Joint Survivor Benefit Rider: [\$XX.XX] Joint Waiver of Premium Rider: [\$XX.XX] Nonforfeiture Benefit – Shortened Benefit Period Rider: [\$XX.XX] Paid-Up Premium Rider: [\$XX.XX] Restoration of Benefits Rider: [\$XX.XX] Return of Premium at Death Benefit Rider: [\$XX.XX] Shared Care Benefit Rider: [\$XX.XX] Waiver of Elimination Period for Home and Community Care Benefits Rider: [\$XX.XX] ANNUAL TOTAL: [\$XX.XX] Modal Premium Amount: [\$XX.XX]

*Premiums payable other than annually are equal to a percentage of the annual premium and include additional premium charges. You will save money by paying the premium on an annual basis.

14. ADDITIONAL FEATURES

Underwriting

We will underwrite your application by reviewing one or more of the following: the information submitted on your application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Care Coordination

Care Coordination is intended to help identify care needs and community resources available to deliver care when you are Chronically Ill.

Care Coordination will provide you with a Care Coordinator who will review your specific situation and develop Plans of Care to meet your needs. Your Care Coordinator will: assess your functional, cognitive and personal needs for care and services on an ongoing basis; work with you to determine the specific services you require; develop and suggest initial and subsequent Plans of Care to assist you in meeting your needs; coordinate and monitor your care needs on an ongoing basis to help you receive appropriate care; and help you arrange for care, if you desire.

There is no Elimination Period for Care Coordination. We will then make arrangements for a Care Coordinator to contact you and begin providing you with this assistance. You are not required to use Care Coordination. Care Coordination may not be available outside the United States.

Continuation for Lapse Due to Cognitive or Functional Impairment

If your coverage terminates due to non-payment of premiums, We will provide a retroactive continuation of coverage if within five (5) months of the termination date you provide Us with proof that you were Chronically Ill, beginning on or before the termination date of the grace period. All past due premiums for your coverage that was in force immediately prior to the date of lapse must be paid. In that event, any benefits for which you qualified during the continuation period will be paid to the same extent they would have been paid if your coverage had remained in force from the date of termination.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE COVERAGE.

DEFINITIONS

This section provides the definitions of words used in this Outline of Coverage that have a special meaning when applied to your coverage. To help You recognize these special words and phrases, the first letter of each word is capitalized wherever it appears.

Activities of Daily Living (ADLs) means the following self-care functions:

Bathing: Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Adult Day Care means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it operates on less than a 24 hour basis;
- it keeps written record of services for each person; and
- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment means an evaluation done by a Licensed Health Care Practitioner to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Facility means a facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets all of the following requirements:

- it provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- it has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- it makes and keeps records of all care and services provided to each resident;
- it provides at least three meals a day and accommodates special dietary needs;
- it provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- it has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- it has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorder; a Nursing Home; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordinator means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill.

Care Coordination means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- the performance of comprehensive individualized Assessments, including reassessments as needed;
- the development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in your condition;
- the coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by you or your Representative and determined necessary by the Care Coordinator.

Care Coordination Provider means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Chronically Ill means that you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that you meet such requirements.

Confinement or Confined means you are a resident in a Nursing Home, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses means costs you incur for Qualified Long Term Care Services and for which a benefit is payable under the policy. Each benefit section defines its own Covered Expenses.

Domestic Partner means a person who lives with You in a domestic partner relationship, provided that You have completed and returned to Us a Declaration of Domestic Partnership in a form and manner required by Us.

Durable Medical Equipment means equipment included in your Plan of Care which:

- can enhance your abilities to perform Activities of Daily Living;
- is functionally necessary and not just for your convenience;
- is designed for repeated and prolonged use; and
- is suited for use in the home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in your body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period means the total number of days that you are Chronically Ill before benefits are payable. You need not receive covered services on a day in order for that day to count towards meeting the Elimination Period. The Elimination Period begins on the first day you contact Us if We verify that you are Chronically Ill. Each day on which you are Chronically Ill will count towards the Elimination Period. The days do not have to be consecutive.

The start of the Elimination Period will be no earlier than the date you contact Us, unless We can reasonably establish that you met these requirements before the filing of a claim. We may require that you provide Us with proof that you received covered services prior to the date You contacted Us. However, in no case will the Elimination Period start date be more than:

- 90 days prior to your contacting Us for a loss related to the inability to perform Activities of Daily Living; or
- 365 days prior to your contacting Us for a loss due to Severe Cognitive Impairment.

The Elimination Period need only be met once during your lifetime. The Elimination Period does not apply to the Stay At Home Support Benefit or Care Coordination.

Flexible Care Monthly Benefit means the total amount of monthly benefits payable under this policy for the Flexible Care Benefit. It is equal to 40% of the Monthly Maximum.

Home means your domicile. Home does not include:

- a Nursing Home, Assisted Living Facility or Hospice Care Facility;
- a hospital; or
- any other institutional setting.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;

- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- have the appropriate state licensure or certification, where required or available.

Home Health Care Services means the following services provided in your Home:

- part-time or intermittent skilled services provided by licensed nursing personnel;
- home health aide services; and
- physical therapy, respiratory therapy, occupational therapy, or speech therapy or medical social services.

Home Modification means the labor, equipment, and supplies used to make changes in your Home. These changes must be designed to:

- enhance your ability to perform Activities of Daily Living; and
- allow you to live safely and independently in your Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Hospice Care means services designed to provide palliative care and alleviate your physical, emotional and social discomforts if you are Terminally Ill and in the last phases of life.

Hospice Care Facility means a facility which provides a formal hospice care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family means your Spouse, your parents, your brothers and sisters and your children by blood, adoption or marriage.

Inflated Lifetime Maximum means the new total amount of lifetime benefits payable to you after We apply any inflation protection increase under an inflation protection rider. Prior to the first inflation protection increase, the Inflated Lifetime Maximum will be the same amount as the Lifetime Maximum.

Informal Caregiver means the person who has responsibility for providing nonprofessional care on an unpaid basis for you in your Home. With the exception of an Informal Caregiver you choose to compensate under the Flexible Care Benefit, a person who is paid to care for you cannot be an Informal Caregiver.

International Lifetime Maximum means the maximum benefit payable under this policy for the International Benefit.

International Monthly Benefit means the total amount of monthly benefits payable under this policy for the International Benefit. It is equal to 40% of the Monthly Maximum.

Licensed Health Care Practitioner means any of the following who is not an Immediate Family member: a Physician (as defined in this section); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Lifetime Maximum means the total amount of lifetime benefits payable under the policy. The Lifetime Maximum will increase in accordance with the terms of any Inflation Protection Rider.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare means title XVIII of the Social Security Act.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of your illness will be used.

Monthly Maximum means the total amount of monthly benefits payable under the policy for either the Facility Care Benefit or the Home and Community Care Benefit. The Monthly Maximum will increase in accordance with the terms of any Inflation Protection Rider in force.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.

Nursing Home means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. It also:

- provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (R.N.) or a Physician;
- maintains a daily medical record of each inpatient; and
- provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home also means a facility that is licensed as a specialized Alzheimer's Unit in all states where such licensure exists.

A Nursing Home is not: a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorder; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home only if it: meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner. It specifies your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- Your functional or cognitive abilities;
- Your social situation; and
- Your care service needs.

Policy Effective Date means the date coverage is effective under the policy.

Policy Anniversary Date means the annually recurring date when coverage began under the Policy.

Qualification Free Period means a period of 180 consecutive days during which a Licensed Health Care Practitioner certifies, and We verify, that you meet the following:

- You are able to perform, without Substantial Assistance from another individual, all six Activities of Daily Living (ADLs); and
- You do not require Substantial Supervision by another person to protect yourself from threats to health and safety due to Severe Cognitive Impairment.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative means a person or entity legally empowered to represent You.

Respite Care means supervision and care you receive while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Rider Effective Date means the date a rider becomes effective under this Policy. A Rider Effective Date is the Policy Effective Date unless otherwise shown on the rider.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

- short-term or long-term memory;
- orientation as to people, places or time; and
- deductive or abstract reasoning.

Spouse means the person to whom you are legally married or your Domestic Partner.

Stay At Home Support Lifetime Maximum means the maximum benefit payable under the Stay at Home Support Benefit, which is not to exceed ten percent of either the Lifetime Maximum or, if an Inflation Protection Rider applies, the Inflated Lifetime Maximum.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which you would be unable to perform the Activities of Daily Living. Standby Assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill means having six months or less to live, as certified by a Physician.

We, Us, Our means American General Life Insurance Company.

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889 Telephone: 888.565.3769]

New Application Reinstatement Coverage Change Exchange

A. Applicant Information **Print clearly – Use black ink**

Name (First) _____ (MI) _____ (Last) _____

Address _____ Apt. # _____

City _____ State _____ ZIP code _____ Date of Birth ____ / ____ / ____

Social Security Number _____ — _____ — _____

Gender: Male Female Marital status: Married Single Widowed Domestic Partner

Work Phone Number _____ — _____ — _____ Home Phone Number _____ — _____ — _____

Cell Phone Number _____ — _____ — _____ Best time to call _____ a.m. _____ p.m. Home Work

Applicant's E-mail Address _____

B. Spouse or Legally Recognized Domestic Partner Information **Please complete the information below for all applicants.**

Name (First) _____ (MI) _____ (Last) _____

Social Security Number _____ Date of Birth _____

Is the applicant's spouse or legally recognized domestic partner applying? Yes No

If No, please explain why: _____

C. Insurability Profile **Please answer these questions BEFORE you continue with other parts of this Application**

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have or have you ever been diagnosed by a healthcare professional as having any of the following: Yes No (If yes, check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test | <input type="checkbox"/> Diabetes with Stroke or TIA | <input type="checkbox"/> More than one TIA or Stroke |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) | <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Myasthenia Gravis, generalized |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Metastatic Cancer (cancer that has spread from its original site) | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> Mild Cognitive Impairment (MCI) | <input type="checkbox"/> Schizophrenia or other forms of Psychosis |
| | | <input type="checkbox"/> Senility |

In most cases, answering "Yes" to questions 1, 2, or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information**Please provide the following information about your personal physician, sometimes called your Primary Health Care Provider (the physician with most of your medical records).**

Physician's Name (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

Have you seen this physician in the last two years? Yes No

Date of last visit: _____ Reason: _____

E. Medication History**IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER**

1. Please list all prescription medications that you are currently taking or have been prescribed in the last 36 months.

Medication	Dosage	Reason

F. Medical History**IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.**

1. In the past 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE.)

- | | |
|---|---|
| <input type="checkbox"/> 1. Alcoholism | <input type="checkbox"/> 28. Hypertension |
| <input type="checkbox"/> 2. Amputation | <input type="checkbox"/> 29. Immune System Disorder |
| <input type="checkbox"/> 3. Anemia | <input type="checkbox"/> 30. Injury due to Falls or Imbalance |
| <input type="checkbox"/> 4. Angioplasty or Heart Surgery | <input type="checkbox"/> 31. Joint Replacement or Surgery |
| <input type="checkbox"/> 5. Arthritis, Osteoarthritis | <input type="checkbox"/> 32. Kidney Disease |
| <input type="checkbox"/> 6. Asthma | <input type="checkbox"/> 33. Leukemia |
| <input type="checkbox"/> 7. Atrial Fibrillation | <input type="checkbox"/> 34. Lupus, Systemic Lupus (SLE) |
| <input type="checkbox"/> 8. Back or Spine Condition | <input type="checkbox"/> 35. Manic Depressive Illness |
| <input type="checkbox"/> 9. Brain Disorder or Brain Tumor | <input type="checkbox"/> 36. Mental Illness |
| <input type="checkbox"/> 10. Cancer | <input type="checkbox"/> 37. Multiple Myeloma |
| <input type="checkbox"/> 11. Cardiomyopathy or Congestive Heart Failure | <input type="checkbox"/> 38. Myasthenia Gravis |
| <input type="checkbox"/> 12. Carotid or other Arterial Surgery | <input type="checkbox"/> 39. Organ Transplant |
| <input type="checkbox"/> 13. Chronic Bronchitis | <input type="checkbox"/> 40. Osteoporosis |
| <input type="checkbox"/> 14. Chronic Fatigue Syndrome | <input type="checkbox"/> 41. Other Conditions Causing Crippling or Limited Motion or Requiring Adaptive Devices |
| <input type="checkbox"/> 15. Depression or Anxiety | <input type="checkbox"/> 42. Other Connective Tissue Disease |
| <input type="checkbox"/> 16. Diabetes | <input type="checkbox"/> 43. Paralysis |
| <input type="checkbox"/> 17. Disorders of Speech | <input type="checkbox"/> 44. Peripheral Vascular Disease (PVD) |
| <input type="checkbox"/> 18. Disorders of Vision | <input type="checkbox"/> 45. Post-Polio Syndrome |
| <input type="checkbox"/> 19. Drug Addiction | <input type="checkbox"/> 46. Rheumatoid Arthritis |
| <input type="checkbox"/> 20. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> 47. Scleroderma |
| <input type="checkbox"/> 21. Epilepsy, Seizures or Convulsions | <input type="checkbox"/> 48. Skin Ulcers |
| <input type="checkbox"/> 22. Fainting Spells or Blacking Out | <input type="checkbox"/> 49. Stroke |
| <input type="checkbox"/> 23. Fibromyalgia | <input type="checkbox"/> 50. Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> 24. Fractures | <input type="checkbox"/> 51. Tremor |
| <input type="checkbox"/> 25. Heart Attack or Angina | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> 26. Hepatitis | |
| <input type="checkbox"/> 27. Hodgkin's Disease or other Lymphoma | |

F. Medical History (Continued)

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

Please give details below to all boxes checked in Question #1.

Number	Dates From/To	Physician's Name / Address / Phone	Describe

2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If **Yes**, please describe and give details. _____

3. In the past 3 years, have you:

a. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If **Yes**, please explain and include dates and reasons. _____

b. Consulted with or been treated for any reason by a Healthcare Professional who is a specialist, OTHER THAN your Primary Health Care Provider, eye doctor or dentist? Yes No

If **Yes**, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

c. Required assistance with shopping, using transportation, housekeeping, cooking, laundry, managing your finances or managing your medication? Yes No

If **Yes**, please explain type of assistance required and include dates and reasons. _____

d. Currently in the midst of a medical work-up or been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

If **Yes**, please explain type, reason and scheduled date of the evaluation, testing or surgery. _____

e. Received disability income, workers' compensation or any state or Social Security Disability Benefits, salary continuation or extended sick leave?..... Yes No

If **Yes**, please explain type, cause and date. _____

f. Used any form of tobacco or nicotine product? Yes No

Date last used	How long? (years)	List type of tobacco or nicotine products used

F. Medical History (Continued)

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

g. Consumed alcoholic beverages? Yes No

If **Yes**, how often? _____ How much? _____

h. Been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? Yes No

If **Yes**, when were you last treated? _____

i. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No

If **Yes**, by which company and for what reason? _____

4. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

G. Applicant Profile

1. Do you work 20 or more hours a week outside your home? Yes No

If **Yes**, please list your occupation and number of hours worked per week. _____

2. Do you perform volunteer work? Yes No

If **Yes**, please list type of work and number of hours worked per week. _____

3. Do you have any hobbies, interests, or participate in any exercise program on a regular basis? Yes No

If **Yes**, please describe. _____

4. Do you drive an automobile? Yes No

If **Yes**, please provide approximate annual mileage: _____ miles

5. Do you have a Handicap Placard and/or automobile license plate? Yes No

If **Yes**, please explain. _____

6. With whom do you live? Alone Spouse Family Other

7. Do you live in some form of a residential retirement community? Yes No

If **Yes**, please list the specific services that you are receiving (e.g., housekeeping, laundry, meals). _____

H. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No

2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No

3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

I. Protection Against Unintended Lapse

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Please check one of the following: I elect **NOT** to name an authorized designee to receive this notice.
 I elect to name an authorized designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

If you wish to name more than one designee, please attach a separate sheet.

You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company, [Long Term Care Correspondence, P.O. Box 64889, St. Paul, MN 55164-0889].

J. Coverage Selections

Please select your coverage options.

Premium Class Quoted: Preferred Standard

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000
 \$9,000 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65
- I reject Automatic Inflation Protection**

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes,** I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No.** I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

K. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First) _____ (MI) _____ (Last) _____

Social Security or Tax ID Number _____

Address _____ Apt. # _____

City _____ State _____ ZIP code _____ Date of Birth _____

Telephone _____

L. Premium Payment Authorization

Complete this section to authorize premium payment

1. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

2. **ELECTRONIC FUNDS TRANSFER.** I have filled out a separate Electronic Funds Transfer form.

[OR

3. **CHARGE MY CREDIT CARD.** I have filled out a separate credit card authorization form.]

M. Premium Receipt

In this receipt, the "Company" refers to American General Life Insurance Company.

Received from:

Name of Applicant (First) _____ (MI) _____ (Last) _____

in the sum of \$ _____ to apply towards the initial modal premium, if the policy applied for is issued for the amount stated in the application.

SUBMISSION OF THE APPLICATION AND TENDER OF THE AMOUNT STATED DOES NOT PLACE ANY INSURANCE IN FORCE.

If the Company determines that the applicant was not entitled under the Company's underwriting rules and standards to insurance for the amount applied for, the insurance will not become effective, and the amount tendered will be returned to the applicant. **ANY DELAY IN THE RETURN OF THE AMOUNT TENDERED CANNOT BE CONSTRUED AS APPROVAL OF THE APPLICATION.**

No agent or medical examiner has authority to determine insurability or to make or modify any contract of insurance or to waive any requirement or rights of the Company.

Agent Signature: _____ Date: _____

Agent Name (First) _____ (MI) _____ (Last) _____

PLEASE SIGN AND LEAVE THIS PAGE WITH THE APPLICANT

N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties. I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health.

I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below

to give the Company, its legal representatives, American General Life Insurance Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part I, Protection Against Unintended Lapse; Part J, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part K, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

E-mail Address _____



Multi-Life Short Form Long Term Care Insurance Application Arkansas Version

American General Life Insurance Company

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889 Telephone: 888.565.3769]

Application type options: New Application, Reinstatement, Coverage Change, Exchange

A. Eligible Employee Information Print clearly - Use black ink

Name (First) (MI) (Last)

Address City State ZIP code Date of Birth

Social Security Number Gender (Male/Female) Marital status (Married/Single/Widowed/Domestic Partner)

Work Phone Number Home Phone Number Cell Phone Number

Best time to call a.m. p.m. Home Work

Eligible Employee's E-mail Address

Name of Eligible Employee's Employer

Date of Hire Position

Actively At Work Certification

I certify that I am an actively at work employee. I understand that coverage will not go into effect for me unless I am Actively at Work for the prior 30 calendar day period. Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a full-time basis [at least 30 hours each week]. I will be considered Actively at Work while on employer-approved vacations, holidays and regularly-scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, Worker's Compensation, short-term or long-term medical or disability leave, sick leave, a sabbatical or retired from the same employer.

X Employee Signature Date

B. Spouse or Legally Recognized Domestic Partner Information Please complete the information below for all applicants.

Name (First) (MI) (Last)

Social Security Number Date of Birth

Is the applicant's spouse or legally recognized domestic partner applying? Yes No

If No, please explain why:

C. Insurability Profile

Please answer these questions **BEFORE** you continue with other parts of this Application

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: ... Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have, or have you ever been diagnosed with, or treated by a healthcare professional for, any of the following: (If yes, check all that apply) Yes No

- | | | |
|---|--|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test | <input type="checkbox"/> Diabetes with Stroke or TIA | <input type="checkbox"/> More than one TIA or Stroke |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) | <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Myasthenia Gravis, generalized |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Metastatic Cancer (cancer that has spread from its original site) | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> Mild Cognitive Impairment (MCI) | <input type="checkbox"/> Schizophrenia or other forms of Psychosis |
| | | <input type="checkbox"/> Senility |

In most cases, answering "Yes" to questions 1, 2 or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Health Care Provider (the physician with most of your medical records).

Physician's Name (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

Have you seen this physician in the last two years? Yes No

Date of last visit: _____ Reason: _____

E. Medication History

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER

1. Please list all prescription medications that you are currently taking or have been prescribed in the past 36 months

Medication	Dosage	Reason

F. Medical History

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

1. In the past 3 years, have you:

a. Received advice, treatment, diagnosis or consultation from a healthcare professional for any of the following?

- Anxiety, bipolar disease, depression Yes No
- Cancer Yes No
- Cardiovascular disease Yes No
- Chronic lung disease, COPD, or emphysema Yes No
- Connective tissue disorder(s), lupus, scleroderma, CREST Yes No
- Diabetes Yes No
- Hepatitis or other liver disease Yes No
- Hypertension Yes No
- Kidney Disease or Kidney Transplant Yes No
- Neurological, neuromuscular disease or disease of the spine Yes No
- Peripheral Vascular Disease (PVD) Yes No
- Rheumatoid Arthritis or other forms of arthritis Yes No
- Stroke or Transient Ischemic Attack (TIA) Yes No

b. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If **Yes**, please explain and include dates and reasons. _____

c. Consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Health Care Provider, eye doctor or dentist? Yes No

If **Yes**, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

d. Had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If **Yes**, please describe. _____

e. Had a medical work-up or been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

If **Yes**, please explain type, reason and scheduled date of the evaluation, testing or surgery. _____

f. Used any form of tobacco or nicotine product? Yes No

Date last used	How long? (years)	List type of tobacco or nicotine products used

g. Consumed alcoholic beverages? Yes No

If **Yes**, how often? _____ How much? _____

h. Been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? Yes No

If **Yes**, when were you last treated? _____

i. Had any Life, Disability, Nursing Home or Long Term Care Insurance Application denied? Yes No

If **Yes**, by which company and why? _____

2. In the past 5 years, have you received disability income, worker's compensation, short or long term disability or any state or Social Security Disability Payments? Yes No

If **Yes**, please describe _____

3. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

G. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

H. Protection Against Unintended Lapse

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

- Please check one of the following: I elect **NOT** to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below **ONLY** if you elect to name an Authorized Designee.

_____ (First) _____ (MI) _____ (Last)

Street Address

_____ City _____ State _____ ZIP code _____ Phone Number

If you wish to name more than one designee, please attach a separate sheet.

You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company
 [Long Term Care Correspondence
 P. O. Box 64889
 St. Paul MN 55164-0889]

I. Coverage Selections

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000 \$9,000
 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65

I reject Automatic Inflation Protection

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes**, I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No**. I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

J. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First)

(MI)

(Last)

Social Security or Tax ID Number

Address

City

State

ZIP code

Telephone

L. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties.

I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health. I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below to give the Company, its legal representatives, American General Life Insurance

Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

L. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part H, Protection Against Unintended Lapse; Part I, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part J, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

Email _____

C. Insurability Profile

Please answer these questions BEFORE you continue with other parts of this Application

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: ... Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have, or have you ever been diagnosed with, or treated by a healthcare professional for, any of the following: (If yes, check all that apply) Yes No

- | | |
|---|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test | <input type="checkbox"/> Mental Retardation |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Metastatic Cancer (cancer that has spread from its original site) |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) | <input type="checkbox"/> Mild Cognitive Impairment (MCI) |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> More than one TIA or Stroke |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Diabetes with Stroke or TIA | <input type="checkbox"/> Myasthenia Gravis, generalized |
| <input type="checkbox"/> Frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Parkinson's Disease |
| <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Schizophrenia or other forms of Psychosis |
| | <input type="checkbox"/> Senility |

In most cases, answering "Yes" to questions 1, 2 or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

- 1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
- 2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
- 3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

- 4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

E. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

- Please check one of the following: I elect **NOT** to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below **ONLY** if you elect to name an Authorized Designee.

_____ (MI) _____
Full Name of Designee (First) (Last)

Street Address

_____ City _____ State _____ ZIP code _____ Phone Number

If you wish to name more than one designee, please attach a separate sheet.
You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company
[Long Term Care Correspondence
P. O. Box 64889
St. Paul MN 55164-0889]

F. Coverage Selections

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000 \$9,000
 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65

I reject Automatic Inflation Protection

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes**, I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No**. I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

G. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First) (MI) (Last)

Social Security or Tax ID Number

Address

City State ZIP code

Telephone

H. Premium Payer

I designate the following person or entity to be the Premium Payer in accordance with the Separate Premium Payer Endorsement that will be attached to the policy, if issued.

Premium Payer Name (Employer)

Premium Payer Address

City State ZIP code

Premium Payer Telephone

Premium Payer E-mail Address

I. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties. I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health. I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below to give the Company, its legal representatives, American General Life Insurance

Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

I. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part E, Protection Against Unintended Lapse; Part F, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part G, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

Email _____



Statement of Good Health and Insurability

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

In further consideration of the issuance to me by American General Life Insurance Company (The Company), Houston, Texas, of Policy Number _____, I do hereby certify that since the date of my Long Term Care insurance application:

1. There has been no change in my health.
2. I am able to perform all activities of daily living without assistance (eating, toileting, transferring, bathing, dressing, continence).
3. The information on my application is correct and there have been no changes to any of my answers to the questions on my application.
4. I have had no illness or injury, have not been seen or treated by any physician or health care provider except for those identified on my application, and have not been hospitalized.
5. I have not been declined, rated, or postponed for long-term care insurance.

If any of the statements 1 through 5 above are not accurate, in the space below (or attach sheets, if necessary), provide full details, including dates, and the name, address, and phone number of any physician or health care provider. The Company reserves the right not to issue this policy if any of the statements 1 through 5 above are not accurate, as set forth below.

CAUTION: If your answers on the application or Statement of Good Health and Insurability are incorrect or untrue, The Company may have the right to deny benefits or rescind your policy.

FRAUD WARNING: Any person who with intent to defraud or knowing that he/she is facilitating a fraud against the Company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Applicant _____ Agent _____

Date _____ Date _____

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

People buy long term care insurance for many reasons. Some do not want to use their own assets to pay for long term care. Some buy insurance to make sure they can choose the type of care they get. Others don't want their family to have to pay for care or don't want to go on Medicaid. But long term care insurance may be expensive, and may not be right for everyone.

By law in some states, the insurance company must fill out part of the information on this worksheet and ask you to fill out the rest to help you and the company decide if you should buy this policy.

Premium Information

Policy Form Number(s) _____

The premium for the coverage you are considering will be \$_____ per month, or
\$_____ per year.

Type of Policy: Guaranteed Renewable

The Company's Right to Increase Premiums

The Company has a right to increase premiums on this policy form in the future, provided it raises rates for all policies in the same class in this state.

Rate Increase History

The Company has sold long-term care insurance since 2001 and has sold this policy form since 2008. The Company has never raised its premium rates for any long-term care policy it has sold in this state or any other state.

Questions Related to Your Income

How will you pay each year's premium? (Check one)

- From my Income From my Savings/Investments My Family will Pay
 Have you considered whether you could afford to keep this policy if the premiums went up, for example, by 20%?

What is your annual income? (Check one)

- Under \$10,000 \$16,000 - \$29,999 Over \$50,000
 \$10,000 - \$15,999 \$30,000 - \$50,000

How do you expect your income to change over the next 10 years? (Check one)

- No change Increase Decrease

If you will be paying premiums with money received only from your own income, a rule of thumb is that you may not be able to afford this policy if the premiums will be more than 7% of your income.

Will you buy inflation protection? (Check one) Yes No

If not, have you considered how you will pay for the difference between future costs and your monthly benefit amount?

- From my Income From my Savings/Investments My Family will Pay



Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate existing accident and sickness or long term care insurance and replace it with an individual long term care insurance policy to be issued by American General Life Insurance Company. Your new policy provides 30 days within which you may decide, without cost, whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

You should review this new coverage carefully, comparing it with all accident and sickness or long term care insurance coverage you now have, and terminate your present policy only if, after due consideration, you find that purchase of this long term care coverage is a wise decision.

STATEMENT TO APPLICANT BY AGENT

I have reviewed your current medical or health insurance coverage. I believe the replacement of insurance involved in this transaction materially improves your position. My conclusion has taken into account the following considerations, which I call to your attention.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay in payment of benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. State law provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods or probationary periods in the new policy for similar benefits to the extent such time was spent (depleted) under the original policy.
3. If you are replacing existing long term care insurance coverage, you may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
4. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, reread it carefully to be certain that all information has been properly recorded.

Agent's Signature

Type Name and Address of Agent

The above "Notice to Applicant" was delivered to me on:

Date

Applicant's Signature

American General Life Insurance Company

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889]

Long Term Care Insurance

- A long term care insurance policy may pay most of the costs for your care in a nursing home. Many policies also pay for care at home or other community settings. Since policies can vary in coverage, you should read this policy and make sure you understand what it covers before you buy it.
- You should **not** buy this insurance policy unless you can afford to pay the premiums every year. Remember that the company can increase premiums in the future.
- The personal worksheet includes questions designed to help you and the company determine whether this policy is suitable for your needs.

Medicare

- Medicare does **not** pay for most long term care.

Medicaid

- Medicaid will generally pay for long term care if you have very little income and few assets. You probably should **not** buy this policy if you are now eligible for Medicaid.
- Many people become eligible for Medicaid after they have used up their own financial resources by paying for long term care services.
- When Medicaid pays your spouse's nursing home bills, you are allowed to keep your house and furniture, a living allowance, and some of your joint assets.
- Your choice of long term care services may be limited if you are receiving Medicaid. To learn more about Medicaid, contact your local or state Medicaid agency.

Shopper's Guide

- Make sure the insurance company or agent gives you a copy of a book called the National Association of Insurance Commissioners' "Shopper's Guide to Long Term Care Insurance." Read it carefully. If you have decided to apply for long term care insurance, you have the right to return the policy within 30 days and get back any premium you have paid if you are dissatisfied for any reason or choose not to purchase the policy.

Counseling

- Free counseling and additional information about long term care insurance are available through your state's insurance counseling program. Contact your state insurance department or department on aging for more information about the senior health insurance counseling program in your state

Facilities

- Some long term care insurance contracts provide for benefit payments in certain facilities only if they are licensed or certified, such as in assisted living centers. However, not all states regulate these facilities in the same way. Also, many people move into a different state from where they purchased their long term care insurance policy. Read the policy carefully to determine what types of facilities qualify for benefit payments, and to determine that payment for a covered service will be made if you move to a state that has a different licensing scheme for facilities than the one in which you purchased the policy.

Contact Information

The following information is being made available to you in the event that you wish to contact us or the Arkansas Department of Insurance.

American General Life Insurance Company
[Long Term Care Correspondence
P. O. Box 64889
St. Paul, MN 55164-0889
1-888-565-3769]

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494
501-371-2640

If you wish to contact the agent that sold you this Policy, please use the information on the business card he presented to you.

SERFF Tracking Number: LTCG-125673815 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 39428
Company Tracking Number: AR AIG IND LTC FILING
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: AR AIG Ind LTC Filing
Project Name/Number: AR AIG Ind LTC Filing/SM9

Supporting Document Schedules

Review Status:

Satisfied -Name: Certification/Notice 05/30/2008

Comments:

These forms are new and the Contact Notice (08020-AR) is also attached under the Forms Schedule tab for your approval.

Attachments:

AGL Readability Certification.pdf
08020-AR Contact Information.pdf
Certification of Compliance with Arkansas Rule and Regulation 19.pdf

Review Status:

Satisfied -Name: Application 05/30/2008

Comments:

These forms are new and the applications are also attached under the Forms Schedule tab for your approval.

Attachments:

AGLC102851-AR.pdf
AGLC102854-AR.pdf
AGLC102990-AR.pdf

Review Status:

Satisfied -Name: Outline of Coverage 05/30/2008

Comments:

These forms are new and the Contact Notice (08014-AR) is also attached under the Forms Schedule tab for your approval

Attachment:

08014-AR OOC.pdf

Review Status:

Satisfied -Name: Authorization to File 06/26/2008

Comments:

The filing is submitted by a third party other than an employee of the company. A letter of authorization to file on behalf of the company is attached.

Attachment:

SERFF Tracking Number: LTCG-125673815 *State:* Arkansas
Filing Company: American General Life Insurance Company *State Tracking Number:* 39428
Company Tracking Number: AR AIG IND LTC FILING
TOI: LTC03I Individual Long Term Care *Sub-TOI:* LTC03I.001 Qualified
Product Name: AR AIG Ind LTC Filing
Project Name/Number: AR AIG Ind LTC Filing/SM9

AGL Auth.pdf

SERFF Tracking Number: LTCG-125673815 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 39428
Company Tracking Number: AR AIG IND LTC FILING
TOI: LTC03I Individual Long Term Care Sub-TOI: LTC03I.001 Qualified
Product Name: AR AIG Ind LTC Filing
Project Name/Number: AR AIG Ind LTC Filing/SM9

Review Status:

Satisfied -Name: Partnership Certification 06/26/2008

Comments:

The policy is intended to be Partnership Qualified if the appropriate inflation protection rider is elected to meet Partnership requirements. Otherwise, the policy will be issued as a non-Partnership policy. A completed Partnership Certification form is attached

Attachment:

Partnership Certification.PDF

Review Status:

Satisfied -Name: Explanation of Variability 06/26/2008

Comments:

Attachment:

AR EXPLANATION OF VARIABILITY.pdf

Review Status:

Satisfied -Name: Cover Letter 06/26/2008

Comments:

Attachment:

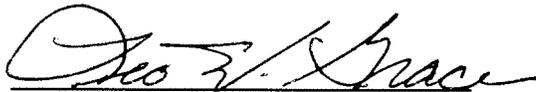
AR Cover Letter.pdf

AMERICAN GENERAL LIFE INSURANCE COMPANY

Readability Certification

This certifies that the Flesch Readability Test was applied to the following forms, and that the Reading ease score for each form is as follows:

<u>FORM</u>	<u>FORM IDENTIFIER</u>	<u>FLESCH SCORE</u>
Long Term Care Insurance Policy	08000	51
Separate Premium Payer Endorsement	08001	50
Automatic Inflation Protection – [3%/5%] Compound for Life Rider	08002	60
Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums	08003	57
Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums to Age 65	08004	58
Joint Survivor Benefit Rider	08005	70
Joint Waiver of Premium Rider	08006	64
Nonforfeiture Benefit Rider – Shortened Benefit Period Rider	08007	50
Paid-Up Premium Rider	08008	50
Restoration of Benefits Rider	08009	65
Return of Premium at Death Benefit Rider	08010	66
Shared Care Benefit Rider	08011	57
Waiver of Elimination Period for Home and Community Care Benefits Rider	08012	71
Outline of Coverage	08014	50



Leo W. Grace
Vice President
Product Compliance
American General Life Insurance Company
April 2, 2008

Contact Information

The following information is being made available to you in the event that you wish to contact us or the Arkansas Department of Insurance.

American General Life Insurance Company
[Long Term Care Correspondence
P. O. Box 64889
St. Paul, MN 55164-0889
1-888-565-3769]

Arkansas Department of Insurance
1200 West Third Street
Little Rock, AR 72201-1904
1-800-852-5494
501-371-2640

If you wish to contact the agent that sold you this Policy, please use the information on the business card he presented to you.

Certification of Compliance with Arkansas Rule and Regulation 19

Name, address and telephone number of issuer:

American General Life Insurance Company
2727-A Allen Parkway, Houston TX 77019. Phone 888-565-3769

Policy form number(s):
08000-AR

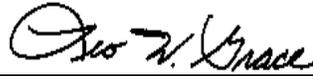
I hereby certify that the filing above meets all applicable Arkansas requirements of Rule and Regulation 19.

June 26, 2008

Date

Leo W. Grace, Vice President

Name and title of officer of the Issuer



Signature of officer of the Issuer

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889 Telephone: 888.565.3769]

New Application Reinstatement Coverage Change Exchange

A. Applicant Information **Print clearly – Use black ink**

Name (First) _____ (MI) _____ (Last) _____

Address _____ Apt. # _____

City _____ State _____ ZIP code _____ Date of Birth ____ / ____ / ____

Social Security Number _____ — _____ — _____

Gender: Male Female Marital status: Married Single Widowed Domestic Partner

Work Phone Number _____ — _____ — _____ Home Phone Number _____ — _____ — _____

Cell Phone Number _____ — _____ — _____ Best time to call _____ a.m. _____ p.m. Home Work

Applicant's E-mail Address _____

B. Spouse or Legally Recognized Domestic Partner Information **Please complete the information below for all applicants.**

Name (First) _____ (MI) _____ (Last) _____

Social Security Number _____ Date of Birth _____

Is the applicant's spouse or legally recognized domestic partner applying? Yes No

If No, please explain why: _____

C. Insurability Profile **Please answer these questions BEFORE you continue with other parts of this Application**

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have or have you ever been diagnosed by a healthcare professional as having any of the following: Yes No (If yes, check all that apply)

- | | | |
|---|--|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test | <input type="checkbox"/> Diabetes with Stroke or TIA | <input type="checkbox"/> More than one TIA or Stroke |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) | <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Myasthenia Gravis, generalized |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Metastatic Cancer (cancer that has spread from its original site) | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> Mild Cognitive Impairment (MCI) | <input type="checkbox"/> Schizophrenia or other forms of Psychosis |
| | | <input type="checkbox"/> Senility |

In most cases, answering "Yes" to questions 1, 2, or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information**Please provide the following information about your personal physician, sometimes called your Primary Health Care Provider (the physician with most of your medical records).**

Physician's Name (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

Have you seen this physician in the last two years? Yes No

Date of last visit: _____ Reason: _____

E. Medication History**IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER**

1. Please list all prescription medications that you are currently taking or have been prescribed in the last 36 months.

Medication	Dosage	Reason

F. Medical History**IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.**

1. In the past 3 years, have you received medical advice or treatment, been diagnosed by or consulted with a healthcare professional for any of the following conditions (check all that apply or NONE OF THE ABOVE.)

- | | |
|---|---|
| <input type="checkbox"/> 1. Alcoholism | <input type="checkbox"/> 28. Hypertension |
| <input type="checkbox"/> 2. Amputation | <input type="checkbox"/> 29. Immune System Disorder |
| <input type="checkbox"/> 3. Anemia | <input type="checkbox"/> 30. Injury due to Falls or Imbalance |
| <input type="checkbox"/> 4. Angioplasty or Heart Surgery | <input type="checkbox"/> 31. Joint Replacement or Surgery |
| <input type="checkbox"/> 5. Arthritis, Osteoarthritis | <input type="checkbox"/> 32. Kidney Disease |
| <input type="checkbox"/> 6. Asthma | <input type="checkbox"/> 33. Leukemia |
| <input type="checkbox"/> 7. Atrial Fibrillation | <input type="checkbox"/> 34. Lupus, Systemic Lupus (SLE) |
| <input type="checkbox"/> 8. Back or Spine Condition | <input type="checkbox"/> 35. Manic Depressive Illness |
| <input type="checkbox"/> 9. Brain Disorder or Brain Tumor | <input type="checkbox"/> 36. Mental Illness |
| <input type="checkbox"/> 10. Cancer | <input type="checkbox"/> 37. Multiple Myeloma |
| <input type="checkbox"/> 11. Cardiomyopathy or Congestive Heart Failure | <input type="checkbox"/> 38. Myasthenia Gravis |
| <input type="checkbox"/> 12. Carotid or other Arterial Surgery | <input type="checkbox"/> 39. Organ Transplant |
| <input type="checkbox"/> 13. Chronic Bronchitis | <input type="checkbox"/> 40. Osteoporosis |
| <input type="checkbox"/> 14. Chronic Fatigue Syndrome | <input type="checkbox"/> 41. Other Conditions Causing Crippling or Limited Motion or Requiring Adaptive Devices |
| <input type="checkbox"/> 15. Depression or Anxiety | <input type="checkbox"/> 42. Other Connective Tissue Disease |
| <input type="checkbox"/> 16. Diabetes | <input type="checkbox"/> 43. Paralysis |
| <input type="checkbox"/> 17. Disorders of Speech | <input type="checkbox"/> 44. Peripheral Vascular Disease (PVD) |
| <input type="checkbox"/> 18. Disorders of Vision | <input type="checkbox"/> 45. Post-Polio Syndrome |
| <input type="checkbox"/> 19. Drug Addiction | <input type="checkbox"/> 46. Rheumatoid Arthritis |
| <input type="checkbox"/> 20. Emphysema/Chronic Obstructive Pulmonary Disease (COPD) | <input type="checkbox"/> 47. Scleroderma |
| <input type="checkbox"/> 21. Epilepsy, Seizures or Convulsions | <input type="checkbox"/> 48. Skin Ulcers |
| <input type="checkbox"/> 22. Fainting Spells or Blacking Out | <input type="checkbox"/> 49. Stroke |
| <input type="checkbox"/> 23. Fibromyalgia | <input type="checkbox"/> 50. Transient Ischemic Attack (TIA) |
| <input type="checkbox"/> 24. Fractures | <input type="checkbox"/> 51. Tremor |
| <input type="checkbox"/> 25. Heart Attack or Angina | <input type="checkbox"/> NONE OF THE ABOVE |
| <input type="checkbox"/> 26. Hepatitis | |
| <input type="checkbox"/> 27. Hodgkin's Disease or other Lymphoma | |

F. Medical History (Continued)

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

Please give details below to all boxes checked in Question #1.

Number	Dates From/To	Physician's Name / Address / Phone	Describe

2. In the past 3 years, have you had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If **Yes**, please describe and give details. _____

3. In the past 3 years, have you:

a. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If **Yes**, please explain and include dates and reasons. _____

b. Consulted with or been treated for any reason by a Healthcare Professional who is a specialist, OTHER THAN your Primary Health Care Provider, eye doctor or dentist? Yes No

If **Yes**, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

c. Required assistance with shopping, using transportation, housekeeping, cooking, laundry, managing your finances or managing your medication? Yes No

If **Yes**, please explain type of assistance required and include dates and reasons. _____

d. Currently in the midst of a medical work-up or been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

If **Yes**, please explain type, reason and scheduled date of the evaluation, testing or surgery. _____

e. Received disability income, workers' compensation or any state or Social Security Disability Benefits, salary continuation or extended sick leave?..... Yes No

If **Yes**, please explain type, cause and date. _____

f. Used any form of tobacco or nicotine product? Yes No

Date last used	How long? (years)	List type of tobacco or nicotine products used

F. Medical History (Continued)

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

- g. Consumed alcoholic beverages? Yes No
 If **Yes**, how often? _____ How much? _____
- h. Been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? Yes No
 If **Yes**, when were you last treated? _____
- i. Had any Nursing Home or Long Term Care Insurance Application denied? Yes No
 If **Yes**, by which company and for what reason? _____
4. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

G. Applicant Profile

1. Do you work 20 or more hours a week outside your home? Yes No
 If **Yes**, please list your occupation and number of hours worked per week. _____
2. Do you perform volunteer work? Yes No
 If **Yes**, please list type of work and number of hours worked per week. _____
3. Do you have any hobbies, interests, or participate in any exercise program on a regular basis? Yes No
 If **Yes**, please describe. _____
4. Do you drive an automobile? Yes No
 If **Yes**, please provide approximate annual mileage: _____ miles
5. Do you have a Handicap Placard and/or automobile license plate? Yes No
 If **Yes**, please explain. _____
6. With whom do you live? Alone Spouse Family Other
7. Do you live in some form of a residential retirement community? Yes No
 If **Yes**, please list the specific services that you are receiving (e.g., housekeeping, laundry, meals). _____

H. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

I. Protection Against Unintended Lapse

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Please check one of the following: I elect **NOT** to name an authorized designee to receive this notice.
 I elect to name an authorized designee to receive this notice.

Complete the information below ONLY if you elect to name an Authorized Designee.

Full Name of Designee (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

If you wish to name more than one designee, please attach a separate sheet.

You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company, [Long Term Care Correspondence, P.O. Box 64889, St. Paul, MN 55164-0889].

J. Coverage Selections

Please select your coverage options.

Premium Class Quoted: Preferred Standard

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000
 \$9,000 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65
- I reject Automatic Inflation Protection**

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes,** I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No.** I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

K. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First) _____ (MI) _____ (Last) _____

Social Security or Tax ID Number _____

Address _____ Apt. # _____

City _____ State _____ ZIP code _____ Date of Birth _____

Telephone _____

L. Premium Payment Authorization

Complete this section to authorize premium payment

1. **BILL ME DIRECTLY.** Select one billing frequency Annually Semi-Annually Quarterly

OR

2. **ELECTRONIC FUNDS TRANSFER.** I have filled out a separate Electronic Funds Transfer form.

[OR

3. **CHARGE MY CREDIT CARD.** I have filled out a separate credit card authorization form.]

M. Premium Receipt

In this receipt, the "Company" refers to American General Life Insurance Company.

Received from:

Name of Applicant (First) _____ (MI) _____ (Last) _____

in the sum of \$ _____ to apply towards the initial modal premium, if the policy applied for is issued for the amount stated in the application.

SUBMISSION OF THE APPLICATION AND TENDER OF THE AMOUNT STATED DOES NOT PLACE ANY INSURANCE IN FORCE.

If the Company determines that the applicant was not entitled under the Company's underwriting rules and standards to insurance for the amount applied for, the insurance will not become effective, and the amount tendered will be returned to the applicant. **ANY DELAY IN THE RETURN OF THE AMOUNT TENDERED CANNOT BE CONSTRUED AS APPROVAL OF THE APPLICATION.**

No agent or medical examiner has authority to determine insurability or to make or modify any contract of insurance or to waive any requirement or rights of the Company.

Agent Signature: _____ Date: _____

Agent Name (First) _____ (MI) _____ (Last) _____

PLEASE SIGN AND LEAVE THIS PAGE WITH THE APPLICANT

N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties. I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health.

I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below

to give the Company, its legal representatives, American General Life Insurance Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part I, Protection Against Unintended Lapse; Part J, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part K, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

E-mail Address _____



Multi-Life Short Form Long Term Care Insurance Application Arkansas Version

American General Life Insurance Company

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889 Telephone: 888.565.3769]

Application type options: New Application, Reinstatement, Coverage Change, Exchange

A. Eligible Employee Information Print clearly - Use black ink

Name (First) (MI) (Last)

Address City State ZIP code Date of Birth

Social Security Number Gender (Male/Female) Marital status (Married/Single/Widowed/Domestic Partner)

Work Phone Number Home Phone Number Cell Phone Number

Best time to call a.m. p.m. Home Work

Eligible Employee's E-mail Address

Name of Eligible Employee's Employer

Date of Hire Position

Actively At Work Certification

I certify that I am an actively at work employee. I understand that coverage will not go into effect for me unless I am Actively at Work for the prior 30 calendar day period. Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a full-time basis [at least 30 hours each week]. I will be considered Actively at Work while on employer-approved vacations, holidays and regularly-scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, Worker's Compensation, short-term or long-term medical or disability leave, sick leave, a sabbatical or retired from the same employer.

X Employee Signature Date

B. Spouse or Legally Recognized Domestic Partner Information Please complete the information below for all applicants.

Name (First) (MI) (Last)

Social Security Number Date of Birth

Is the applicant's spouse or legally recognized domestic partner applying? Yes No

If No, please explain why:

C. Insurability Profile

Please answer these questions **BEFORE** you continue with other parts of this Application

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: ... Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have, or have you ever been diagnosed with, or treated by a healthcare professional for, any of the following: (If yes, check all that apply) Yes No

- | | | |
|---|--|--|
| <input type="checkbox"/> Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test | <input type="checkbox"/> Diabetes with Stroke or TIA | <input type="checkbox"/> More than one TIA or Stroke |
| <input type="checkbox"/> Alzheimer's Disease | <input type="checkbox"/> Frequent or persistent forgetfulness or memory loss | <input type="checkbox"/> Multiple Sclerosis (MS) |
| <input type="checkbox"/> Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease) | <input type="checkbox"/> Huntington's Chorea | <input type="checkbox"/> Muscular Dystrophy |
| <input type="checkbox"/> Cirrhosis of the Liver | <input type="checkbox"/> Hydrocephalus | <input type="checkbox"/> Myasthenia Gravis, generalized |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Mental Retardation | <input type="checkbox"/> Organic Brain Syndrome |
| <input type="checkbox"/> Dementia | <input type="checkbox"/> Metastatic Cancer (cancer that has spread from its original site) | <input type="checkbox"/> Parkinson's Disease |
| | <input type="checkbox"/> Mild Cognitive Impairment (MCI) | <input type="checkbox"/> Schizophrenia or other forms of Psychosis |
| | | <input type="checkbox"/> Senility |

In most cases, answering "Yes" to questions 1, 2 or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Personal Physician Information

Please provide the following information about your personal physician, sometimes called your Primary Health Care Provider (the physician with most of your medical records).

Physician's Name (First) _____ (MI) _____ (Last) _____

Street Address _____

City _____ State _____ ZIP code _____ Phone Number _____

Have you seen this physician in the last two years? Yes No

Date of last visit: _____ Reason: _____

E. Medication History

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER

1. Please list all prescription medications that you are currently taking or have been prescribed in the past 36 months

Medication	Dosage	Reason

F. Medical History

IF YOU NEED MORE SPACE TO EXPLAIN ANY ANSWER BELOW, PLEASE ATTACH ANOTHER SHEET OF PAPER.

1. In the past 3 years, have you:

a. Received advice, treatment, diagnosis or consultation from a healthcare professional for any of the following?

- Anxiety, bipolar disease, depression Yes No
- Cancer Yes No
- Cardiovascular disease Yes No
- Chronic lung disease, COPD, or emphysema Yes No
- Connective tissue disorder(s), lupus, scleroderma, CREST Yes No
- Diabetes Yes No
- Hepatitis or other liver disease Yes No
- Hypertension Yes No
- Kidney Disease or Kidney Transplant Yes No
- Neurological, neuromuscular disease or disease of the spine Yes No
- Peripheral Vascular Disease (PVD) Yes No
- Rheumatoid Arthritis or other forms of arthritis Yes No
- Stroke or Transient Ischemic Attack (TIA) Yes No

b. Been confined in or advised to enter a hospital or rehabilitation facility? Yes No

If **Yes**, please explain and include dates and reasons. _____

c. Consulted with or been treated for any reason by a healthcare professional OTHER THAN your Primary Health Care Provider, eye doctor or dentist? Yes No

If **Yes**, please provide the Healthcare Professional's name, location, specialty, reason consulted and dates.

Name	City and State	Specialty	Reason(s)	Dates

d. Had any symptoms or knowledge of any other health condition that is not disclosed above? Yes No

If **Yes**, please describe. _____

e. Had a medical work-up or been advised by a healthcare professional to have a special evaluation, testing or a surgery that has not been performed? Yes No

If **Yes**, please explain type, reason and scheduled date of the evaluation, testing or surgery. _____

f. Used any form of tobacco or nicotine product? Yes No

Date last used	How long? (years)	List type of tobacco or nicotine products used

g. Consumed alcoholic beverages? Yes No

If **Yes**, how often? _____ How much? _____

h. Been medically treated, hospitalized or counseled for the use of alcohol or controlled substances? Yes No

If **Yes**, when were you last treated? _____

i. Had any Life, Disability, Nursing Home or Long Term Care Insurance Application denied? Yes No

If **Yes**, by which company and why? _____

2. In the past 5 years, have you received disability income, worker's compensation, short or long term disability or any state or Social Security Disability Payments? Yes No

If **Yes**, please describe _____

3. Please provide your height _____ (ft. & in.) and weight _____ (lbs.)

G. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

H. Protection Against Unintended Lapse

I understand that I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

- Please check one of the following: I elect **NOT** to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below **ONLY** if you elect to name an Authorized Designee.

_____ (First) _____ (MI) _____ (Last)

Street Address

_____ City _____ State _____ ZIP code _____ Phone Number

If you wish to name more than one designee, please attach a separate sheet.

You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company
 [Long Term Care Correspondence
 P. O. Box 64889
 St. Paul MN 55164-0889]

I. Coverage Selections

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000 \$9,000
 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65

I reject Automatic Inflation Protection

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes**, I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No**. I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

J. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First)

(MI)

(Last)

Social Security or Tax ID Number

Address

City

State

ZIP code

Telephone

L. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties.

I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health. I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below to give the Company, its legal representatives, American General Life Insurance

Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

L. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part H, Protection Against Unintended Lapse; Part I, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part J, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

Email _____



Executive Carveout Form Long Term Care Insurance Application Arkansas Version

American General Life Insurance Company (the Company)

A subsidiary of American International Group, Inc. (AIG)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, Minnesota 55164-0889 Telephone: 888.565.3769]

Application type options: New Application, Reinstatement, Coverage Change, Exchange

A. Eligible Employee Information Print clearly - Use black ink

Name (First) (MI) (Last)

Address

City State ZIP code Date of Birth

Social Security Number Gender (Male/Female) Marital status (Married/Single/Widowed/Domestic Partner)

Work Phone Number Home Phone Number Cell Phone Number

Best time to call a.m. p.m. Home Work

Eligible Employee's E-mail Address

Name of Eligible Employee's Employer

Date of Hire Position

Actively At Work Certification

I certify that I am an actively at work employee. I understand that coverage will not go into effect for me unless I am Actively at Work for the prior 30 calendar day period. Actively at Work means I am an employee who is performing the usual duties of my job at my usual place of work as required by my employer on a full-time basis [at least 30 hours each week]. I will be considered Actively at Work while on employer-approved vacations, holidays and regularly-scheduled days off, or during temporary business closures. I will not be considered to be Actively at Work if I am unable to perform my usual duties due to a sickness, accident or injury or if I am on a leave of absence, Worker's Compensation, short-term or long-term medical or disability leave, sick leave, a sabbatical or retired from the same employer.

X Employee Signature Date

B. Spouse or Legally Recognized Domestic Partner Information Please complete the information below for all applicants.

Name (First) (MI) (Last)

Social Security Number Date of Birth

Is the applicant's spouse or legally recognized domestic partner applying? Yes No

If No, please explain why:

C. Insurability Profile

Please answer these questions BEFORE you continue with other parts of this Application

Please answer "Yes" or "No" by checking the box.

1. Within the past 24 months, have you used or been advised by a healthcare professional to use any of the following: ... Yes No

- Home Health Care Services, Adult Day Care services, or care in a Nursing Home, Assisted Living Facility, or any other Long Term Care Facility; or
- A walker, wheelchair, quad cane, motorized scooter, hospital bed, oxygen or kidney dialysis?

2. Do you currently or in the past 24 months have you required human assistance or supervision for any of the following activities: bathing, dressing, eating, getting in or out of a bed or chair, walking, using the toilet, managing bowel or bladder control? Yes No

3. Do you have, or have you ever been diagnosed with, or treated by a healthcare professional for, any of the following: (If yes, check all that apply) Yes No

- Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or positive HIV test
- Alzheimer's Disease
- Amyotrophic Lateral Sclerosis (ALS also called Lou Gehrig's disease)
- Cirrhosis of the Liver
- Cystic Fibrosis
- Dementia
- Diabetes with Stroke or TIA
- Frequent or persistent forgetfulness or memory loss
- Huntington's Chorea
- Hydrocephalus

- Mental Retardation
- Metastatic Cancer (cancer that has spread from its original site)
- Mild Cognitive Impairment (MCI)
- More than one TIA or Stroke
- Multiple Sclerosis (MS)
- Muscular Dystrophy
- Myasthenia Gravis, generalized
- Organic Brain Syndrome
- Parkinson's Disease
- Schizophrenia or other forms of Psychosis
- Senility

In most cases, answering "Yes" to questions 1, 2 or 3 will disqualify you from having coverage. If you feel you have fully recovered or are no longer requiring services described above, please attach an explanation including conditions, services used and time frames. If your circumstances change, you may consider reapplying again at that time.

D. Replacement

Please complete whether or not you have existing coverage and/or plan to replace it with this new coverage. All questions must be answered.

- 1. Do you have another long term care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)? Yes No
- 2. Did you have another Long Term Care, Nursing Home, or Home Health Care insurance policy or certificate in force during the past 12 months? Yes No
- 3. Do you intend to replace the above or any other long term care, medical or health insurance with this coverage? Yes No

If "Yes" is answered to question 1, 2 or 3 above, provide details below:

Company Name	Company Address (required if replacing)	Policy # (required if replacing)	Type of Plan	Benefit Amount (required if replacing)	Annual Premium (required if replacing)	Lapse Date	Replace?*
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No
							<input type="checkbox"/> Yes <input type="checkbox"/> No

* If any policy is being replaced, please complete any applicable replacement related form required by the state.

- 4. Are you covered by Medicaid? (not a reference to Medicare) Yes No

E. Protection Against Unintended Lapse

I understand that if I pay my premium other than through payroll deductions, I have the right to designate at least one Authorized Designee other than myself to receive notice of lapse or termination of this long term care coverage for nonpayment of premium. I understand that notice will not be given until 30 days after a premium is due and unpaid.

Please check one of the following: I elect **NOT** to name an Authorized Designee to receive this notice.
 I elect to name an Authorized Designee to receive this notice.

Complete the information below **ONLY** if you elect to name an Authorized Designee.

_____ (MI) _____
Full Name of Designee (First) (MI) (Last)

Street Address

_____ City _____ State _____ ZIP code _____ Phone Number

If you wish to name more than one designee, please attach a separate sheet.

You may change the named designee at any time by notifying us in writing at the following address:

American General Life Insurance Company
[Long Term Care Correspondence
P. O. Box 64889
St. Paul MN 55164-0889]

F. Coverage Selections

Lifetime Maximum: \$100,000 \$250,000 \$400,000 \$500,000 \$600,000 \$750,000 \$1,000,000

Monthly Maximum: \$2,000 \$3,000 \$4,000 \$5,000 \$6,000 \$7,000 \$8,000 \$9,000
 \$10,000 \$11,000 \$12,000

Elimination Period: 30 Days 90 Days 180 Days 365 Days

Inflation Protection Rider:

I have reviewed the outline of coverage and the graphs that compare the benefits and premiums of the policy with and without automatic inflation protection. I select the following option:

- Automatic Inflation Protection – 5% Compound for Life
- Automatic Inflation Protection – 3% Compound for Life
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases
- Automatic Inflation Protection – 5% Compound for Life Funded With Graded Premium Increases to Age 65
- Automatic Inflation Protection – 3% Compound for Life Funded With Graded Premium Increases to Age 65

I reject Automatic Inflation Protection

NOTE: The premiums for Automatic Inflation Protection With Graded Premium Increases increase along with your inflation protection benefits. In addition, the premiums for Automatic Inflation Protection and Automatic Inflation Protection With Graded Premium Increases may change, but only if we change the premiums for all similar policies issued in the same state and on the same policy form.

Nonforfeiture Benefit – Shortened Benefit Period Rider:

- Yes**, I elect to include the Nonforfeiture Benefit – Shortened Benefit Period in my coverage.
- No**. I have reviewed the outline of coverage and compared the benefits and premiums of the policy with and without the Nonforfeiture Benefit – Shortened Benefit Period Rider, and I reject this rider.

Other Optional Riders:

- Joint Survivor Benefit Rider
- Joint Waiver of Premium Rider
- Paid-Up Premium Rider
- Restoration of Benefits Rider
- Return of Premium at Death Benefit Rider
- Shared Care Benefit Rider
- Waiver of Elimination Period for Home and Community Care Benefit Rider

G. Beneficiary Designation

I designate the following person or entity to receive any benefits or proceeds due upon my death.

Name (First) (MI) (Last)

Social Security or Tax ID Number

Address

City State ZIP code

Telephone

H. Premium Payer

I designate the following person or entity to be the Premium Payer in accordance with the Separate Premium Payer Endorsement that will be attached to the policy, if issued.

Premium Payer Name (Employer)

Premium Payer Address

City State ZIP code

Premium Payer Telephone

Premium Payer E-mail Address

I. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

American General Life Insurance Company (the "Company") is responsible for the obligations and payment of benefits under any policy it may issue. No other company is responsible for such obligations and payments.

Authorization: I, the Applicant signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief and shall be considered to be representations and not warranties. I understand that this application and, if applicable, related attachments including supplements and addendum(s) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation was material to the acceptance for coverage; (2) such misrepresentation pertains to the conditions for which benefits are sought; or (3) I knowingly or intentionally misrepresented relevant facts related to my health. I further understand that any knowing and intentional misrepresentation of relevant facts in this application may be used to reduce or deny a claim after the policy's contestable period. I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in my health that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded. I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements. I give my consent to all of the entities listed below to give the Company, its legal representatives, American General Life Insurance

Companies LLC (AGLC) (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me or my spouse. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB). I understand the information obtained will be used by the Company to determine (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent. I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at [Long Term Care Correspondence P. O. Box 64889, St. Paul, Minnesota 55164-0889.] This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report.

With regard to the investigative report, check if you

wish to be interviewed or not to be interviewed.

CAUTION: If your answers on this application are incorrect or untrue, The Company may have the right to deny benefits or rescind your coverage.

I acknowledge receipt of a copy of or have been read the following:

- | | |
|--|---|
| <input type="checkbox"/> Outline of Coverage | <input type="checkbox"/> Things You Should Know Before You Buy Form |
| <input type="checkbox"/> Potential Rate Increase Disclosure Form | <input type="checkbox"/> Shopper's or Buyer's Guide |
| <input type="checkbox"/> Suitability Personal Worksheet | <input type="checkbox"/> Replacement Notice (if applicable) |

I. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures (con't)

I acknowledge that I have read the Fraud Notice below.

NOTE: Your signature below also confirms the elections you made in Part E, Protection Against Unintended Lapse; Part F, Coverage Selections (including any rejection of Automatic Inflation Protection); and Part G, Beneficiary Designation.

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

Sign Here X _____ Date: _____

Applicant

Signed at (city, county, state): _____

Agent(s) Signature(s)

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

Writing Agent Name (print) _____ Writing Agent # _____

Writing Agent Signature X _____ Countersigned _____

(Licensed resident agent if state required)

FRAUD 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 conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent act, which is a crime and subjects such person to criminal and civil penalties.

Agent Report

1. Other Policies

a. List all health insurance policies you have sold to the applicant which are still in force.

b. List all health insurance policies you have sold to the applicant in the past five years, which are no longer in force.

2. Commission, Agent/Agency Information (Please list servicing agent first.)

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split
Servicing: _____	_____	_____	_____ %
_____	_____	_____	_____ %
_____	_____	_____	_____ %

Writing Agent Name (Please Print) _____ Date _____

Writing Agent Signature X _____ Phone _____

State License # _____ Fax # _____

Email _____

AMERICAN GENERAL LIFE INSURANCE COMPANY

(herein called We, Us and Our)

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

[Long Term Care Correspondence: P. O. Box 64889, St. Paul, MN 55164-0889

Phone Number 888.565.3769]

LONG TERM CARE INSURANCE - OUTLINE OF COVERAGE

Policy Form Series 08000

NOTICE TO BUYER: This coverage may not cover all of the costs associated with long term care incurred by the buyer during the period of coverage. You are advised to review carefully all limitations.

CAUTION: The issuance of this long term care insurance policy is based upon the responses to questions on your application. A copy of your application will be attached to your policy. If your answers are incorrect or untrue, We have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact Us at this address: American General Life Insurance Company, [Long Term Care Correspondence, P.O. Box 64889, St. Paul, MN 55164-0889].

1. POLICY DESIGNATION

The policy is an individual policy of insurance issued in the state of residence.

2. PURPOSE OF THE OUTLINE OF COVERAGE

This outline of coverage provides a very brief description of the important features of the policy. You should compare this outline of coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual or group policy contains governing contractual provisions. This means that the policy or group policy sets forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you **READ YOUR POLICY (OR CERTIFICATE) CAREFULLY!**

3. FEDERAL TAX CONSEQUENCES

The policy is intended to be a federally tax-qualified long term care insurance contract under Section 7702B(b) of the Internal Revenue Code of 1986, as amended.

4. TERMS UNDER WHICH YOUR POLICY MAY BE CONTINUED IN FORCE OR DISCONTINUED

Renewability: THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue your policy as long as premiums for your policy are paid on time. We cannot change any of the terms of your policy on Our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY.

Waiver of Premium: We will waive your premium payments that become due when you are receiving benefits under the policy, except for benefits payable during the Elimination Period.

5. TERMS UNDER WHICH WE MAY CHANGE PREMIUMS

We have a limited right to change the premium rates for your coverage. The premium rates for your coverage will not increase due to a change in your age or health. Premium rates may change on a premium class basis if We change the premiums for all similar policies issued in the same state and on the same policy form. We will give you at least 45 days written notice before We change the premiums for your coverage.

6. TERMS UNDER WHICH THE POLICY MAY BE RETURNED AND PREMIUM REFUNDED

You may return your policy for any reason within 30 days after you receive it. To do so, mail it to Us at the [Long Term Care Correspondence] address shown at the top of Page 1 in this Outline of Coverage; or return it to the agent or office through which it was bought. We will refund the full amount of any premium paid within 30 days of such a return; and the policy will be considered void from the start.

You may purchase an optional Return of Premium at Death Benefit Rider with the policy. See the Optional Riders section of this Outline of Coverage for details.

We will return unearned premium in the event your coverage terminates due to death, surrender or cancellation.

7. THIS IS NOT MEDICARE SUPPLEMENT COVERAGE

If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from Us. Neither We nor our agents represent Medicare, the federal government, or any state government.

8. LONG TERM CARE COVERAGE

Policies of this category are designed to provide coverage for one or more necessary or medically necessary diagnostic, preventive, therapeutic, rehabilitative, maintenance, or personal care services, provided in a setting other than an acute care unit of a hospital, such as in a Nursing Home, in the community, or in the Home.

This coverage includes two types of benefits, reimbursement and indemnity. Reimbursement benefits reimburse you for covered long term care expenses you incur. Indemnity benefits pay a fixed dollar amount regardless of expenses incurred. Both types of benefits are subject to limitations, an Elimination Period and other requirements.

9. BENEFITS PROVIDED BY THE POLICY – BENEFIT ELIGIBILITY

BENEFITS

Benefits are available up to the monthly and lifetime maximums until your Lifetime Maximum is exhausted. You must meet the Limitations or Conditions On Eligibility for Benefits requirements in order to receive benefits. The maximums are based on your coverage selections as shown on the solicitation materials and stated in the policy schedule you will receive if you become insured.

BASE POLICY BENEFITS

The following benefits are included in the base policy:

FACILITY CARE BENEFIT

Monthly benefits are payable for Covered Expenses you incur during your Confinement in a Nursing Home or Assisted Living Facility. Covered Expenses for Facility Care means expenses you incur during your Confinement for: room and board; ancillary services such as therapy services; patient supplies; and bed reservation to keep your bed in the facility while you are absent for any reason except discharge. Covered Expenses do not include expenses you incur for drugs or any charges for your comfort and convenience such as televisions, telephones, beauty care, entertainment and guest meals. We will pay up to the Monthly Maximum for Covered Expenses you incur during your Confinement. The Facility Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. There is a maximum benefit for bed reservation of 30 days per calendar year. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

HOME AND COMMUNITY CARE BENEFIT

Monthly benefits are payable for Covered Expenses you incur for Home and Community Care. Covered Expenses for Home and Community Care means fees charged for the following services when provided to you by a Home Health Care Agency or by an Independent Provider: Home Health Care Services; and Maintenance or Personal Care Services. Covered Expenses also include care in an Adult Day Care Center. We will pay up to the Monthly Maximum for Covered Expenses you incur. The Home and Community Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

FLEXIBLE CARE BENEFIT

You are eligible to receive monthly cash benefits instead of the Facility Care Benefit or the Home and Community Care Benefit. If you choose to receive the Flexible Care Benefit, no other benefit is payable under the policy for any calendar month except for the Stay At Home Support Benefit. Additionally, this cash benefit might be used to pay for care not otherwise covered by the policy, such as care provided by an Immediate Family member. This cash benefit will be available beginning on the date you first satisfy the Limitations or Conditions On Eligibility for Benefits requirements. You are not required to incur any Covered Expenses in order to receive this benefit. However, you must be in compliance with the written individualized plan of services in your Plan of Care. You must notify Us in advance to receive Flexible Care Benefits. The Flexible Care Monthly Benefit is equal to 40% of the Monthly Maximum. The Flexible Care Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated.

INTERNATIONAL BENEFIT

You are eligible to receive monthly cash benefits when you are outside the United States, its territories, possessions and Canada. No other benefit is payable under the policy during any calendar month for which you receive the International Benefit. This cash benefit will be available beginning on the date you first satisfy the Limitations or Conditions On Eligibility for Benefits requirements. You are not required to incur any Covered Expenses in order to receive this benefit. However, you must be in compliance with the written individualized plan of services in your Plan of Care. You must provide written proof, in English, that you are Chronically Ill. You must also notify Us in advance to receive International Benefits. The notice must be made in writing and in English. The International Monthly Benefit is equal to 40% of the Monthly Maximum. The International Benefit is subject to the International Lifetime Maximum, which is 24 times the International Monthly Maximum. The International Benefit is also subject to the Elimination Period and the Lifetime Maximum. If you are not Chronically Ill each day of the calendar month, your benefit will be pro-rated. All benefit payments will be made in U.S. dollars.

STAY AT HOME SUPPORT BENEFIT

Benefits are payable for Covered Expenses you incur for Stay At Home Support. Covered Expenses for Stay At Home Support means Covered Expenses you incur for: Respite Care; Hospice Care; Caregiver Training; Home Modification; and Durable Medical Equipment. The Stay At Home Support Benefit is subject to the Stay At Home Support Lifetime Maximum and the Lifetime Maximum. It is not subject to the Elimination Period.

RESPITE CARE. Respite Care provides temporary relief for those persons who ordinarily care for you on a regular basis. Covered Expenses for Respite Care means: Covered Expenses for care in a Nursing Home or an Assisted Living Facility; or Covered Expenses for Home Health Care Services.

HOSPICE CARE. We must verify that you are Chronically Ill and Terminally Ill in order for Stay At Home Support Benefits to be payable for Hospice Care. Covered Expenses for Hospice Care means expenses you incur during your Confinement in a Hospice Care Facility or a Nursing Home for room and board, ancillary services provided by the facility and patient supplies; or expenses for Home Health Care Services.

CAREGIVER TRAINING. Stay At Home Support Benefits are payable for Covered Expenses you incur for training an Informal Caregiver (family or friend) to provide care for you in your Home. Covered Expenses for Caregiver Training means expenses you incur for Caregiver Training in the proper use and care of a therapeutic device or an appropriate caregiving procedure. We will not pay for training provided to someone who will be paid to care for you. The training cannot be received when you are confined in a hospital, Assisted Living Facility or Nursing Home, unless it is reasonably expected that the training will make it possible for you to return to your Home where you can be cared for by the person receiving the training.

HOME MODIFICATION. The Stay At Home Support Benefit is payable if Home Modification is recommended by a Care Coordinator in your Plan of Care and is mutually agreeable to you and Us as a cost-effective alternative to benefits otherwise provided by the policy. Covered Expenses for Home Modification means the cost of Home Modification if your Care Coordinator finds that modification to your Home is a cost effective alternative method of care and recommends the modification. We will pay the actual charges incurred for labor, equipment, and supplies for modifications to your Home that will enhance your ability to perform the Activities of Daily Living and allow you to remain in your Home safely.

DURABLE MEDICAL EQUIPMENT. The Stay At Home Support Benefit is payable if the use of Durable Medical Equipment is specified in your Plan of Care and is mutually agreeable to you and Us as a cost-effective alternative to benefits otherwise provided by the policy. Covered Expenses for Durable Medical Equipment are the rental charges for Durable Medical Equipment that is normally rented on a daily or weekly basis or the purchase price of such equipment if it is more cost-effective to purchase such equipment and it is specified in your Plan of Care. We will decide whether a rental or purchase of the Durable Medical Equipment is more appropriate.

FUTURE CARE BENEFIT

We reserve the right to authorize benefits for providers, treatments or services not otherwise specified in the policy. Benefits and services can be authorized if We determine that they: are cost-effective; are appropriate to your needs; are consistent with general standards of care; provide you with an equal or greater quality of care; and are for and constitute Qualified Long Term Care Services. Any benefits, treatments or services We authorize must also be agreed to by you or your Representative and, if appropriate, your Physician. We reserve the right to decline to authorize benefits and services.

CONTINGENT NONFORFEITURE BENEFIT

You will receive coverage under this benefit if you do not elect the Nonforfeiture Benefit Rider. If there is a substantial increase in premium rates, you will be given the right to reduce coverage or convert to a paid-up status with a reduced Lifetime Maximum called the Shortened Benefit Period Allowance. The Shortened Benefit Period Allowance is equal to the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) your Monthly Maximum in effect at the time of lapse. In no event will the total of benefits payable under the policy exceed the Lifetime Maximum.

OPTIONAL RIDERS

The following are optional benefit riders that may be purchased:

OPTIONAL JOINT SURVIVOR BENEFIT RIDER

In order to be eligible for benefits under this rider, you and your Spouse must both have been insured under the same policy form number and the same Joint Survivor Benefit Rider form, for a minimum of ten years

and benefits cannot have been paid under either policy during this minimum period. If either you or your Spouse die while this rider is in force, We will waive premiums for the policy and any riders in force for the surviving spouse.

OPTIONAL JOINT WAIVER OF PREMIUM BENEFIT RIDER

In order to be eligible for this rider, you and your Spouse must both be insured under the same policy form number and both You and Your Spouse must elect the same Joint Waiver of Premium Rider form. If either you or your Spouse become eligible for and begin to receive benefits while this rider is in effect, We will waive the premiums for the other spouse while the spouse receiving benefits continues to receive benefits. As long as you or your Spouse continue to receive benefits, additional premiums will not be required. If you or your Spouse cease to receive benefits, premium payments will again be required.

OPTIONAL NONFORFEITURE BENEFIT RIDER

If you are covered by the Nonforfeiture Benefit Rider, it will provide a continuation of your coverage up to a specified dollar amount, called the Shortened Benefit Period Allowance, if your coverage terminates due to non-payment of premium before your Lifetime Maximum has been paid. If your coverage terminates due to non-payment of premium on or after the third anniversary of your Policy Effective Date, We will pay benefits, subject to all of the terms and conditions of your policy: until the Shortened Benefit Period Allowance has been reached; or the date you no longer meet the Limitations or Conditions On Eligibility for Benefits requirements; whichever occurs first. The Shortened Benefit Allowance We will pay will be the greater of: (a) one hundred percent (100%) of the sum of all premiums paid for your coverage, excluding any waived premiums; or (b) your Monthly Maximum in effect at the time of lapse. In no event will the total of benefits payable under the policy exceed the Lifetime Maximum.

OPTIONAL PAID-UP PREMIUM RIDER

This rider allows you to discontinue paying premiums after the later of: the first anniversary of the Policy Effective Date following your 65th birthday; or the tenth anniversary of your Policy Effective Date. After the later of these dates has occurred, no additional premiums will be due. If you elect this rider and are eligible for the Contingent Nonforfeiture Benefit in the policy, should that benefit activate you may choose between the Contingent Nonforfeiture Benefit in the policy and a different one available only to those who have the Paid-Up Premium Rider. If you are not eligible for the Contingent Nonforfeiture Benefit in the policy, the one available to those who have the Paid-Up Premium Rider will automatically activate should it be triggered.

OPTIONAL RESTORATION OF BENEFITS RIDER

Following a period during which We had been paying benefits but you did not exhaust: your Lifetime Maximum; or your Inflated Lifetime Maximum if an inflation protection rider increased your coverage; We will restore your Lifetime Maximum or your Inflated Lifetime Maximum after you meet the Qualification Free Period. Your Lifetime Maximum or Inflated Lifetime Maximum may be restored an unlimited number of times, provided the Qualification Free Period is met each time.

OPTIONAL RETURN OF PREMIUM AT DEATH BENEFIT RIDER

A Return of Premium At Death Benefit will be paid if you die while your policy and this rider are in force. We will pay the total amount of premiums paid for the policy and any applicable riders, from the Policy Effective Date up to the date of your death. The amount of claims paid under your policy, including claims paid prior to a restoration of benefits pursuant to a Restoration of Benefits Rider, if applicable, will be deducted from the premiums paid.

OPTIONAL SHARED CARE BENEFIT RIDER

In order to be eligible for this rider, you and your Spouse must be insured under the same policy form number and maintain identical coverage. Your Policy Effective Dates must be the same. If you and your

Spouse have inflation protection riders, the riders must have become effective on the same date. This rider establishes a separate fund, called the Shared Care Lifetime Maximum. The Shared Care Lifetime Maximum is available to you upon exhaustion of your Lifetime Maximum. The Shared Care Lifetime Maximum is available to your insured Spouse upon the exhaustion of your insured Spouse's Lifetime Maximum. You and your insured Spouse may access the Shared Care Lifetime Maximum at the same time, provided you both meet the Limitations or Conditions On Eligibility for Benefits requirements and have exhausted your own Lifetime Maximums.

OPTIONAL WAIVER OF ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE BENEFIT RIDER

If you meet the Limitations or Conditions On Eligibility for Benefits requirements and you incur Covered Expenses for Home and Community Care, We will waive the requirement that you must meet the Elimination Period before receiving Home and Community Care Benefits. This rider does not waive the Elimination Period for any other benefit for which it is required, even if you receive the Home and Community Care Benefit first and then apply for another benefit.

AUTOMATIC INFLATION PROTECTION RIDERS - SEE RELATIONSHIP OF COST OF CARE AND BENEFITS

LIMITATIONS OR CONDITIONS ON ELIGIBILITY FOR BENEFITS

For you to be eligible for benefits provided by your coverage, We must verify that you are Chronically Ill and that you have been certified as Chronically Ill within the past 12 months by a Licensed Health Care Practitioner. In addition:

- The service, if applicable, must be covered under the policy and provided pursuant to a written Plan of Care for you that is appropriate and consistent with generally accepted standards of care for persons who are Chronically Ill;
- Coverage under the policy must be in force on the date(s) the care is received;
- You must satisfy the applicable Elimination Period;
- You must not have exhausted the applicable limits on the specific benefits claimed, or the Lifetime Maximum for the policy; and
- You must meet the additional requirements for the specific benefits you claim.

Benefit payments cease when your Lifetime Maximum is exhausted and are subject to: the Elimination Period; and all other limits determined from the specific benefits.

Those limits are based on your coverage selections as shown on the application and stated in the policy schedule you will receive if you become insured.

10. EXCLUSIONS AND LIMITATIONS

There are no pre-existing conditions exclusions or limitations for conditions disclosed on your application.

Non-eligible Facilities/Providers: Any facility or provider for a given benefit that does not fall within the "Definitions" section would be a non-eligible facility/provider for that benefit.

Non-eligible Levels of Care: Coverage is not based on the specific level of care. Rather, coverage is for care furnished for a specific covered reason, by or through the covered facilities and providers. Care from family members is covered only when specifically indicated.

Exclusions/Exceptions and Limitations: We will not pay benefits for any room and board, care, treatment, services, equipment, or other items for:

- Care or services provided by your Immediate Family unless he or she is a regular employee of an organization which is providing the treatment, service or care and the organization receives the payment for such treatment, service or care;
- Care or services provided by your Immediate Family member unless you are compensating him or her through proceeds from your Flexible Care Benefit;
- Care or services for which no charge is normally made in the absence of insurance;
- Care or services provided outside the United States of America, its territories and possessions and Canada, except as described in the International Benefit;
- Care or services that result from an attempt at suicide (while sane or insane) or an intentionally self-inflicted injury;
- Care or services that result from war or any act of war (whether declared or undeclared);
- Treatment provided in a government facility (unless otherwise required by law); or services for which benefits are available under Medicare or other governmental program (except Medicaid); or
- Services received while the policy is not in force.

Non-Duplication: We will not pay benefits for services or items for which benefits are payable by Medicare. We will pay the difference between your actual expense and the benefits payable by Medicaid or private insurance.

THE POLICY MAY NOT COVER ALL THE EXPENSES ASSOCIATED WITH YOUR LONG TERM CARE NEEDS.

11. RELATIONSHIP OF COST OF CARE AND BENEFITS

Because the costs of long term care services will likely increase over time, you should consider whether and how the benefits of the policy may be adjusted. You may purchase one of the inflation protection riders to increase your coverage. Only increases taken in accordance with one of the inflation protection riders do not require proof of insurability.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the anniversary of the Rider Effective Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.

AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the anniversary of the Rider Effective Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 5%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will continue as long as this rider and your policy remain in effect.

AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 3%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will continue as long as this rider and your policy remain in effect.

AUTOMATIC INFLATION PROTECTION – 5% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES TO AGE 65

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 5%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 5%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will cease once you reach 65 years of age.

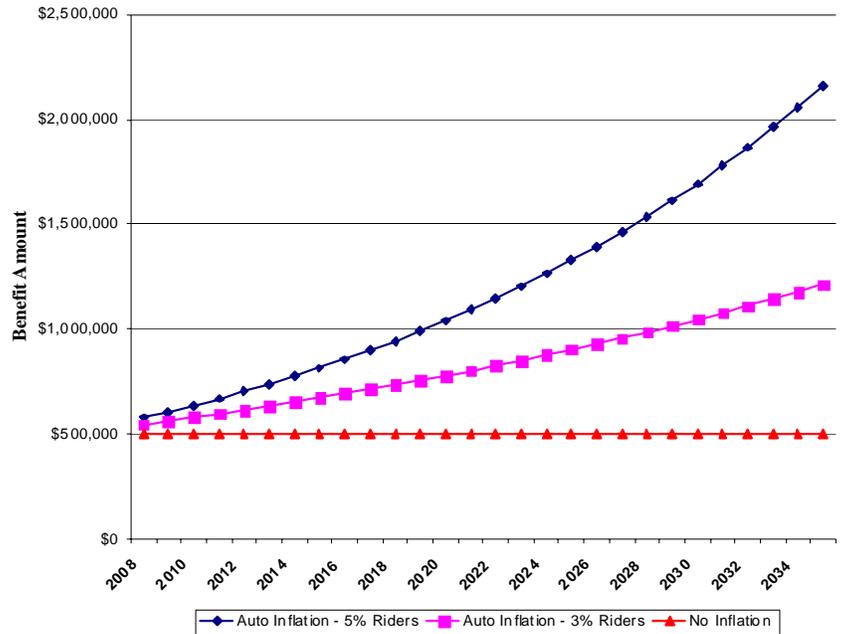
AUTOMATIC INFLATION PROTECTION – 3% COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES TO 65

If you have this rider, We will increase your Inflated Lifetime Maximum and your Monthly Maximum by 3%, compounded annually on the Policy Anniversary Date, as long as this rider and your policy remain in force. The amount available under this rider is equal to your Inflated Lifetime Maximum, reduced by claims paid. All increased amounts will be rounded to the nearest whole dollar. Your premium rate will also increase by 3%, compounded annually, on the Policy Anniversary Date, as a result of these annual benefit increases. These premium increases will cease once you reach 65 years of age.

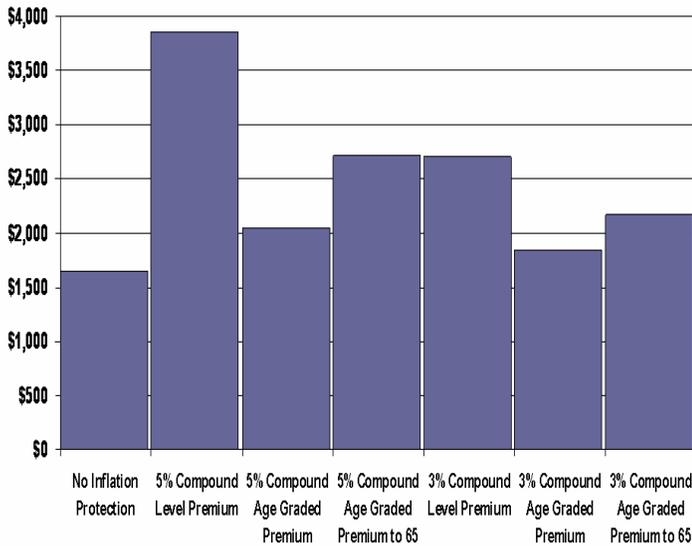
Inflation Protection – Graphic Comparisons

Benefit Levels

The chart to the right compares and contrasts benefit levels for a policy with no inflation protection rider and policies with the 5% compound and 3% compound automatic inflation protection riders offered with the policy. The chart assumes that the insured starts with a Lifetime Maximum of \$500,000.



Inflation Protection Initial Annual Premium Illustration



The chart to the left compares the initial annual premium paid by an insured, whose policy was issued when he was 52, for one policy with no inflation protection rider and one policy with each of the following automatic inflation protection riders available under the policy:

- 5% Compound For Life
- 3% Compound For Life
- 5% Compound For Life Funded With Graded Premium Increases
- 3% Compound For Life Funded With Graded Premium Increases
- 5% Compound For Life Funded With Graded Premium Increases To Age 65
- 3% Compound For Life Funded With Graded Premium Increases To Age 65

It assumes the following: a Lifetime Maximum of \$500,000; a Monthly Maximum of \$6,000; and no other riders in force under the policy.

12. ALZHEIMER'S DISEASE AND OTHER ORGANIC BRAIN DISORDERS

Once your application for coverage is approved, the policy provides coverage for those who are Chronically Ill as a result of Alzheimer's disease, Parkinson's disease, senile dementia, and all other forms of organic brain disease.

13. PREMIUM

The initial premium for your coverage will be determined based on the amount of coverage and riders selected and your issue age as described in your application. The chart below can be completed to show your annual premiums.

PREMIUM	
Premium Payment Mode* (Adjustment Factor)	Base Policy Coverage: [\$XX.XX]
<ul style="list-style-type: none"> ○ Annual = 1.00 ○ Semi-Annual = .52 ○ Quarterly = .265 ○ Monthly = .090 	Automatic Inflation Protection – 3%/5% Compound For Life Rider: [\$XX.XX] Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases: [\$XX.XX] Automatic Inflation Protection – 3%/5% Compound For Life Rider Funded With Graded Premium Increases to Age 65: [\$XX.XX] Joint Survivor Benefit Rider: [\$XX.XX] Joint Waiver of Premium Rider: [\$XX.XX] Nonforfeiture Benefit – Shortened Benefit Period Rider: [\$XX.XX] Paid-Up Premium Rider: [\$XX.XX] Restoration of Benefits Rider: [\$XX.XX] Return of Premium at Death Benefit Rider: [\$XX.XX] Shared Care Benefit Rider: [\$XX.XX] Waiver of Elimination Period for Home and Community Care Benefits Rider: [\$XX.XX] ANNUAL TOTAL: [\$XX.XX] Modal Premium Amount: [\$XX.XX]

*Premiums payable other than annually are equal to a percentage of the annual premium and include additional premium charges. You will save money by paying the premium on an annual basis.

14. ADDITIONAL FEATURES

Underwriting

We will underwrite your application by reviewing one or more of the following: the information submitted on your application; an attending Physician's report; copies of your medical records; a medical evaluation; a telephone interview; and an in-person interview.

Care Coordination

Care Coordination is intended to help identify care needs and community resources available to deliver care when you are Chronically Ill.

Care Coordination will provide you with a Care Coordinator who will review your specific situation and develop Plans of Care to meet your needs. Your Care Coordinator will: assess your functional, cognitive and personal needs for care and services on an ongoing basis; work with you to determine the specific services you require; develop and suggest initial and subsequent Plans of Care to assist you in meeting your needs; coordinate and monitor your care needs on an ongoing basis to help you receive appropriate care; and help you arrange for care, if you desire.

There is no Elimination Period for Care Coordination. We will then make arrangements for a Care Coordinator to contact you and begin providing you with this assistance. You are not required to use Care Coordination. Care Coordination may not be available outside the United States.

Continuation for Lapse Due to Cognitive or Functional Impairment

If your coverage terminates due to non-payment of premiums, We will provide a retroactive continuation of coverage if within five (5) months of the termination date you provide Us with proof that you were Chronically Ill, beginning on or before the termination date of the grace period. All past due premiums for your coverage that was in force immediately prior to the date of lapse must be paid. In that event, any benefits for which you qualified during the continuation period will be paid to the same extent they would have been paid if your coverage had remained in force from the date of termination.

15. CONTACT THE STATE SENIOR HEALTH INSURANCE ASSISTANCE PROGRAM IF YOU HAVE GENERAL QUESTIONS REGARDING LONG TERM CARE INSURANCE. CONTACT THE INSURANCE COMPANY IF YOU HAVE SPECIFIC QUESTIONS REGARDING YOUR LONG TERM CARE INSURANCE COVERAGE.

DEFINITIONS

This section provides the definitions of words used in this Outline of Coverage that have a special meaning when applied to your coverage. To help You recognize these special words and phrases, the first letter of each word is capitalized wherever it appears.

Activities of Daily Living (ADLs) means the following self-care functions:

Bathing: Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

Toileting: Getting to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.

Transferring: Moving into or out of a bed, chair or wheelchair.

Continence: The ability to maintain control of bowel and bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for catheter or colostomy bag.)

Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup, or table) or by a feeding tube or intravenously.

Adult Day Care means a program for six or more individuals of social and health-related services provided during the day in a community group setting for the purpose of supporting frail, impaired elderly or other disabled adults who can benefit from care in a group setting outside the Home.

Adult Day Care Center means a facility that is licensed or certified to provide a planned program of Adult Day Care services by the state in which it operates. If the state does not license or certify such facilities, then it must be operated pursuant to law and meet all of the following standards:

- it provides Adult Day Care services in a protective setting and under appropriate supervision, including personal, social, and related supportive services that are designed to meet the needs of functionally or cognitively impaired adults through an individualized service plan;
- it operates on less than a 24 hour basis;
- it keeps written record of services for each person; and
- it has established procedures for obtaining appropriate aid in the event of a medical emergency.

Assessment means an evaluation done by a Licensed Health Care Practitioner to determine or verify that You are Chronically Ill. The Assessment uses generally accepted tests and instruments that use objective measures and produce verifiable results.

Assisted Living Facility means a facility that is engaged primarily in providing ongoing care and related services that: (a) has the appropriate state licensure or certification as an Assisted Living Facility where required; and (b) meets all of the following requirements:

- it provides services and care on a continuous 24-hour basis sufficient to support the needs resulting from the inability to perform Activities of Daily Living or from a Severe Cognitive Impairment;
- it has trained and ready-to-respond personnel actively on duty in the facility at all times to provide the services and care;
- it makes and keeps records of all care and services provided to each resident;
- it provides at least three meals a day and accommodates special dietary needs;
- it provides residential services and Maintenance or Personal Care Services for at least six inpatients in one location;
- it has formal arrangements with a Physician or Nurse to furnish medical care in case of an emergency; and
- it has appropriate procedures to provide onsite assistance with prescription medications.

An Assisted Living Facility is not: a hospital; clinic; a place that operates primarily for the treatment of alcoholism, drug addiction or Mental or Nervous Disorder; a Nursing Home; an individual residence; an independent living unit; or a group living situation that fails to meet the above requirements.

If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as an Assisted Living Facility only if it is engaged primarily in providing care and services that meet all of the above criteria.

Care Coordinator means a Licensed Health Care Practitioner employed by or under contract to a Care Coordination Provider who is qualified by training and experience to assess and coordinate the overall care needs of a person who is Chronically Ill.

Care Coordination means identifying a person's functional, cognitive, personal, and social needs for care and services and can help link the person to a full range of appropriate services. It may include but is not limited to the following:

- the performance of comprehensive individualized Assessments, including reassessments as needed;
- the development of Plans of Care, including an initial Plan of Care and subsequent Plans of Care as needed for changes in your condition;
- the coordination of appropriate services and ongoing monitoring of the delivery of such services, when desired by you or your Representative and determined necessary by the Care Coordinator.

Care Coordination Provider means an agency, entity or person that provides Care Coordination and meets certain standards that pertain to staffing requirements, quality assurance, agency functions, reporting and records maintenance requirements.

Chronically Ill means that you have been certified by a Licensed Health Care Practitioner as:

- being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period that is expected to last at least 90 consecutive days due to a loss of functional capacity; or
- requiring Substantial Supervision to protect yourself from threats to health and safety due to a Severe Cognitive Impairment.

You will not meet the definition of Chronically Ill unless within the preceding 12-month period a Licensed Health Care Practitioner has certified that you meet such requirements.

Confinement or Confined means you are a resident in a Nursing Home, an Assisted Living Facility or a Hospice Care Facility for a period for which a room and board charge is made.

Covered Expenses means costs you incur for Qualified Long Term Care Services and for which a benefit is payable under the policy. Each benefit section defines its own Covered Expenses.

Domestic Partner means a person who lives with You in a domestic partner relationship, provided that You have completed and returned to Us a Declaration of Domestic Partnership in a form and manner required by Us.

Durable Medical Equipment means equipment included in your Plan of Care which:

- can enhance your abilities to perform Activities of Daily Living;
- is functionally necessary and not just for your convenience;
- is designed for repeated and prolonged use; and
- is suited for use in the home.

Infusion pumps, special hospital-style beds, walkers or wheelchairs are examples of types of equipment that may be considered Durable Medical Equipment. Durable Medical Equipment does not include any drug, medicine or equipment implanted in your body, temporarily or permanently. Also not included is any Home Modification, motorized scooter, or sporting, protective, athletic or exercise equipment.

Elimination Period means the total number of days that you are Chronically Ill before benefits are payable. You need not receive covered services on a day in order for that day to count towards meeting the Elimination Period. The Elimination Period begins on the first day you contact Us if We verify that you are Chronically Ill. Each day on which you are Chronically Ill will count towards the Elimination Period. The days do not have to be consecutive.

The start of the Elimination Period will be no earlier than the date you contact Us, unless We can reasonably establish that you met these requirements before the filing of a claim. We may require that you provide Us with proof that you received covered services prior to the date You contacted Us. However, in no case will the Elimination Period start date be more than:

- 90 days prior to your contacting Us for a loss related to the inability to perform Activities of Daily Living; or
- 365 days prior to your contacting Us for a loss due to Severe Cognitive Impairment.

The Elimination Period need only be met once during your lifetime. The Elimination Period does not apply to the Stay At Home Support Benefit or Care Coordination.

Flexible Care Monthly Benefit means the total amount of monthly benefits payable under this policy for the Flexible Care Benefit. It is equal to 40% of the Monthly Maximum.

Home means your domicile. Home does not include:

- a Nursing Home, Assisted Living Facility or Hospice Care Facility;
- a hospital; or
- any other institutional setting.

Home Health Care Agency means an entity that is regularly engaged in providing Home Health Care Services or Maintenance or Personal Care Services for compensation and employs staff who are qualified by training or experience to provide such care. The entity must:

- be supervised by a qualified professional such as a Registered Nurse (RN), a licensed social worker, or a Physician;

- keep clinical records or care plans on all patients;
- provide ongoing supervision and training to its employees appropriate to the services to be provided; and
- have the appropriate state licensure or certification, where required or available.

Home Health Care Services means the following services provided in your Home:

- part-time or intermittent skilled services provided by licensed nursing personnel;
- home health aide services; and
- physical therapy, respiratory therapy, occupational therapy, or speech therapy or medical social services.

Home Modification means the labor, equipment, and supplies used to make changes in your Home. These changes must be designed to:

- enhance your ability to perform Activities of Daily Living; and
- allow you to live safely and independently in your Home.

Examples include installation of a ramp in the Home or grab bars in the bathroom. It cannot include home repair, remodeling, or installation of a hot tub, swimming pool, or jacuzzi or other similar items or services.

Hospice Care means services designed to provide palliative care and alleviate your physical, emotional and social discomforts if you are Terminally Ill and in the last phases of life.

Hospice Care Facility means a facility which provides a formal hospice care program directed by a Physician on an inpatient basis. Hospice Care Facility does not mean a hospital or clinic, a community living center or a place that provides residential care only.

Immediate Family means your Spouse, your parents, your brothers and sisters and your children by blood, adoption or marriage.

Inflated Lifetime Maximum means the new total amount of lifetime benefits payable to you after We apply any inflation protection increase under an inflation protection rider. Prior to the first inflation protection increase, the Inflated Lifetime Maximum will be the same amount as the Lifetime Maximum.

Informal Caregiver means the person who has responsibility for providing nonprofessional care on an unpaid basis for you in your Home. With the exception of an Informal Caregiver you choose to compensate under the Flexible Care Benefit, a person who is paid to care for you cannot be an Informal Caregiver.

International Lifetime Maximum means the maximum benefit payable under this policy for the International Benefit.

International Monthly Benefit means the total amount of monthly benefits payable under this policy for the International Benefit. It is equal to 40% of the Monthly Maximum.

Licensed Health Care Practitioner means any of the following who is not an Immediate Family member: a Physician (as defined in this section); a registered professional nurse; a licensed social worker; or any other individual who meets such requirements as may be prescribed by the Secretary of the Treasury of the United States.

Lifetime Maximum means the total amount of lifetime benefits payable under the policy. The Lifetime Maximum will increase in accordance with the terms of any Inflation Protection Rider.

Maintenance or Personal Care Services means any care the primary purpose of which is the provision of needed assistance with any of the disabilities as a result of which you are a Chronically Ill individual. This includes protection from threats to health and safety due to Severe Cognitive Impairment.

Medicare means title XVIII of the Social Security Act.

Mental or Nervous Disorder means neurosis, psychoneurosis, psychopathology, psychosis, or mental or emotional disease or disorder, as classified in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association. If the DSM is discontinued or replaced, the diagnostic manual in use by the American Psychiatric Association as of the date of your illness will be used.

Monthly Maximum means the total amount of monthly benefits payable under the policy for either the Facility Care Benefit or the Home and Community Care Benefit. The Monthly Maximum will increase in accordance with the terms of any Inflation Protection Rider in force.

Nurse means someone who is licensed as a Registered Graduate Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) and is operating within the scope of that license.

Nursing Home means a facility or distinctly separate part of a hospital or other institution that is appropriately licensed or certified or complies with the state's facility licensing requirements to engage primarily in providing nursing care to inpatients under a planned program supervised by a Physician. It also:

- provides 24 hour-a-day nursing care by a Nurse under the supervision of a Registered Nurse (R.N.) or a Physician;
- maintains a daily medical record of each inpatient; and
- provides nursing care at skilled, intermediate, or custodial levels.

Nursing Home also means a facility that is licensed as a specialized Alzheimer's Unit in all states where such licensure exists.

A Nursing Home is not: a hospital or clinic; a place which operates primarily for the treatment of alcoholism, drug addiction, or Mental or Nervous Disorder; an Assisted Living Facility; an adult residential care home; a domiciliary care facility; or your primary place of residence in an area used principally for independent residential living; or a similar establishment. If a facility has multiple licenses, a portion, wing, ward, or unit will qualify as a Nursing Home only if it: meets all of the above criteria; is authorized to provide nursing care to inpatients; and is engaged principally in providing such nursing care in accordance with that license.

Physician, (as defined in section 1861(r)(1) of the Social Security Act) means a doctor of medicine or osteopathy legally authorized to practice medicine and surgery by the state in which he or she performs such function or action.

Plan of Care means a written individualized plan of services prescribed by a Licensed Health Care Practitioner. It specifies your long term care needs and the type, frequency, and providers of the services appropriate to meet those needs and the costs, if any, of those services. The Plan of Care will be modified as required to reflect changes in:

- Your functional or cognitive abilities;
- Your social situation; and
- Your care service needs.

Policy Effective Date means the date coverage is effective under the policy.

Policy Anniversary Date means the annually recurring date when coverage began under the Policy.

Qualification Free Period means a period of 180 consecutive days during which a Licensed Health Care Practitioner certifies, and We verify, that you meet the following:

- You are able to perform, without Substantial Assistance from another individual, all six Activities of Daily Living (ADLs); and
- You do not require Substantial Supervision by another person to protect yourself from threats to health and safety due to Severe Cognitive Impairment.

Qualified Long Term Care Services means necessary diagnostic, preventive, therapeutic, curing, treating, mitigating, and rehabilitative services and Maintenance or Personal Care Services which are required by a Chronically Ill individual and are provided pursuant to a Plan of Care prescribed by a Licensed Health Care Practitioner.

Representative means a person or entity legally empowered to represent You.

Respite Care means supervision and care you receive while the family or other individuals who normally provide substantial amounts of care on a daily basis take short-term leave or rest that provides them with temporary relief from the responsibilities of providing care.

Rider Effective Date means the date a rider becomes effective under this Policy. A Rider Effective Date is the Policy Effective Date unless otherwise shown on the rider.

Severe Cognitive Impairment means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

- short-term or long-term memory;
- orientation as to people, places or time; and
- deductive or abstract reasoning.

Spouse means the person to whom you are legally married or your Domestic Partner.

Stay At Home Support Lifetime Maximum means the maximum benefit payable under the Stay at Home Support Benefit, which is not to exceed ten percent of either the Lifetime Maximum or, if an Inflation Protection Rider applies, the Inflated Lifetime Maximum.

Substantial Assistance means either Hands-on Assistance or Standby Assistance. Hands-on Assistance is the physical assistance of another person without which you would be unable to perform the Activities of Daily Living. Standby Assistance means the presence of another person, within your arm's reach, that is necessary to prevent, by physical intervention, your injury while you are performing the Activity of Daily Living.

Substantial Supervision means continual supervision (which may include cueing by verbal prompting, gestures, or other demonstrations) by another person that is necessary to protect you from threats to your health or safety (including, but not limited to, such threats as may result from wandering.)

Terminally Ill means having six months or less to live, as certified by a Physician.

We, Us, Our means American General Life Insurance Company.

April 3, 2008

Dear Insurance Commissioner:

This letter authorizes the Long Term Care Group, Inc. to make various policy form filings, including premium rate filings on behalf of American General Life Insurance Company.

This authorization will remain in full force and effect until the earlier of (a) your receipt of a written notification from American General Life Insurance Company expressly terminating this authorization; or (b) 31st of December 2009.

Please feel free to contact me directly should you have any questions concerning this authorization, c/o American General Life Companies, 2929 Allen Parkway, Mail Stop A38-40, Houston, TX, 77019. My e-mail address, telephone and fax numbers are below.

Sincerely,



Leo W. Grace
Vice President
Product Compliance
Phone: (800) 247-8837, ext 3508
Fax: 713-342-7550
e-mail: leo_grace@aigag.com

APPENDIX C

**ISSUER CERTIFICATION FORM
(relating to Qualified State Long-Term Care Insurance Partnership)**

In order to provide the Insurance Commissioner with information necessary to provide a certification for policies, this Issuer Certification Form requires information and a certification from issuers of long-term care insurance policies with respect to policy forms that may be covered under the Qualified Partnership of the State.

An insurance company may request certification of policies from time to time and, accordingly, may supplement this issuer certification form, e.g., as it introduces new long-term care insurance policy forms for issuance.

I. GENERAL INFORMATION

A. Name, address and telephone number of issuer:

American General Life Insurance Company
2727-A Allen Parkway, Houston TX 77019. Phone 888-565-3769

B. Name, address, telephone number, and email address (If available) of an employee of issuer who will be the contact person for information relating to this form:

Timothy P. Cassidy, tcassidy@ltcg.com
c/o Long Term Care Group, Inc, 5 Commonwealth Road, Suite 2B
Natick, MA 01760, Phone 508-651-8804

C. Policy form number(s) (or other identifying information, such as certificate series) for policies covered by this Issuer Certification Form (expand the space below as required):

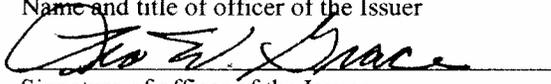
08000-AR

Specimen copies of each of the above policy forms, including any riders and endorsements, shall be provided upon request.

II. CERTIFICATIONS

- A. I hereby certify that the policy forms listed above are in compliance with Rule 13 and Rule 94 and all other Arkansas statutes and rules regarding long-term care insurance.
- B. I hereby certify to the best of my knowledge and belief that all producers who sell, solicit or negotiate long-term care insurance products on insert issuer name's) behalf have received the training required for Partnership policies and that they demonstrate an understanding of the policies and their relationship to public and private long-term care coverage.
- C. I hereby certify that the answers, accompanying documents, and other information set forth herein are, to the best of my knowledge and belief, true, correct, and complete.

June 26, 2008
Date

Leo W. Grace, Vice President
Name and title of officer of the Issuer

Signature of officer of the Issuer

EXPLANATION OF VARIABILITY

Officer Signatures: Please consider all officer signatures in the forms to be bracketed so that they may be replaced without filing should the officers change in the future.

INDIVIDUAL LONG TERM CARE INSURANCE POLICY 08000-AR

Page 1

- The address and telephone number are bracketed so that they may be changed without filing.
- “Long Term Care Correspondence” is bracketed under the Caution and 30-Day Right To Examine Your Policy sections so that it can be deleted or changed without filing should the address change.

Page 25

- Under the Claim Forms section, “for Long Term Care Correspondence” is bracketed so that it can be deleted or changed without filing should the address change.

INDIVIDUAL LONG TERM CARE INSURANCE POLICY SCHEDULE 08000-AR

- The telephone number is bracketed so that it may be changed without filing.
- The data fields for Policyholder, Policy Number, Age At Issue, Policy Effective Date and Current Coverage Effective Date are populated with sample data. Real data will appear at issue.
- Insured Spouse and the data field for Insured Spouse will appear only if both spouses are covered under one or more of the following riders: the Joint Survivor Benefit Rider, the Joint Waiver of Premium Rider or the Shared Care Benefit Rider.
- The Lifetime Maximum data field is bracketed so that only the Lifetime Maximum selected will appear at issue.
- The Inflated Lifetime Maximum data field is bracketed so that the applicable dollar amount at time of Policy Schedule issue may appear.
- The Monthly Maximum data field is bracketed so that the elected amount may appear at issue.
- The data fields for the Flexible Care Monthly Benefit, International Lifetime Maximum, International Monthly Benefit and Stay At Home Support Lifetime Maximum are bracketed so that the applicable dollar amounts may appear at issue.
- The Shared Care Lifetime Maximum is bracketed because it will appear only if the Shared Care Benefit Rider is elected. Its data field will be populated by the applicable dollar amount at issue.
- The Elimination Period data field is bracketed so that the applicable number of days may appear at issue.
- The Rate Classification data field will be populated with the applicable rate classification and any applicable discounts at issue.

- The optional riders under the Additional Coverages and Annual Premiums section are bracketed because only those that apply will appear at issue, along with their data fields with the corresponding premiums listed. Rider restrictions are as follows: only one inflation protection rider may be elected; inflation protection riders with graded premium increases may not be purchased with the Paid-Up Premium Rider; and an individual who has reached his or her 55th birthday may not be issued the Paid-Up Premium Rider in combination with the Joint Survivor Benefit Rider.
- The applicable mode of premium payment (annual, semi-annual, quarterly or monthly) will appear at issue.
- The Modal Premium Amount data field will be populated with the applicable dollar amount for the modal premium.
- The Policy Schedule Print Date data field will be populated with the date the most current Policy Schedule.

AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER 08002

- The percentages are bracketed in the form title so that the percentage selected by the insured (either 3% or 5%) may appear at issue.
- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES 08003

- The percentages are bracketed in the form title so that the percentage selected by the insured (either 3% or 5%) may appear at issue.

AUTOMATIC INFLATION PROTECTION – [3%/5%] COMPOUND FOR LIFE RIDER FUNDED WITH GRADED PREMIUM INCREASES TO AGE 65 08004

- The percentages are bracketed in the form title so that the percentage selected by the insured (either 3% or 5%) may appear at issue.

JOINT SURVIVOR BENEFIT RIDER 08005

- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

JOINT WAIVER OF PREMIUM RIDER 08006

- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

RESTORATION OF BENEFITS RIDER 08009

- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

SHARED CARE BENEFIT RIDER 08011

- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

WAIVER OF ELIMINATION PERIOD FOR HOME AND COMMUNITY CARE BENEFITS RIDER 08012

- The Rider Effective Date data field is bracketed so that the actual date may appear at issue.

INDIVIDUAL LONG TERM CARE INSURANCE OUTLINE OF COVERAGE 08014-AR

Page 1

- The address and telephone number are bracketed so that they may be changed without filing.

Page 2

- “Long Term Care Correspondence” is bracketed under the Terms Under Which The Policy May Be Returned and Premium Refunded section so that it can be deleted or changed without filing should the address change.

Page 10

- The data fields for the Base Policy, all the optional riders, the Annual Total and Modal Premium Amount are bracketed because they will be blank, with the applicable dollar amounts to be filled in by the agent at time of solicitation.

INDIVIDUAL APPLICATION FOR LONG TERM CARE INSURANCE AGLC102851-AR

Page 1 - Heading

- The address and telephone number are bracketed so that they may be changed without filing.

Page 5 – Section I. Protection Against Unintended Lapse

- The address and telephone number are bracketed so that they may be changed without filing.

Page 6 – Section L. Premium Payment Authorization

- The entry for charging the applicant’s credit card will appear once the Company is prepared to accept premium payments via credit card.

Page 8 – Section N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

- The address is bracketed so that it may be changed without filing.

MULTI-LIFE SHORT FORM LONG TERM CARE INSURANCE APPLICATION AGLC102854-AR

Page 1 - Heading

- The address and telephone number are bracketed so that they may be changed without filing.

Page 1 – Section A. Eligible Employee Information – Actively At Work Certification

- The language “at least 30 hours each week” is bracketed so that it may be replaced by other criteria (e.g., “at least 35 hours each week”) should the sponsoring employer wish.

Page 4 – Section H. Protection Against Unintended Lapse

- The address is bracketed so that it may be changed without filing.

Page 7 – Section N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

- The address is bracketed so that it may be changed without filing.

Page 8 – Section N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

- The address is bracketed so that it may be changed without filing.

**EXECUTIVE CARVEOUT FORM LONG TERM CARE INSURANCE
APPLICATION AGLC102990-AR**

Page 1 - Heading

- The address and telephone number are bracketed so that they may be changed without filing.

Page 1 – Section A. Eligible Employee Information – Actively At Work Certification

- The language “at least 30 hours each week” is bracketed so that it may be replaced by other criteria (e.g., “at least 35 hours each week”) should the sponsoring employer wish.

Page 3 – Section E. Protection Against Unintended Lapse

- The address is bracketed so that it may be changed without filing.

Page 6 – Section N. Agreement, Authorization to Obtain and Disclose Information, Acknowledgement and Signatures

- The address is bracketed so that it may be changed without filing.

STATEMENT OF GOOD HEALTH AND INSURABILITY AGLC102986

- The address is bracketed so that it may be changed without filing.

LONG TERM CARE INSURANCE PERSONAL WORKSHEET AGLC102987

- The address is bracketed so that it may be changed without filing.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF INDIVIDUAL ACCIDENT AND
SICKNESS OR LONG TERM CARE INSURANCE AGLC102988**

- The address is bracketed so that it may be changed without filing.

**THINGS YOU SHOULD KNOW BEFORE YOU BUY
LONG TERM CARE INSURANCE AGLC102989**

- The address is bracketed so that it may be changed without filing.



Long Term Care Group, Inc.

5 Commonwealth Road
Suite 2B
Natick, MA 01760
(508) 651-8800
(508) 651-8804 FAX

June 26, 2008

Arkansas Insurance Department
Life and Health Division
1200 West Third Street
Little Rock, AR 72201

RE: **American General Life Insurance Company**
FEIN No. 25-0598210 NAIC No. 011-60488
INDIVIDUAL ACCIDENT AND HEALTH INSURANCE
Long Term Care Insurance Policy 08000-AR, et al.

SUBMITTED VIA SERFF

Dear Sir or Madam:

Purpose. On behalf of American General Life Insurance Company (Company), we at Long Term Care Group, Inc. (LTCG) are submitting the long term care insurance forms cited in Attachment A to this letter for your review and approval. A letter of filing authorization from the Company is attached.

These forms provide individual long term care insurance and are filed for general use in accordance with the applicable statutes and regulations of your jurisdiction. The policy is guaranteed renewable and intended to provide federally tax qualified long term care insurance under the Health Insurance Portability and Accountability Act of 1996.

In addition, the policy is intended to be Partnership Qualified if the appropriate inflation protection rider is elected to meet Partnership requirements. Otherwise, the policy will be issued as a non-Partnership policy. A completed Partnership Certification form is attached

State of Domicile Review Status. Substantially similar forms were submitted to the domiciliary state of Texas on May 21, 2008.

The filing fee of \$100.00 is provided through the SERFF system via electronic funds transfer, as required. This is the required retaliatory fee for companies domiciled in Texas, the Company's home state.

Variability of Forms. The enclosed Explanation of Variability form addresses the purpose of any bracketed fields found in the policy and related forms.

Format. We reserve the right to change the lines in the applications and related forms from conventional, flat lines to three-sided Optical Character Recognition (OCR) boxes or another similar format to support the technology selected at that time to expedite application data entry functionality.

Benefit Provisions. Each policy will be issued with the following benefits: Facility Care Benefit, Home and Community Care Benefit, Flexible Care Benefit, International Benefit, Stay At Home Support Benefit (includes Respite Care, Hospice Care, Caregiver Training, Home Modification and Durable Medical Equipment), and Future Care Benefit.

Applicants will choose from Lifetime Maximums of \$100,000, \$250,000, \$400,000, \$500,000, \$600,000, \$750,000 and \$1,000,000 and from Monthly Maximums ranging from \$2,000 through \$12,000 in \$1,000 increments. Benefits will be paid on a monthly basis and there is no daily benefit amount. Only combinations of Lifetime Maximums and Monthly Maximums that meet your state's minimum benefit requirements will be available. For instance, an applicant may not elect a \$100,000 Lifetime Maximum with a \$12,000 Monthly Benefit, as selection of that combination could result (if the maximum benefit was paid every month) in a coverage duration of between eight and nine months, which is a shorter duration than your state requires. In addition, combinations of Lifetime Maximums and Monthly Maximums that exceed 13.89 years in benefit duration are not available.

Applicants may elect from elimination periods of 30, 90, 180 and 365 days. The elimination period does not apply to the Stay At Home Support Benefit.

Optional Riders. The following riders are available only at the time of policy issue: Paid-Up Premium Rider; Nonforfeiture Benefit – Shortened Benefit Period Rider; Return of Premium at Death Benefit Rider; Automatic Inflation Protection – [3%/5%] Compound for Life Funded With Graded Premium Increases Rider; and Automatic Inflation Protection – [3%/5%] Compound for Life Funded With Graded Premium Increases to Age 65 Rider. If an applicant purchases the Paid-Up Premium Rider, no riders may be added to the policy after the policy effective date. The applicant must be younger than age 65 in order to purchase the inflation protection riders that are funded with graded premium increases to age 65.

The following optional riders are available on the date of policy issue or may be added later (subject to underwriting): Shared Care Benefit Rider; Restoration of Benefits Rider; Automatic Inflation Protection – [3%/5%] Compound for Life Rider ; Joint Survivor Benefit Rider; Joint Waiver of Premium Rider; and Waiver of Elimination Period for Home and Community Care Benefit Rider.

The following are restrictions in terms of purchasing rider combinations:

- Only one inflation protection rider may be purchased;
- Inflation protection riders with graded premium increases may not be purchased with the Paid-Up Premium Rider; and
- An individual who has reached his or her 55th birthday may not be issued the Paid-Up Premium Rider in combination with the Joint Survivor Benefit Rider.

Applications. Individuals ranging from 21 through 84 years of age may apply for coverage under the policy. Application for Long Term Care Insurance AGLC102851-AR must be completed by members of the general population to apply for coverage. Multi-Life Short Form

June 26, 2008

Page 3

Long Term Care Insurance Application AGLC102854-AR must be completed when the individual is a member of an eligible sponsoring employer. Executive Carve Out Short Form Long Term Care Insurance Application AGLC102990-AR must be completed by members of an eligible sponsoring employer seeking to cover key employees. The dependents of eligible employees of sponsoring employers must complete Application AGLC102851-AR to apply for coverage. The applications may, in some instances, be completed electronically which may also include the use of electronic signatures.

Underwriting. Coverage is medically underwritten based on information provided in the application and from other sources, such as attending physician statements, copies of medical records and assessments of functional capacity.

Marketing Method. The submitted policy form will be marketed through agents.

Additional Forms. The Attachment A to this cover letter also lists ancillary forms such as the Suitability Personal Worksheet that are included in and to be used in connection with this filing.

We trust that you will find our filing to be in order and hope that you will be able to grant your Department's approval to this submission. If you have any questions or would like to discuss any of the materials included in this filing submission, please feel free to call me toll free at 1-888-312-5824. You may also send an email to smantle@lctg.com.

We look forward to hearing from you.

Sincerely,



Sheryll Mantle, ACS, AIRC, FLMI
Compliance Consultant
Long Term Care Group, Inc
5 Commonwealth Road, Suite 2B
Natick, MA 01760
Phone: 888-312-5824
Fax: 508-651-8804

Attachment A

<u>Form Number</u>	<u>Description</u>
08000-AR	Policy
08001	Separate Premium Payer Endorsement
08002	Automatic Inflation Protection – [3%/5%] Compound for Life Rider
08003	Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums
08004	Automatic Inflation Protection – [3%/5%] Compound for Life Rider Funded With Age Graded Premiums to Age 65
08005	Joint Survivor Benefit Rider
08006	Joint Waiver of Premium Rider
08007	Nonforfeiture Benefit – Shortened Benefit Period Rider
08008	Paid-Up Premium Rider
08009	Restoration of Benefits Rider
08010	Return of Premium At Death Benefit Rider
08011	Shared Care Benefit Rider
08012	Waiver of Elimination Period for Home and Community Care Benefits Rider
08013	Long Term Care Insurance Potential Rate Increase Disclosure Form
08014-AR	Outline of Coverage
AGLC102851-AR	Application for Long Term Care Insurance
AGLC102854-AR	Multi-Life Short Form Long Term Care Insurance Application
AGLC102990-AR	Executive Carve Out Short Form Long Term Care Insurance Application
AGLC102986	Statement of Good Health and Insurability
AGLC102987	Long Term Care Insurance Personal Worksheet
AGLC102988	Notice to Applicant Regarding Replacement of Individual Accident and Sickness or Long Term Care Insurance
AGLC102989	Things You Should Know Before You Buy Long Term Care Insurance
08020-AR	Contact Notice

Actuarial Certification and Rate Sheets