Filing at a Glance

Company: American General Assurance Company

Product Name: Group Life / Disability (AGAC)
SERFF Tr Num: AMGN-126654533
State: Arkansas

TOI: L04G Group Life - Term
SERFF Status: Closed-Approved-Closed
State Tr Num: 45849

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
Status of Filing in Domicile: Pending

Project Number: G-MIQ-40060
Date Approved in Domicile:

Requested Filing Mode: Review & Approval
Domicile Status Comments:

Explanation for Combination/Other:
Market Type: Group

Submission Type: New Submission
Group Market Size: Small and Large

Overall Rate Impact:
Group Market Type: Employer, Association, Trust, Other

Filing Status Changed: 06/03/2010
Explanation for Other Group Market Type: all statutory eligible groups

State Status Changed: 06/03/2010

Deemer Date:
Created By: Bernadette Pham

Submitted By: Bernadette Pham
Corresponding Filing Tracking Number:

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 AGAC. (For US Life, please reference: 126654532; for AGLDE, please reference: 126654531.)

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
3600 Route 66
Neptune, NJ 07754

bernadette.pham@aglife.com
732-922-7225 [Phone]
732-922-5593 [FAX]

Filing Company Information

American General Assurance Company
1000 Woodfield Road
Schaumburg, IL 60173
(732) 922-7682 ext. [Phone]

CoCode: 68373
Group Code: 12
Group Name: AIG
FEIN Number: 36-1677770

State of Domicile: Illinois
Company Type:
State ID Number:

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 Assurance Company	$50.00	06/02/2010	36945135

Correspondence Summary

Dispositions

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

Disposition

Disposition Date: 06/03/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number:	*AMGN-126654533*	*State:*	*Arkansas*
Filing Company:	*American General Assurance Company*	*State Tracking Number:*	*45849*
Company Tracking Number:	*G-MIQ-40060*		
TOI:	*L04G Group Life - Term*	*Sub-TOI:*	*L04G.500 Other*
Product Name:	*Group Life / Disability (AGAC)*		
Project Name/Number:	*13 Medical Questionnaires/G-MIQ-40060*		

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

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/Enrollment Form	[GENERAL] MEDICAL INFORMATION QUESTIONNAIRE	Initial		51.000	G-MIQ-40060 13-Med Q&A.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: _____ **Policy No.**_____

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) _____

		Beer	Wine	Liquor
Quantity:	Daily	_____	_____	_____

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	Beer	Wine	Liquor
Weekly	_____	_____	_____

2. Date of last drink? _____
3. Did you ever drink more than at present? (Y/N) _____

Quantity:		Beer	Wine	Liquor
	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. Diazempam, '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._____
   _____
2. Have you ever sought medical treatment due to drug usage or detoxification? (Y/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) _____ If Yes, please provide details.
   _____
4. Are you now drug-free? (Y/N) _____ If Yes, please state when usage ceased.
   _____
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.
   _____

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- 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	During Treatment (One reading must be within last 30 days)
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____
Mo. _____ Yr. _____ Reading _____	Mo. _____ Yr. _____ Reading _____

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: _____ _____]

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[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? _____
8. Have you used any type of steroid, methotrexate or gold injections? (Y/N) _____

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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.

_____ Signature of Applicant

_____ 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]

Supporting Document Schedules

Item Status: **Status Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachments:

Final Readability Certification (KC).pdf

AR LH214AR_112805.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

Keith W. Coleman

Keith Coleman
Compliance Officer &
Assistant Secretary

Certificate of Compliance with Arkansas Rule and Regulation 19

Insurer: American General Assurance Company

Form Number(s): G-MIQ-40060

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.

Signature of Company Officer

Keith Coleman
Name

Compliance Officer & Assistant Secretary
Title

June 1, 2010
Date