

SERFF Tracking Number: AMGN-126654531 State: Arkansas  
Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 45851  
Company Tracking Number: G-MIQ-40060  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Group Life / Disability (AGLDE)  
Project Name/Number: 13 Medical Questionnaires/G-MIQ-40060

## Filing at a Glance

Company: American General Life Insurance Company of Delaware

Product Name: Group Life / Disability (AGLDE) SERFF Tr Num: AMGN-126654531 State: Arkansas

TOI: L04G Group Life - Term SERFF Status: Closed-Approved- Closed State Tr Num: 45851

Sub-TOI: L04G.500 Other Co Tr Num: G-MIQ-40060 State Status: Approved-Closed

Filing Type: Form Reviewer(s): Linda Bird

Author: Bernadette Pham Disposition Date: 06/03/2010

Date Submitted: 06/02/2010 Disposition Status: Approved-Closed

Implementation Date Requested: Implementation Date:

State Filing Description:

## General Information

Project Name: 13 Medical Questionnaires

Project Number: G-MIQ-40060

Requested Filing Mode: Review & Approval

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Filing Status Changed: 06/03/2010

Deemer Date:

Submitted By: Bernadette Pham

Filing Description:

We wish to submit the above referenced questionnaires filing for your review and approval for three underwriting companies, The United States Life Insurance Company in the City of New York (US Life), American General Life Insurance Company of Delaware (AGLDE), and American General Assurance Company (AGAC).

This submission is for AGLDE. (For US Life, please reference: AMGN-126654532; for AGAC, please reference: 126654533.)

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments:

Market Type: Group

Group Market Size: Small and Large

Group Market Type: Employer, Association, Trust, Other

Explanation for Other Group Market Type: all eligible statutory groups

State Status Changed: 06/03/2010

Created By: Bernadette Pham

Corresponding Filing Tracking Number:

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The purpose of these questionnaires, G-MIQ-40060, is to supplement information provided on the insurance application by the proposed insured for any of our group medically underwritten products. For example, a proposed insured may disclose a history of hypertension on the insurance application without providing the required details. A hypertension questionnaire will provide the underwriter with an opportunity to obtain the required information and make a more informed decision. Please note that the authorization and fraud language would have already been presented to the proposed insured when the insurance application was signed. Thus, we are not including them in this questionnaire form.

Although this questionnaire form will primarily be used by employer/employee and association groups, we are requesting approval for use by all other statutory eligible groups as well. This individual questionnaire is a new form and is not intended to replace any existing forms previously filed and approved. The only information that is bracketed is the different underwriting companies, the title or titles of the questionnaire based on the section or sections of medical questions being used based upon responses to the initial medical application. In addition, the TOI selected is " L04G Group Life - Term ". However, this is a combined application for both life and disability coverages. We ask that the application be reviewed for both coverages under this submission.

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed. In addition, please note that the base application includes the fraud notice language, thus this individual application does not require one.

This application will be implemented for use upon approval by your Department. Your review of this filing is appreciated. Please contact me if you have any questions.

Thank you.

## Company and Contact

### Filing Contact Information

Bernadette Pham, Analyst bernadette.pham@aglife.com  
3600 Route 66 732-922-7225 [Phone]  
Neptune, NJ 07754 732-922-5593 [FAX]

### Filing Company Information

American General Life Insurance Company of CoCode: 66842 State of Domicile: Delaware

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Delaware

600 King Street  
 Wilmington, DE 19801  
 (713) 831-3508 ext. [Phone]

Group Code: 12  
 Group Name:  
 FEIN Number: 25-1118523

Company Type:  
 State ID Number:

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## Filing Fees

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

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life Insurance Company of Delaware	\$50.00	06/02/2010	36945155

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/03/2010	06/03/2010

SERFF Tracking Number: AMGN-126654531 State: Arkansas  
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## Disposition

Disposition Date: 06/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	[GENERAL] MEDICAL INFORMATION QUESTIONNAIRE		Yes

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## Form Schedule

Lead Form Number: **G-MIQ-40060**

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	G-MIQ-40060	Application/[GENERAL] Enrollment Form MEDICAL INFORMATION QUESTIONNAIRE	Initial		51.000	G-MIQ-40060 13-Med Q&A (John Doe).pdf

[LOGO]

[American General Life Insurance Company of Delaware]\*  
[American International Life Assurance Company of New York]\*  
[American General Assurance Company]\*  
[The United States Life Insurance Company in the City of New York]\*  
(\*Herein called the Company)

[GENERAL] MEDICAL INFORMATION QUESTIONNAIRE [Psychological / Psychiatric Conditions / Anxiety / Stress]  
[Alcohol Usage][Drugs][Growths, Cysts, Lumps, and Tumors][Diabetes][Digestive Disorders][Heart Disorders][High  
Blood Pressure / Hypertension][Asthma][COPD/Emphysema][Arthritis][Back Disorders]

Name of Applicant: John Doe Policy No. G-12345

The insurance company above (Company) is responsible for the obligation and payment of benefits under any certificate that it may issue.

Please answer all questions pertaining to the person for whom the condition applies.

[GENERAL MEDICAL QUESTIONNAIRE

1.	Treated for (exact diagnosis is needed): _____
2.	What was the cause? _____
3.	What tests were done to confirm the diagnosis? _____
4.	Date first treated? _____ Date last treated? _____
5.	Please state the names, dosages and frequency for taking any prescribed medications: _____
6.	Is medication still being taken? (Y/N) _____ If Yes, which medications? _____ If No, reason and date stopped: _____
7.	Has any surgery or treatment been performed or recommended for this or any other condition? (Y/N) _____ If Yes, give complete details: _____
8.	Has any other treatment, tests or follow-up for this condition been recommended any time within the next 12 months? _____
9.	Are you still being treated? (Y/N) _____ If No, date released: _____
10.	Degree of recovery? _____
11.	Complications or remaining problems: _____
12.	Name, address and phone number of treating physician: _____

[MEDICAL INFORMATION QUESTIONNAIRE Psychological / Psychiatric Conditions / Anxiety / Stress

1.	Please indicate Diagnosis and the DSM III-R Diagnosis / Diagnosis Code (if known): _____
2.	Date you were first treated: _____
3.	Type of treatment (family, group, individual; marital, grief, stress): _____
4.	Frequency of visits / treatments: _____
5.	Estimated duration of treatment, or date all treatment will end: _____
6.	Have you ever been hospitalized for this or any other psychiatric conditions ? (Y/N) _____ If yes, please give complete details: _____
7.	Name, address and phone number of the hospital / facility where confined: _____
8.	Have you ever contemplated or attempted suicide? (Y/N) _____ If yes, please provide complete details: _____
9.	Have you ever been prescribed any medication for this or any other psychological condition? (Y/N) _____ If yes, please provide the name, dosages dates and frequency: _____ Is medication still being taken? (Y/N) _____ If yes, which medications ? _____
10.	Has this condition ever caused you to be off work? (Y/N) _____ If yes, give details and dates: _____
11.	Name, address and phone number of treating counselor, therapist or physician: _____

[MEDICAL INFORMATION QUESTIONNAIRE Alcohol Usage

1.	Do you presently use alcoholic beverages? (Y/N) _____
	Quantity: <u>Daily</u> <u>Beer</u> <u>Wine</u> <u>Liquor</u>

Weekly \_\_\_\_\_

2. Date of last drink? \_\_\_\_\_

3. Did you ever drink more than at present? (Y/N) \_\_\_\_\_

Beer                      Wine                      Liquor

Quantity:              Daily                      \_\_\_\_\_

Weekly                      \_\_\_\_\_

4. Have you had a DUI, DWI, OUI, or OWI within the last 5 years? (Y/N) \_\_\_\_\_

If Yes, please provide the date and state: \_\_\_\_\_

5. Have you ever received treatment for alcohol abuse or been advised to reduce or discontinue drinking? (Y/N) \_\_\_\_\_

If Yes, give details: \_\_\_\_\_

Type of treatment (hospital, medication, therapy): \_\_\_\_\_

Dates of treatment and length of treatment: \_\_\_\_\_

Name, address and phone number of treating counselor, facility and physician: \_\_\_\_\_

6. Are you currently a member of Alcoholics Anonymous or a similar aftercare program? (Y/N) \_\_\_\_\_

If Yes, date joined and how often do you attend? \_\_\_\_\_

7. Do you have any medical conditions/problems related to your alcohol use? (Y/N) \_\_\_\_\_

If Yes, please give details: \_\_\_\_\_

8. Have you had a liver function or liver enzyme test? (Y/N) \_\_\_\_\_ If Yes, please provide date and results of most recent test: \_\_\_\_\_

Name of Doctor who administered tests: \_\_\_\_\_

9. Name, address and phone number of primary care physician: \_\_\_\_\_

[MEDICAL INFORMATION QUESTIONNAIRE Drugs

1. Are you now using or have you ever used any of the following other than for treatment of a medical condition under proper medical supervision?

a. Amphetamines i.e. 'Ecstasy', 'Ice', MDMA, 'Speed', 'Uppers', etc.	YES/NO
b. Barbiturates i.e. 'Downers', etc.	YES// NO
c. Cannabis i.e. 'Hashish', Marijuana, 'Pot', 'Weed', etc.	YES// / NO
d. Cocaine i.e. 'Coke', 'Crack', 'Snow', etc.	YES// / NO
e. Hallucinogens i.e. 'Acid', 'Angel Dust', 'Haze', LSD, 'Microdots', etc.	YES// / NO
f. Herbs i.e. catnip, poppy, kavakava, lobelia, etc.	YES// / NO
g. Opiates i.e. Codeine, Heroin, Methadone, Morphine, Opium, 'Smack', etc.	YES// NO
h. Sedatives i.e. Diazepam, 'Downers', Nitrazepam, 'Tranks', etc.	YES// NO
i. Solvents ie. Aerosols, glue, etc.	YES// / NO
j. Others	YES// / NO

If YES to any of the above, please provide full details including name of drug and dates when usage commenced and ceased. \_\_\_\_\_ N/A \_\_\_\_\_

2. Have you ever sought medical treatment due to drug usage or detoxification? (Y/N) \_\_N\_\_ If Yes, please provide details including date(s) of attendance and name and address of doctor(s). \_\_\_\_\_

3. Have you suffered from any impairments associated with drug usage? i.e. hepatitis B, HIV infection, mental illness, etc.? (Y/N) \_\_N\_\_ If Yes, please provide details. \_\_\_\_\_

4. Are you now drug-free? (Y/N) \_Y\_ If Yes, please state when usage ceased. \_\_\_\_\_ 02.24.2009 \_\_\_\_\_

5. Please provide any additional information which you feel will be helpful in processing your application. \_\_\_\_\_ ]

[MEDICAL INFORMATION QUESTIONNAIRE Growths, Cysts, Lumps and Tumors

1. When was the growth, cyst, lump or tumor first discovered? \_\_\_\_\_

2. In which part of the body was it located? \_\_\_\_\_

3. Please state the precise diagnosis if known: \_\_\_\_\_

4. Has the growth been removed? (Y/N) \_\_\_\_\_

5. If NO, please provide details of investigations that have been carried out including dates and results of tests: \_\_\_\_\_

- Details of any proposed treatment or surgery: \_\_\_\_\_

6. If YES, please provide date and method of removal (i.e. Local anesthetic, cryosurgery, operation with general anesthetic, etc. \_\_\_\_\_

- Name, address and phone number of surgeon, general practitioner, consultant, hospital or clinic.  
\_\_\_\_\_
- 7. What treatment have you had following removal? (i.e. tablets, radiotherapy, chemotherapy, etc.)  
\_\_\_\_\_
- 8. Have you been given any information regarding outlook/prognosis? (Y/N) \_\_\_\_\_ If YES, give details:  
\_\_\_\_\_
- 9. Are you still being treated or followed up? (Y/N) \_\_\_\_\_ How often?  
\_\_\_\_\_ If NO, when were you discharged from follow-up?  
\_\_\_\_\_
- 10. Have you lost any time off work? (Y/N) \_\_\_\_\_ If YES, please give details including dates and duration of time off work:  
\_\_\_\_\_
- 11. Please provide any additional information on your condition which you feel will be helpful in processing your application.  
\_\_\_\_\_  
\_\_\_\_\_

[MEDICAL INFORMATION QUESTIONNAIRE Diabetes

1. Date diabetes was first diagnosed? \_\_\_\_\_
2. How often do you see your physician? \_\_\_\_\_ Date of last visit? \_\_\_\_\_
3. Is your diabetes: Diet controlled? (Y/N) \_\_\_\_\_ Do you take oral medication? (Y/N) \_\_\_\_\_  
If Yes, give name, dosage and frequency of medication prescribed: \_\_\_\_\_  
Do you use Insulin? (Y/N) \_\_\_\_\_ If Yes, give breakdown of dosages: \_\_\_\_\_
4. Please list all medications taken in the last 12 months and reason for taking the medication:  
\_\_\_\_\_
5. Please indicate which medications are still being taken:  
\_\_\_\_\_
6. What is your current height? \_\_\_\_\_ Scale Weight? \_\_\_\_\_ lbs
7. Do you have, or ever had: Elevated Blood Pressure? (Y/N) \_\_\_\_\_ Recurrent Infections? (Y/N) \_\_\_\_\_  
Heart Trouble? (Y/N) \_\_\_\_\_ Eye Problems? (Y/N) \_\_\_\_\_ Kidney Problems? (Y/N) \_\_\_\_\_ Nerve Problems (Neuropathy) Circulatory Problems? (Y/N) \_\_\_\_\_ If Yes to any of these, please give details (including dates of treatment, diagnosis, type of treatment and degree of recovery, if any):  
\_\_\_\_\_
8. Do you perform home glucose monitoring? (Y/N) \_\_\_\_\_ If Yes, how often? \_\_\_\_\_ What have your readings been averaging? A.M. \_\_\_\_\_ P.M. \_\_\_\_\_
9. What was your most recent A1C level? \_\_\_\_\_
10. Have you ever had an insulin reaction? (Y/N) \_\_\_\_\_ If Yes, how frequent are the reactions and what is the severity of the reaction?  
\_\_\_\_\_
11. Have you ever been hospitalized for this condition? (Y/N) \_\_\_\_\_ If yes, when and what was the length of the hospital stay?  
\_\_\_\_\_
12. Do you currently use or have you used alcohol within the past 12 months? (Y/N) \_\_\_\_\_ If Yes, type of alcohol, amount and frequency of use: \_\_\_\_\_
13. Do you currently or have you used any tobacco products within the past 12 months? (Y/N) \_\_\_\_\_ If Yes, give type of product, amount and frequency of use: \_\_\_\_\_
14. Name, address and phone number of treating physician:  
\_\_\_\_\_

[MEDICAL INFORMATION QUESTIONNAIRE][Digestive Disorders]

1. Treated for (exact diagnosis is needed): \_\_\_\_\_
2. What was the cause? \_\_\_\_\_
3. What tests were done to confirm the diagnosis and what were the results of the tests? \_\_\_\_\_
4. What treatment has been prescribed for your condition? \_\_\_\_\_  
Date first treated? \_\_\_\_\_ Date last treated? \_\_\_\_\_  
Date first treated? \_\_\_\_\_ Date last treated? \_\_\_\_\_
5. How many attacks/flare-ups/episodes have you had since the initial diagnosis? \_\_\_\_\_
6. Please state the names, dosages and frequency for taking any prescribed medications: \_\_\_\_\_
7. Is medication still being taken? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_  
If No, reason and date stopped: \_\_\_\_\_
8. Have you ever taken any type of oral steroids or azulfidine/sulfasalazine/asacol? (Y/N) \_\_\_\_\_ If Yes, which medication and dates taken: \_\_\_\_\_
9. Has any surgery or treatment been performed or recommended for this or any other related condition? (Y/N) \_\_\_\_\_  
If Yes, give complete details: \_\_\_\_\_
10. Have there been any hospitalizations for this or any related condition? (Y/N) \_\_\_\_\_ If Yes, give dates of \_\_\_\_\_

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confinement and length of stay: \_\_\_\_\_

11. Has there been any change in your weight in the past two years? (Y/N) \_\_\_\_\_ If Yes, give details (weight gain or loss and # of pounds): \_\_\_\_\_

12. Name, address and phone number of treating physician: \_\_\_\_\_ ]

## [MEDICAL INFORMATION QUESTIONNAIRE Heart Disorders

1. What type of heart condition do you have? \_\_\_\_\_
2. When was the diagnosis made? \_\_\_\_\_
3. Have you ever had problems with fainting, dizziness, shortness of breath, heart rhythm disturbance or chest pain? \_\_\_\_\_ If Yes, please explain in detail including date of last occurrence \_\_\_\_\_
4. What is the name, address and phone number of the physician consulted for your heart condition? \_\_\_\_\_
5. Has cardiac surgery been performed or is there any intention to do so in the future? If so, please provide details, including date, nature of procedure and name of hospital. \_\_\_\_\_
6. Was an echocardiogram done? (Y/N) \_\_\_\_\_ If Yes, when and what were the results? \_\_\_\_\_
7. Were there any other tests done? (Y/N) \_\_\_\_\_ If Yes, give details: \_\_\_\_\_
8. Was any treatment or medication prescribed? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_
9. Are you still taking medication or receiving treatment? (Y/N) \_\_\_\_\_ If Yes, what dosage and how often is it taken? \_\_\_\_\_
10. Have you ever been hospitalized for this condition? (Y/N) \_\_\_\_\_ If Yes, when and what was the length of the hospital stay? \_\_\_\_\_
11. Any resulting physical restrictions or impairments? (Y/N) \_\_\_\_\_ If Yes, give details: \_\_\_\_\_
12. Have any of your family members received medical treatment for heart related problems? (Y/N) \_\_\_\_\_ If Yes, which family member and what was the problem? \_\_\_\_\_
13. Have you been off work due to your condition? (Y/N) \_\_\_\_\_ If Yes, how long? \_\_\_\_\_
14. Have you ever been diagnosed with the following: Lung disease, heart enlargement, liver disease, heart failure, stroke or TIA (ministroke), poor circulation in the legs or feet, or diabetes? (Y/N) \_\_\_\_\_ If Yes, please give details including when diagnosed and what the diagnosis was: \_\_\_\_\_
15. Have your job duties or leisure activities been modified in any way because of this condition? \_\_\_\_\_

## [MEDICAL INFORMATION QUESTIONNAIRE High Blood Pressure/Hypertension

1. Please provide blood pressure reading and dates as listed below:
 

Prior To Treatment Mo. _____ Yr. _____ Reading _____ Mo. _____ Yr. _____ Reading _____ Mo. _____ Yr. _____ Reading _____	During Treatment (One reading must be within last 30 days) Mo. _____ Yr. _____ Reading _____ Mo. _____ Yr. _____ Reading _____ Mo. _____ Yr. _____ Reading _____
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2. Date first treated with medication? \_\_\_\_\_
3. Please state the names, dosages and frequency of medications prescribed: \_\_\_\_\_
4. Is medication still being taken? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_  
If No, date and reason stopped: \_\_\_\_\_
5. What is your current exact height? \_\_\_\_\_ Ft. \_\_\_\_\_ In. Exact weight? \_\_\_\_\_ lbs.  
Has there been any marked change in your weight during the past two years? (Y/N) \_\_\_\_\_ If Yes, give details: \_\_\_\_\_ lbs. Gained \_\_\_\_\_ lbs. Lost
6. Have you ever experienced chest pain? (Y/N) \_\_\_\_\_ palpitations? (Y/N) \_\_\_\_\_ kidney disorder? (Y/N) \_\_\_\_\_  
If Yes, when, how often, last episode and treatment? \_\_\_\_\_
7. Do you have any other circulatory conditions, including any found through the use of ECG/EKG, X-rays, holter monitor, stress/treadmill or thallium tests? (Y/N) \_\_\_\_\_ If Yes, please explain: \_\_\_\_\_
8. Do you smoke cigarettes? (Y/N) \_\_\_\_\_ If Yes, how much: \_\_\_\_\_
9. Name, address and phone number of treating physician: \_\_\_\_\_

[MEDICAL INFORMATION QUESTIONNAIRE Asthma

1. Severity of condition (mild, moderate or severe): \_\_\_\_\_  
 Mild - Seasonal, easily controlled with non-steroid medications, lungs clear between attacks, no hospitalizations.  
 Moderate - Occasional past or present use of steroid medication, hospitalization (other than initial), continuous treatment with bronchodilators or desensitization shots.  
 Severe - Prolonged or continuous use of steroids, multiple hospitalizations, constant wheezing or crackling rales.

2. Age at Onset: \_\_\_\_\_ Date of last moderate or severe attack: \_\_\_\_\_

3. Please state the names, dosages and frequency of any medications prescribed in the last 12 months:  
 \_\_\_\_\_

4. Is medication still being taken? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_  
 \_\_\_\_\_ If No, date stopped: \_\_\_\_\_

5. Have you ever taken any oral steroids? (Y/N) \_\_\_\_\_ If Yes, give name of medications and dates taken:  
 \_\_\_\_\_

6. Have there been any hospitalizations or emergency room visits for this or any other related condition? (Y/N) \_\_\_\_\_  
 If Yes,  
 number and dates of visits/confinements: \_\_\_\_\_  
 Name, address and phone number of hospital where seen:  
 \_\_\_\_\_

7. Has the asthma been linked to allergies? (Y/N) \_\_\_\_\_

8. Is the asthma exercise induced? (Y/N) \_\_\_\_\_

9. Have you ever had an abnormal Chest x-ray or Pulmonary function test? (Y/N) \_\_\_\_\_

10. Do you Smoke? (Y/N) \_\_\_\_\_ If Yes, for how long? \_\_\_\_\_ How much? \_\_\_\_\_

11. Name, address and phone number of treating physician: \_\_\_\_\_ ]

[MEDICAL INFORMATION QUESTIONNAIRE COPD/Emphysema

1. Treated for (exact diagnosis is needed): \_\_\_\_\_

2. Date first treated: \_\_\_\_\_

3. What tests were performed to confirm the diagnosis and what were the results of these tests? (chest x-ray, challenge test, pulmonary function test): \_\_\_\_\_

4. Please state the names, dosages and frequency for medications prescribed: \_\_\_\_\_  
 \_\_\_\_\_

5. Is medication still being taken? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_

6. Have you ever taken any type of steroids (oral/inhaled)? (Y/N) \_\_\_\_\_ Have you ever required the use of oxygen? (Y/N) \_\_\_\_\_ If Yes, give name of medication/oxygen and dates taken/used:  
 \_\_\_\_\_

7. Have there been any hospitalizations for this or any related condition? (Y/N) \_\_\_\_\_ If Yes, give details:  
 Dates of confinement: \_\_\_\_\_ Length of Stay: \_\_\_\_\_  
 Name, address and phone number of hospital: \_\_\_\_\_

8. Do you have any cardiovascular conditions/complications? (Y/N) \_\_\_\_\_ If Yes, please give complete details:  
 \_\_\_\_\_

9. Do you smoke? (Y/N) \_\_\_\_\_ If Yes, for how long? \_\_\_\_\_ How much per day? \_\_\_\_\_

10. Does this condition limit you from performing your normal/usual daily activities? (Y/N) \_\_\_\_\_ If Yes, please give complete details:  
 \_\_\_\_\_

11. Name, address and phone number of treating physician: \_\_\_\_\_ ]

[MEDICAL INFORMATION QUESTIONNAIRE Arthritis

1. Type of arthritis: Osteoarthritis, Degenerative, Rheumatoid, Gouty, Psoriatic, Spondylitis or Other:  
 \_\_\_\_\_

2. Age condition was first diagnosed:  
 \_\_\_\_\_

3. Are you currently experiencing active arthritic symptoms? (Y/N) \_\_\_\_\_

4. Which areas of the body are affected?  
 \_\_\_\_\_

5. Is condition Mild, Moderate or Severe?  
 \_\_\_\_\_  
*Mild* – Minimal swelling or joint motion limitation, mild occasional pain relieved by nonprescription medications, no disability.  
*Moderate* – Minimal joint motion limitation, moderate pain requiring prescription medication (non-steroid), no permanent deformity or joint surgery, no hospitalization.  
*Severe* – Permanent deformity, hospitalizations, functional impairment, pain requires medications or steroids.

6. Please state the names, dosages and frequency for any medications prescribed:  
 \_\_\_\_\_

7. Is medication still being taken? (Y/N) \_\_\_\_\_ If Yes, which medications? \_\_\_\_\_

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8.	Have you used any type of steroid, methotrexate or gold injections? (Y/N) _____
9.	Have you had surgery or joint replacement performed or recommended for this condition? _____ If Yes, please provide details: _____
10.	Has any other treatment, test or follow-up for this condition been recommended for any time within the next months? (Y/N) _____ If Yes, give details: _____
11.	Have you lost any time from work? (Y/N) _____ If yes, please give details including dates and duration of time off from work _____
12.	Name, address and phone number of treating physician? _____

[MEDICAL INFORMATION QUESTIONNAIRE Back Disorders

1.	Physician's specific diagnosis and area of spine affected (cervical, thoracic, lumbar, sacral): _____
2.	Type of treatment: _____
3.	Date first treated? _____ Date last treated? _____ Frequency of treatment? _____
4.	Please state the names, dosages and frequency for taking any medications prescribed: _____
5.	What tests have been performed? _____
6.	Is medication still being taken? (Y/N) _____ If Yes, which medications? _____ If No, date stopped and why: _____
7.	Has there been any curvature of the spine, disc bulging, dislocation, herniation or arthritis? (Y/N) _____ If Yes, please explain in detail: _____ If curvature, give degree of curvature: _____
8.	Has any surgery been recommended or performed for this or any other related condition? (Y/N) _____ If Yes, give details: _____
9.	Has there been any hospitalizations for this or any related condition? (Y/N) _____ If Yes, give details: _____
10.	Has any treatment, test or follow-up been recommended for any time within the next 12 months? (Y/N) _____ If Yes, give details: _____ Are you still being treated? (Y/N) _____ Date of expected release: _____ If No, date released and degree of recovery: _____
11.	Are you in maintenance therapy? (Y/N) _____ How often? _____
12.	Are there any residuals/limitations or disability remaining? (Y/N) _____ If Yes, please give details: _____
13.	Name, address and phone number of treating physician: _____ ]

I represent that all of the above statements and answers to questions pertaining to my or my dependents' health history are complete and true to the best of my knowledge and belief and shall form a part of my application. All statements are representations and not warranties.

John Doe  
Signature of Applicant

02/24/2010  
Date

DO NOT DETACH – MAIL ENTIRE FORM DIRECTLY TO

The Company at the administrative address of [3600 Route 66, Medical Underwriting, P.O. Box 1588 Neptune, NJ 07754-1588]

SERFF Tracking Number: AMGN-126654531 State: Arkansas  
Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 45851  
Company Tracking Number: G-MIQ-40060  
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other  
Product Name: Group Life / Disability (AGLDE)  
Project Name/Number: 13 Medical Questionnaires/G-MIQ-40060

## Supporting Document Schedules

**Item Status:** **Status**  
**Date:**

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachment:**

Final Readability Certification (KC).pdf

**Item Status:** **Status**  
**Date:**

**Bypassed - Item:** Application

**Bypass Reason:** N/A

**Comments:**

READABILITY CERTIFICATION

I, Keith Coleman, Compliance Officer & Assistant Secretary, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Score is as follows:

Application for [GENERAL] MEDICAL INFORMATION QUESTIONNAIRE  
51.0 G-MIQ-40060

Date: 06/01/2010



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Keith Coleman  
Compliance Officer &  
Assistant Secretary