

SERFF Tracking Number: AGLA-126780757 State: Arkansas  
Filing Company: American General Life and Accident Insurance Company State Tracking Number: 46570  
Company Tracking Number: AGLA1000-AR (0510), ETAL  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: AGLA1000-AR (0510) Application for Life Insurance, etal  
Project Name/Number: AGLA1000-AR (0510) Application for Life Insurance, etal/AGLA1000-AR (0510)

## Filing at a Glance

Company: American General Life and Accident Insurance Company

Product Name: AGLA1000-AR (0510) SERFF Tr Num: AGLA-126780757 State: Arkansas

Application for Life Insurance, etal

TOI: L08 Life - Other SERFF Status: Closed-Approved- Closed State Tr Num: 46570

Sub-TOI: L08.000 Life - Other Co Tr Num: AGLA1000-AR (0510), State Status: Approved-Closed ETAL

Filing Type: Form

Reviewer(s): Linda Bird

Author: Marilyn Ellis

Disposition Date: 08/24/2010

Date Submitted: 08/23/2010

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: AGLA1000-AR (0510) Application for Life Insurance, etal Status of Filing in Domicile: Pending

Project Number: AGLA1000-AR (0510)

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 08/24/2010

Explanation for Other Group Market Type:

State Status Changed: 08/24/2010

Deemer Date:

Created By: Marilyn Ellis

Submitted By: Marilyn Ellis

Corresponding Filing Tracking Number:  
AGLA1000-AR (0510)

Filing Description:

AGLA1000-AR (0510) Application for Life Insurance

AGLA1000E-AR (0510) Application for Life Insurance

AGLA2001-XAR REV0510 Medical Examiner's Report

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The above forms are being submitted for your review and approval. These forms are new and do not replace any forms previously approved by your department.

AGLA1000-AR (0510) is a paper application for individual, nonparticipating life insurance including whole life, term life and universal life policies to be used by agents in their normal daily activities and a copy of the application will be made a part of the policy at issue.

AGLA1000E-AR (0510) is an electronic application for individual, nonparticipating life insurance including whole life, term life and Universal Life policies to be used by agents in their normal daily activities and a copy of the application will be made a part of the policy at issue.

AGLA2001-XAR REV0510 will be completed by the Medical Examiner for all life and health coverage when a medical examination is required. Only Part 1M will be made a part of the policy, but the entire form is being filed for approval.

A Statement of Variability is enclosed for the life applications included in this filing for item 6 as the Accelerated Benefit Rider 2 Initial Defined Benefit for the Primary Proposed Insured and the Additional Proposed Insured with options of 5%, 10% or Other is variable in these application. This rider is currently being written and will not have been filed when the application is submitted and in case the rider has not been approved when the new application is approved we may begin using the rider without this rider information and add it after the rider is approved.

Unless otherwise informed, we reserve the right to change the layout of the enclosed forms, including sequential ordering of the provisions, and type font, size and color.

## Company and Contact

### Filing Contact Information

Kathryn Mitchell, Kathryn.Mitchell@aglife.com  
American General Center 615-749-1139 [Phone]  
Nashville, TN 37250-0001

### Filing Company Information

American General Life and Accident Insurance CoCode: 66672 State of Domicile: Tennessee  
Company  
American General Center Group Code: Company Type: L&H  
Nashville, TN 37250-0001 Group Name: State ID Number:  
(615) 749-1139 ext. [Phone] FEIN Number: 62-0306330

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## Filing Fees

Fee Required? Yes  
Fee Amount: \$150.00  
Retaliatory? No  
Fee Explanation: 3 forms x \$50 = \$150.00  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life and Accident Insurance Company	\$150.00	08/23/2010	38949446

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	08/24/2010	08/24/2010

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## Disposition

Disposition Date: 08/24/2010

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	No	No
Supporting Document	Application	No	No
Supporting Document	Statements of Variability	No	No
Form	Application for Life Insurance	No	No
Form	Application for Life Insurance	No	No
Form	Medical Examiner's Report	No	No

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## Form Schedule

**Lead Form Number: AGLA1000 (0510), etal**

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	AGLA1000-AR (0510)	Application/ Enrollment Form	Application for Life Insurance	Initial		51.000	1000-AR JD WL.pdf
	AGLA 1000E-AR (0510)	Application/ Enrollment Form	Application for Life Insurance	Initial		51.000	1000E-AR (0510) YES.pdf
	AGLA2001-XAR REV0510	Application/ Enrollment Form	Medical Examiner's Report	Initial		55.600	2001-XAR.pdf

**APPLICATION FOR LIFE INSURANCE**  
**American General Life and Accident Insurance Company**  
 American General Center • Nashville, Tennessee 37250-0001

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

b. Address 123 4th Street Little Rock AR 72203 USA  
Street City State Zip Code Country

c. SSN: 012-45-6789 Birth Date and Place: 01 01 1971 AR US Age 35 Gender  Male  Female

d. Marital/Domestic Status:  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

e. Driver's License No. 12345678 f. State of Issue AR  
 If over age 16 and no license, please explain. \_\_\_\_\_

g. Annual Earned Income \$55,000 h. Other Sources of Income None

i. Occupation Mechanic j. How long in occupation 10 Years

k. Employer ABC Repair l. Job duties repairing cars

m. Length of time employed by current employer 10 Years n. Average No. of hours worked per week in occupation 40

o. Is Primary Proposed Insured actively at work and able to perform all regular job duties?  Yes  No  
 If "No," explain: \_\_\_\_\_

p. If no earned income, provide details of prior employment and job duties \_\_\_\_\_

q. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation \_\_\_\_\_

2. a. Additional Proposed Insured (If coverage applied for) Jane Doe

b. Address 123 4th Street Little Rock AR 72203 USA  
Street City State Zip Code Country

c. SSN: 987-65-4320 Birth Date and Place: \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female

d. Marital/Domestic Status:  Single  Married  Widowed  Divorced  Other \_\_\_\_\_

e. Driver's License No. 87654321 f. State of Issue AR  
 If over age 16 and no license, please explain. \_\_\_\_\_

g. Annual Earned Income \$20,000 h. Other Sources of Income None

i. Occupation Clerk j. How long in occupation 5 Years

k. Employer ABR Store l. Job duties operating cash register

m. Length of time employed by current employer 5 Years n. Average No. of hours worked per week in occupation 40

o. Is Additional Proposed Insured actively at work and able to perform all regular job duties?  Yes  No  
 If "No," explain: \_\_\_\_\_

p. If no earned income, provide details of prior employment and job duties \_\_\_\_\_

q. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation \_\_\_\_\_

3. Enter names of children, stepchildren and legally adopted children for whom application for coverage under a Child Term Rider is made who are: (1) members of your immediate family and household; and (2) under the age of 18.

Full Name	Age	Birth Date			Gender	Relationship (If stepchild, consent required)	For any child under age one (including Primary Proposed Insured) Name: _____ Birth Weight _____ lbs. _____ oz. Weight Now _____ lbs. _____ oz.
		Month	Day	Year			
a. <u>John Doe, Jr</u>	<u>10</u>	<u>01</u>	<u>01</u>	<u>2000</u>	<u>Male</u>	<u>Son</u>	
b. _____	_____	_____	_____	_____	_____	_____	
c. _____	_____	_____	_____	_____	_____	_____	
d. _____	_____	_____	_____	_____	_____	_____	

4. Owner Name (If other than Primary Proposed Insured) \_\_\_\_\_  
 Address \_\_\_\_\_  
Street City State Zip Code

SSN/TIN: \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_

**Home Office Use Only**

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

Address \_\_\_\_\_  
 \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
 SSN/TIN: \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_

6. Complete for Primary Proposed Insured:

a. Plan Name Whole Life If Term: Duration \_\_\_\_\_ Ins Amount \$ 100,000

If Universal Life: Death Benefit  Option A  Option B

b. Benefits & Riders

- |  |   |
|--|---|
| <input type="checkbox"/> Waiver Rider  | <input type="checkbox"/> Terminal Illness Rider                               |
| <input type="checkbox"/> Additional Insurance Option \$ _____  | <input type="checkbox"/> Monthly Guarantee Premium Rider                      |
| <input type="checkbox"/> Accidental Death \$ _____   | <input checked="" type="checkbox"/> Children's Term Rider \$ <u>5,000</u> Amt |
| <input type="checkbox"/> Single Premium Whole Life \$ _____  | <input type="checkbox"/> Level Term Rider \$ _____ Amt                        |
| <input checked="" type="checkbox"/> Spouse Level Term Rider \$ <u>12,500</u> Amt   | <input type="checkbox"/> Additional Insured Rider \$ _____ Amt                |
| <input type="checkbox"/> Accelerated Benefit Rider 2 Initial Defined Benefit – Primary Proposed Insured <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Other _____ ]    |   |
| <input type="checkbox"/> Accelerated Benefit Rider 2 Initial Defined Benefit – Additional Proposed Insured <input type="checkbox"/> 5% <input type="checkbox"/> 10% <input type="checkbox"/> Other _____ ] |   |
| <input type="checkbox"/> Primary Proposed Insured  | <input type="checkbox"/> Additional Proposed Insured                          |
| <input type="checkbox"/> Disability Income Rider 2   | <input type="checkbox"/> Disability Income Rider 2                            |
| <input type="checkbox"/> Disability Income Rider 5   | <input type="checkbox"/> Disability Income Rider 5                            |
| Monthly Benefit _____  | Monthly Benefit _____   |
| Occ. Class _____   | Occ. Class _____  |
| <input type="checkbox"/> Other _____   | <input type="checkbox"/> Other _____  |

Chronic Illness Accelerated Benefit Rider II – Primary Proposed Insured

To apply for the Chronic Illness Accelerated Death Benefit Rider II, select the appropriate boxes in items 1 and 2 below

1. a)  I am applying for the Chronic Illness Accelerated Death Benefit Rider II.
- b) Initial Monthly Benefit Amount \$ \_\_\_\_\_
- c) Benefit Period  24 Months  36 Months  48 Months  60 Months
- d) Other \_\_\_\_\_
2. a)  I am NOT applying for the Extension of Benefit option.
- I am applying for the Extension of Benefit option WITH the Cost of Living Allowance benefit.  
Cost of Living Increase Percentage \_\_\_\_\_ %
- I am applying for the Extension of Benefit option WITHOUT the Cost of Living Allowance benefit.  
 I have reviewed the Outline of Coverage and the graphs that compare the benefits and cost of insurance of this Rider with and without the Cost of Living Allowance benefit. Specifically, I have reviewed my options and I reject the Cost of Living Allowance benefit.
- b) Benefit Period (must be less than or equal to the Benefit Period designated for the Rider)  24 Months  36 Months  48 Months  60 Months

Chronic Illness Accelerated Benefit Rider II – Additional Proposed Insured

To apply for the Chronic Illness Accelerated Death Benefit Rider II, select the appropriate boxes in items 1 and 2 below

1. a)  I am applying for the Chronic Illness Accelerated Death Benefit Rider II.
- b) Initial Monthly Benefit Amount \$ \_\_\_\_\_
- c) Benefit Period  24 Months  36 Months  48 Months  60 Months
- d) Other \_\_\_\_\_
2. a)  I am NOT applying for the Extension of Benefit option.
- I am applying for the Extension of Benefit option WITH the Cost of Living Allowance benefit.  
Cost of Living Increase Percentage \_\_\_\_\_ %
- I am applying for the Extension of Benefit option WITHOUT the Cost of Living Allowance benefit.  
 I have reviewed the Outline of Coverage and the graphs that compare the benefits and cost of insurance of this Rider with and without the Cost of Living Allowance benefit. Specifically, I have reviewed my options and I reject the Cost of Living Allowance benefit.
- b) Benefit Period (must be less than or equal to the Benefit Period designated for the Rider)  24 Months  36 Months  48 Months  60 Months

7. First Beneficiary Jane Doe Spouse 35 987-65-1234  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

Secondary Beneficiary \_\_\_\_\_  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

8. Premium and Payment

a. Premium \$ 21.86 Lump Sum \_\_\_\_\_  1035 exchange

b. Payment Mode:  A  S  Q  M Planned Periodic Premium \_\_\_\_\_

Other \_\_\_\_\_

Automatic Bank Check  Add to existing ABC account, policy no. \_\_\_\_\_

AG Payroll Deduction (AGLA employees only)  New payroll account no. \_\_\_\_\_

Payroll Deduction  Add to existing PD account no. \_\_\_\_\_

If premium mode is payroll deduction, are premiums to be paid with pre-tax dollars under a Section 125 (cafeteria plan sponsored by your employer)?

Yes  No Anticipated Effective Date of Coverage \_\_\_\_\_

c. If Available, is Automatic Premium Loan Provision to be in effect?  Yes  No

**If one or more policies are being applied for at this time having the same Owner and Premium Mode/Method, please complete the section(s) below:**

9. a. Individual to be insured is the  Primary Proposed Insured or  Additional Proposed Insured listed on this application.

b. Plan Name Term If Term: Duration 10 Years Ins Amount \$ 100,000 If UL: Death Benefit  Option A  Option B

c. Benefits & Riders

Waiver Rider

[  Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 9.a.  5%  10%  Other \_\_\_\_\_ ]

Other \_\_\_\_\_  Other \_\_\_\_\_

d. If beneficiary is to be other than as listed in question 7 above, please complete the following:

First Beneficiary \_\_\_\_\_  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

Secondary Beneficiary \_\_\_\_\_  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

e. Premium \$ 8.58  Lump Sum \_\_\_\_\_  1035 exchange  Planned Periodic Premium \_\_\_\_\_

10. a. Individual to be insured is the  Primary Proposed Insured or  Additional Proposed Insured listed on this application.

b. Plan Name \_\_\_\_\_ If Term: Duration \_\_\_\_\_ Ins Amount \$ \_\_\_\_\_ If UL: Death Benefit  Option A  Option B

c. Benefits & Riders

Waiver Rider

[  Accelerated Benefit Rider 2 Initial Defined Benefit for individual in 10.a.  5%  10%  Other \_\_\_\_\_ ]

Other \_\_\_\_\_  Other \_\_\_\_\_

d. If beneficiary is to be other than as listed in question 7 above, please complete the following:

First Beneficiary \_\_\_\_\_  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

Secondary Beneficiary \_\_\_\_\_  
Name Relationship Age SSN/TIN

\_\_\_\_\_  
Address

e. Premium \$ \_\_\_\_\_  Lump Sum \_\_\_\_\_  1035 exchange  Planned Periodic Premium \_\_\_\_\_

**BACKGROUND/HEALTH QUESTIONS**

**YES NO**

11. Does any proposed insured have any of the coverages listed below inforce or have any pending application for such coverage with this Company or any other company? Check all applicable boxes. ....  
If "Yes,"

YES  NO

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

Name	Co. Name	Amt. of Coverage/Benefit	Pol. No.
<input type="checkbox"/> Life	<input type="checkbox"/> Health	<input type="checkbox"/> Long-term Care	<input type="checkbox"/> Disability/Period _____
			<input type="checkbox"/> Annuity

12. Will any existing insurance coverage or annuity contract be replaced or changed if any policy applied for is issued? .....  
If "Yes," complete the necessary replacement forms and provide details below.

YES  NO

Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
------	----------	------------------	--------------------------	----------

Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
------	----------	------------------	--------------------------	----------

Name	Co. Name	Type of Coverage	Amt. of Coverage/Benefit	Pol. No.
------	----------	------------------	--------------------------	----------

13. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? If "Yes," provide details below .....

YES  NO

Name	Type	Date of Last Use	Frequency/Amount
------	------	------------------	------------------

Name	Type	Date of Last Use	Frequency/Amount
------	------	------------------	------------------

14. Has any proposed insured ever had an application for insurance modified, rated, declined, postponed, or withdrawn? .....  
If "Yes," provide details below.

YES  NO

Name	Type of Coverage	Date	Details
------	------------------	------	---------

Name	Type of Coverage	Date	Details
------	------------------	------	---------

15. Within the past 5 years, has any proposed insured been convicted of, paid a fine/ticket or pled guilty to reckless driving, driving while intoxicated, or had a driver's license revoked or suspended, or, within the past 3 years, had any moving traffic violations?.....  
If "Yes,"

YES  NO

Name	Type of Violation	Duration (if applicable)	Date of Incident	State of Incident
------	-------------------	--------------------------	------------------	-------------------

Details

Name	Type of Violation	Duration (if applicable)	Date of Incident	State of Incident
------	-------------------	--------------------------	------------------	-------------------

Details

16. Has any proposed insured ever been convicted of, pled guilty to, or pled no contest to a felony, or is any such charge pending against him/her? .....

YES  NO

Name	Date of Occurrence	County and State	Disposition
------	--------------------	------------------	-------------

Details

Name	Date of Occurrence	County and State	Disposition
------	--------------------	------------------	-------------

Details

17. Does any proposed insured intend to travel or reside outside of the United States within the next year? ..... If "Yes,"	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>				
<table border="0" style="width: 100%;"> <tr> <td style="width: 25%;">Name(s)</td> <td style="width: 30%;">City/Country where traveling</td> <td style="width: 20%;">Length of Stay</td> <td style="width: 25%;">Times Per Year</td> </tr> </table>	Name(s)	City/Country where traveling	Length of Stay	Times Per Year		
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Purpose of Travel	Do you plan to visit non-urban areas	Trips outside of U.S. in prior two years				

18. Is any proposed insured <b>NOT</b> a citizen of the United States? ..... If "Yes,"	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>																
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Name of proposed insured _____</td> <td style="width: 50%;">Name of proposed insured _____</td> </tr> <tr> <td>Date of entry into the U.S. _____</td> <td>Date of entry into the U.S. _____</td> </tr> <tr> <td>Name of country of citizenship _____</td> <td>Name of country of citizenship _____</td> </tr> <tr> <td>Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>If "Yes," Provide A # _____</td> <td>If "Yes," Provide A # _____</td> </tr> <tr> <td>If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>If "Yes," Type of Visa: _____ (provide copy)</td> <td>If "Yes," Type of Visa: _____ (provide copy)</td> </tr> <tr> <td>Intentions after expiration of Visa _____</td> <td>Intentions after expiration of Visa _____</td> </tr> </table>	Name of proposed insured _____	Name of proposed insured _____	Date of entry into the U.S. _____	Date of entry into the U.S. _____	Name of country of citizenship _____	Name of country of citizenship _____	Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," Provide A # _____	If "Yes," Provide A # _____	If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," Type of Visa: _____ (provide copy)	If "Yes," Type of Visa: _____ (provide copy)	Intentions after expiration of Visa _____	Intentions after expiration of Visa _____		
Name of proposed insured _____	Name of proposed insured _____																	
Date of entry into the U.S. _____	Date of entry into the U.S. _____																	
Name of country of citizenship _____	Name of country of citizenship _____																	
Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No	Have Permanent Resident Card? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
If "Yes," Provide A # _____	If "Yes," Provide A # _____																	
If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No	If No, does the proposed insured have a Visa? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
If "Yes," Type of Visa: _____ (provide copy)	If "Yes," Type of Visa: _____ (provide copy)																	
Intentions after expiration of Visa _____	Intentions after expiration of Visa _____																	
<table border="0" style="width: 100%;"> <tr> <td style="width: 50%;">Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td style="width: 50%;">Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> <td>Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No</td> </tr> <tr> <td>If "Yes," give details _____</td> <td>If "Yes," give details _____</td> </tr> <tr> <td>If no Permanent Resident Card and no Visa, please explain: _____</td> <td>If no Permanent Resident Card and no Visa, please explain: _____</td> </tr> </table>	Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," give details _____	If "Yes," give details _____	If no Permanent Resident Card and no Visa, please explain: _____	If no Permanent Resident Card and no Visa, please explain: _____										
Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No	Does the proposed insured own a home in the U.S.? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No	Are any family members U.S. Citizens or Permanent Residents? <input type="checkbox"/> Yes <input type="checkbox"/> No																	
If "Yes," give details _____	If "Yes," give details _____																	
If no Permanent Resident Card and no Visa, please explain: _____	If no Permanent Resident Card and no Visa, please explain: _____																	

19. Within the past 5 years, has any proposed insured flown as a pilot, student pilot or crew member of any aircraft, or does any proposed insured have any intention to do so in the next 2 years? ..... If "Yes," Name _____ Details _____ Name _____ Details _____ If "Yes," submit an Aviation Questionnaire.	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
--	---------------------------------	---

20. Within the past 5 years, has any proposed insured engaged in motor sports events or racing (auto, truck, cycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning)? ..... If "Yes," Name _____ Details _____ Name _____ Details _____ If "Yes," submit an Avocation Questionnaire.	YES <input type="checkbox"/>	NO <input checked="" type="checkbox"/>
--	---------------------------------	---

**AGENT USE ONLY**

MEDICAL EXAMINATION WILL BE SCHEDULED FOR: Primary Proposed Insured .....	<input type="checkbox"/>	<input type="checkbox"/>
Additional Proposed Insured .....	<input type="checkbox"/>	<input type="checkbox"/>

**For any person who will be scheduled for a medical examination, please complete Questions 21. a. and 21. b.**

21. a. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for alcoholism, cancer or malignancy, HIV, heart attack, angina, kidney failure, Type 1 diabetes, emphysema, organ transplant or stroke, or been advised to have any diagnostic test or surgery not yet performed? ..... If "Yes," name(s) of proposed insured(s) _____	<input type="checkbox"/>	<input type="checkbox"/>
b. Is any proposed insured age 71 or older? ..... If "Yes," name(s) of proposed insured(s) _____	<input type="checkbox"/>	<input type="checkbox"/>

If "Yes" to 21. a. or 21. b., **no premium may be collected with this application.**

YES NO

**Questions 22 through 38 are only for persons proposed for insurance who are NOT expected to be subject to a Medical Examination. All applicants may, nevertheless, be subject to a Medical Examination at the Company's option.**

Please complete questions 22-38 for each person who did not check "Yes" above, and for each child who is not an additional proposed insured:

22. a. Primary Proposed Insured: Height 6'0" Weight 190 b. Additional Proposed Insured: Height 5'5" Weight 135  
 c. Has any proposed insured had a change in weight of 10 or more pounds in the past year? .....  YES  NO  
 If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_  
 If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_

23. Is any proposed insured currently taking any medication or under medical observation, treatment, or therapy? .....  YES  NO  
 If "Yes," Name \_\_\_\_\_  
 Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.  
 \_\_\_\_\_  
 \_\_\_\_\_  
 If "Yes," Name \_\_\_\_\_  
 Give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.  
 \_\_\_\_\_  
 \_\_\_\_\_

24. Within the past 5 years, has any proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility, or gone to a hospital emergency room or walk-in or similar clinic for medical care or consultation? .....  YES  NO  
 If "Yes," Name \_\_\_\_\_  
 Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type of Visit/Stay \_\_\_\_\_  
 (hospital, clinic, treatment facility, ER, walk-in or clinic)  
 Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility \_\_\_\_\_  
 \_\_\_\_\_  
 Give details \_\_\_\_\_  
 Name \_\_\_\_\_  
 Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type of Visit/Stay \_\_\_\_\_  
 (hospital, clinic, treatment facility, ER, walk-in or clinic)  
 Name, Address, and Telephone Number of the doctor, hospital, clinic, ER or treatment facility \_\_\_\_\_  
 \_\_\_\_\_  
 Give details \_\_\_\_\_

25. In the immediate family of any proposed insured, is there a history of high blood pressure, heart disease prior to age 60, kidney disease, stroke, diabetes prior to age 55, sickle cell anemia, cerebrovascular disorder, aneurysm, or cancer? .....  YES  NO  
 If "Yes," Name of Proposed Insured: \_\_\_\_\_  
 Relationship to Proposed Insured \_\_\_\_\_ Type/Details \_\_\_\_\_  
 Name of Proposed Insured: \_\_\_\_\_  
 Relationship to Proposed Insured \_\_\_\_\_ Type/Details \_\_\_\_\_

26. Does any proposed insured have a history of high blood pressure? .....  YES  NO

If "Yes," Name _____	If "Yes," Name _____
Date of diagnosis _____	Date of diagnosis _____
Treatment _____	Treatment _____
Last blood pressure reading and date _____	Last blood pressure reading and date _____
Highest blood pressure reading in past 12 months _____	Highest blood pressure reading in past 12 months _____
Average blood pressure reading _____	Average blood pressure reading _____
Name and address of physician treating high blood pressure. _____	Name and address of physician treating high blood pressure. _____
_____	_____
_____	_____

YES NO

27. Does any proposed insured have diabetes? .....

If "Yes," Name \_\_\_\_\_

If "Yes," Name \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Date of diagnosis \_\_\_\_\_

Describe treatment \_\_\_\_\_

Describe treatment \_\_\_\_\_

List any disability related to diabetes \_\_\_\_\_

List any disability related to diabetes \_\_\_\_\_

Last blood sugar or HA1C reading and date \_\_\_\_\_

Last blood sugar or HA1C reading and date \_\_\_\_\_

Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes?  Yes  No

Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes?  Yes  No

If "Yes," provide details \_\_\_\_\_

If "Yes," provide details \_\_\_\_\_

Name and address of physician treating diabetes \_\_\_\_\_

Name and address of physician treating diabetes \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

28. Within the past 5 years, has any proposed insured consumed alcoholic beverages? .....

If "Yes," Name \_\_\_\_\_ Average No. of drinks per week \_\_\_\_\_

Maximum No. of drinks per day \_\_\_\_\_ Type (Beer, Wine, Liquor) and Date of last use \_\_\_\_\_

Name \_\_\_\_\_ Average No. of drinks per week \_\_\_\_\_

Maximum No. of drinks per day \_\_\_\_\_ Type (Beer, Wine, Liquor) and Date of last use \_\_\_\_\_

29. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician? .....

If "Yes," Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) \_\_\_\_\_

Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) \_\_\_\_\_

\_\_\_\_\_

30. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)? .....

If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

If "Yes," Name \_\_\_\_\_ Details \_\_\_\_\_

Name and Address of Physician \_\_\_\_\_

31. Within the past 12 months, has any proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness, or paralysis for which the cause is not known and for which a doctor has not been consulted? .....

If "Yes," Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details \_\_\_\_\_

Name \_\_\_\_\_ Date(s) \_\_\_\_\_ Duration \_\_\_\_\_ Type \_\_\_\_\_

Details \_\_\_\_\_



38. Does any proposed insured have any symptoms or knowledge of any other condition that is **NOT** disclosed in previous questions? .....

**YES**  **NO**

Explain "Yes" answers to Questions 36-38.

Name	Date	Duration	Details	Name(s) and Address(es) of Doctor(s) or Hospital(s)
------	------	----------	---------	---


The space below may also be used to elaborate on any other question on this application.

**OWNER'S CERTIFICATION**

Under penalties of perjury, I certify that the following number, 012-45-6789, is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:

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

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

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

X John Doe July 1, 2010  
 Signature of Owner Date

**Consent to Insurance on Life of Minor Primary Proposed Insured**

I hereby consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor Primary Proposed Insured.

X \_\_\_\_\_  
 Signature of Biological/Adoptive Father or Mother or of Legal Guardian Date

X \_\_\_\_\_  
 Signature of Biological/Adoptive Father or Mother or of Legal Guardian Date

**Consent to Children's Term Rider on Life of Minor Stepchild of Primary Proposed Insured or Additional Proposed Insured**

I hereby consent to the insurance plan and amount shown on this application as to any biological and adopted child(ren) of mine listed in this application. I understand that the beneficiary of such applied-for coverage on such child(ren) will be the Owner of the policy. I affirm the answers to the health questions on this application as to such child(ren).

X \_\_\_\_\_  
 Signature of Biological/Adoptive Father or Mother Date

**SECONDARY ADDRESSEE FOR CHRONIC ILLNESS ACCELERATED BENEFIT RIDER II (not applicable to any other coverage).**

Name and address of person to receive notice of lapse or termination of the applied-for coverage (in addition to the payer of the Policy):

Name \_\_\_\_\_ Address \_\_\_\_\_

Protection Against Unintended Lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this accelerated death benefit rider for nonpayment of cost of insurance. I understand that notice will not be given until thirty (30) days after cost of insurance is due and unpaid. By not providing a name and address, I signify that I elect NOT to designate any person to receive such notice.

**AGENT'S CERTIFICATION**

I certify that I have asked each question and that the answers have been truly and accurately recorded as given. I have recorded any unfavorable information which I have knowledge of concerning any proposed insured. I confirm that any and all signatures of the Primary Proposed Insured, Additional Proposed Insured, Owner and Witness(es) in this application were signed in my presence.

July 1, 2010  
 Date

Sally Shield  
 Signature of Licensed Agent

**ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZATION – NOTICE**

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

**Acknowledge** that, if a Conditional Receipt was issued to me as a result of this application, I have read, or have been given the opportunity to read or to have read to me, all terms and provisions of such Conditional Receipt.

**Agree** that, under the Conditional Receipt, if any, given to me as the result of this application and under any additional pending application for other life, accident and/or health insurance coverage from American General Life and Accident Insurance Company (“the Company”), the aggregate liability on account of all coverages applied for with the Company will be the amount of coverage applied for or \$250,000, whichever is less.

**Agree** that any temporary insurance arising under the terms of any Conditional Receipt given to me as a result of this application shall become effective only if and when such Conditional Receipt is delivered to the Owner.

**Agree** that all statements and answers in this application are complete and true to the best of my knowledge and belief and are the basis for any policy issued by the Company and agree that no information shall be deemed to have been given to the Company unless it is set forth in this application or in any supplemental application.

**Agree** that, except as stated in any Conditional Receipt, if such Conditional Receipt was given to me as a result of this application, the insurance will take effect on the Policy Date shown in the Policy if (a) the Policy has been delivered to me; (b) the first full modal premium for the Issued Policy has been paid while each proposed insured is alive; and (c) there has been no change in the health of any proposed insured that would change the answer to any question in this or any supplemental application before the conditions in items (a) and (b) above are met.

**Agree** that no agent of the Company or Medical Examiner has authority to waive any answer or otherwise modify this or any supplemental application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

**Authorize:** (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau (“MIB”), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company’s reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for insurance policy, and (3) the duration of a claim for benefits.

**ACKNOWLEDGE** receipt of the following notices: (a) “Notice of Information Practices” required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; and (c) Investigative Consumer Report.

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

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

**PRIMARY PROPOSED INSURED** - If an investigative consumer report is prepared in connection with this application:

I elect to be interviewed.  I elect NOT to be interviewed.

**ADDITIONAL PROPOSED INSURED** - If an investigative consumer report is prepared in connection with this application:

I elect to be interviewed.  I elect NOT to be interviewed.

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

Signed at Little Rock AR July 1, 2010 X John Doe  
City State Date SIGNATURE OF PRIMARY PROPOSED INSURED

X Jane Doe X \_\_\_\_\_  
SIGNATURE OF ADDITIONAL PROPOSED INSURED (IF APPLICABLE) SIGNATURE OF OWNER (IF OTHER THAN PRIMARY PROPOSED INSURED)

X \_\_\_\_\_ X Sally Shield  
SIGNATURE OF WITNESS (IF APPLICABLE) SIGNATURE OF LICENSED AGENT



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**NOTICE TO HOLDER OF CONDITIONAL RECEIPT**

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:

- (a) decline to issue insurance; or
- (b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our Home Office, American General Center, Nashville, TN 37250-0001.

AGLA1000-AR (0510) CR

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**NOTICE OF INFORMATION PRACTICES**

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

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

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

AGLA1000 NIP (1004)

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**(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES)  
CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT**

This Receipt is Valuable. Keep It in a Safe Place.

On this date, American General Life and Accident Insurance Company ("the Company") has received \$ \_\_\_\_\_ for life insurance applied for on \_\_\_\_\_ . We agree to provide temporary insurance if (a) this deposit is equal to at least \_\_\_\_\_  
(Primary or Additional Proposed Insured)

one twelfth (1/12) of the annual premium for the policy applied for and (b) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters in Nashville, Tennessee for the plan, insurance amount, and premium applied for on the date of this premium deposit and on the date of any required medical examination.

ANY TEMPORARY INSURANCE UNDER THIS CONDITIONAL RECEIPT IS SUBJECT TO THE AMOUNT AND TERMS OF THE POLICY APPLIED FOR EXCEPT THAT THE AGGREGATE LIABILITY FOR TEMPORARY INSURANCE FOR EACH PROPOSED INSURED UNDER THIS CONDITIONAL RECEIPT AND UNDER CONDITIONAL RECEIPT FOR ANY ADDITIONAL, PENDING APPLICATION FOR OTHER LIFE, ACCIDENT AND/OR HEALTH INSURANCE COVERAGE FROM THE COMPANY WILL BE THE AMOUNT OF COVERAGE APPLIED FOR OR \$250,000.00, WHICHEVER IS LESS. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT, IF EARLIER.

No agent has authority to change or waive the terms and conditions of this Receipt. This receipt is not valid if its date differs from that in the application or if any check tendered as a premium deposit shown above is not honored when presented for payment.

---

Date

Local Office

Agency No.

Signature of Licensed Agent

**ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.**

AGLA1000-AR (0510) CR

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**MIB PRE-NOTICE**

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

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

American General Life and Accident Insurance Company, or its reinsurer(s), may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

AGLA1000 MIB (1004)

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**NOTICE TO HOLDER OF CONDITIONAL RECEIPT**

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:

- (a) decline to issue insurance; or
- (b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our Home Office, American General Center, Nashville, TN 37250-0001.

AGLA1000-AR (0510) CR

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**NOTICE OF INFORMATION PRACTICES**

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

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

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

AGLA1000 NIP (1004)

**APPLICATION FOR LIFE INSURANCE**

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

**For Home Office use only****Plan Information (as applied)**

Plan Name: *WHOLE LIFE* Amount: *\$100,000* Premium: *\$190.28*  
Is Automatic Premium Loan Provision to be in effect? *NA* Billing Type: *ABC* Frequency: *MONTHLY (M)*

**Additional Benefits:** *ACCIDENTAL DEATH \$100,000.00* **Riders:** *CHILDREN'S TERM RIDER \$10,000.00* **UL Death Benefit Option:**  
*PREMIUM WAIVER* *20 YR SPOUSE LEVEL TERM RIDER*  
*\$75,000.00*

Premium Calculation Age: *42*

**Primary Proposed Insured Information**

<b>Name:</b>	<i>JOHN Q DOE</i>	<b>Social Security No:</b>	<i>123-00-1233</i>
<b>Street/Box:</b>	<i>123 MAIN STREET</i>	<b>Sex:</b>	<i>MALE</i>
		<b>Status:</b>	<i>MARRIED</i>
<b>City, State, Zip:</b>	<i>LITTLE ROCK, AR 37250-0001</i>	<b>Driver's License No.:</b>	<i>12345678</i>
<b>Country:</b>	<i>USA</i>	<b>State of Issue:</b>	<i>AR</i>
<b>Home Phone No.:</b>	<i>(615)749-1000</i>	<b>Birth Date:</b>	<i>10-01-1968</i>
<b>Work Phone No.:</b>	<i>(615)749-2222</i>	<b>Birth State:</b>	<i>KY</i>
<b>Best Time to Call:</b>	<i>HOME 07:00 PM</i>	<b>Birth Country:</b>	<i>USA</i>
	<i>WORK 12:00 PM</i>	<b>Name of Employer:</b>	<i>BORDEN</i>
<b>Annual Earned Income:</b>	<i>\$45,000.00</i>	<b>Owner Duties:</b>	<i>BOTH</i>
<b>Occupation Category:</b>	<i>FACTORY/INDUSTRIAL</i>		
<b>Current Occupation:</b>	<i>DAIRY WORKER</i>	<b>Length of Time:</b>	<i>LESS THAN ONE YEAR</i>
<b>Nature of Business:</b>	<i>AGRICULTURAL PRODUCTION</i>	<b>Job Status:</b>	<i>FULL TIME</i>
	<i>LIVESTOCK AND ANIMAL</i>		
	<i>SPECIALTIES</i>	<b>Height:</b>	<i>6 ft. 0 in.</i>
<b>Most Recent Occupation:</b>	<i>COMPUTER PROGRAMMER</i>	<b>Weight:</b>	<i>190 lbs.</i>
<b>Job Duties:</b>	<i>MILK COWS</i>		
<b>Occupation Class:</b>	<i>S-3</i>		
<b>Other Sources of Income:</b>	<i>NONE</i>		

Is the Proposed Insured the Owner? *NO*

Length of time employed by current Employer: *LESS THAN ONE YEAR*

Length of time employed in occupation: *ONE YEAR OR MORE*

Average number of hours worked per week in occupation: *30 OR MORE*

Is the Primary Proposed Insured actively at work and able to perform all regular job duties? *NO*

If No, explain: *BROKEN LEG*

Working Spouse Life Insurance Coverage: *\$5,000*

No Driver's License Explanation: *EXPLANATION GOES HERE IF NO LICENSE*

**Additional Proposed Insured Information**

<b>Name:</b>	<i>JANE R DOE</i>	<b>Social Security No:</b>	<i>321-54-9876</i>
<b>Annual Earned Income:</b>	<i>\$35,000.00</i>	<b>Sex:</b>	<i>FEMALE</i>

<b>Occupation Category:</b>	MANAGEMENT/PROFESSIONAL	<b>Driver's License No.:</b>	98765432
<b>Current Occupation:</b>	TEACHER/PROFESSOR	<b>State of Issue:</b>	AR
<b>Nature of Business:</b>	EDUCATIONAL SERVICES	<b>Birth Date:</b>	03-01-1970
<b>Most Recent Occupation:</b>	COMPUTER PROGRAMMER	<b>Age:</b>	40
<b>Job Duties:</b>	TEACH ELEMENTARY	<b>Birth State:</b>	AZ
<b>Job Status:</b>	FULL TIME	<b>Birth Country:</b>	USA
<b>Name of Employer:</b>	SOME SCHOOL SYSTEM	<b>Length of Time:</b>	LESS THAN ONE YEAR
<b>Occupation Class:</b>	S-3	<b>Owner Duties:</b>	BOTH
		<b>Relationship:</b>	SPOUSE
		<b>Height:</b>	5 ft. 5 in.
		<b>Weight:</b>	125 lbs.

**Other Sources of Income:**  
NONE

**Length of time employed by current Employer:** ONE YEAR OR MORE

**Length of time employed in occupation:**

**Average number of hours worked per week in occupation:** 30 OR MORE

**Is the Additional Proposed Insured actively at work and able to perform all regular job duties?** NO

**If No, explain:** ILLNESS

**No Driver's License Explanation:** EXPLANATION GOES HERE IF NO LICENSE

### Proposed Children Information

Enter names of children, stepchildren and legally adopted children for whom application for coverage under a Child Term Rider is made who are: (1) members of your immediate family and household; and (2) under the age 18.

Name	Relationship	Birth Date	Age	Children Under Age One	
				Birth Weight	Current Weight
JOE S DOE	SON	02-12-1996	15		

### Owner Information

<b>Name:</b>	JAMES T DOE	<b>Relationship:</b>	FATHER
<b>Street/Box:</b>	234 MAIN STREET	<b>SSN/TIN:</b>	123-99-2345
		<b>Home Phone:</b>	(615)749-1111
<b>City, State, Zip:</b>	LITTLE ROCK, AR 37250-0001	<b>Work Phone:</b>	(615)749-1000
		<b>Best Time to Call:</b>	HOME 07:00 PM WORK 12:00 PM

### Payer Information

<b>Name:</b>	JOHN Q DOE	<b>Relationship:</b>	PRIMARY PROPOSED INSURED
<b>Street/Box:</b>	123 MAIN STREET	<b>SSN/TIN:</b>	123-12-1234
		<b>Home Phone:</b>	(615)749-1111
<b>City, State, Zip:</b>	LITTLE ROCK, AR 37250-0001	<b>Work Phone:</b>	(615)749-1000
<b>Family Group:</b>	1500	<b>Best Time to Call:</b>	HOME 07:00 PM WORK 12:00 PM

**Are premiums to be paid with pre-tax dollars under a section 125 (cafeteria) plan sponsored by your employer?** YES

**Anticipated Effective Date of Coverage:** 04-30-2010

### Beneficiary Information, with right to change

<b>Name:</b>	JANE R DOE	<b>Relationship:</b>	SPOUSE
<b>Street/Box:</b>	123 MAIN STREET	<b>Beneficiary Class:</b>	FIRST
		<b>Age:</b>	36
<b>City, State, Zip:</b>	LITTLE ROCK, AR 37250-0001	<b>Beneficiary Type:</b>	INDIVIDUAL
		<b>SSN/TIN:</b>	123-12-1234
<b>Name:</b>	JOE Q DOE	<b>Relationship:</b>	SON
<b>Street/Box:</b>	123 MAIN STREET	<b>Beneficiary Class:</b>	SECOND
		<b>Age:</b>	15
<b>City, State, Zip:</b>	LITTLE ROCK, AR 37250-0001	<b>Beneficiary Type:</b>	INDIVIDUAL
		<b>SSN/TIN:</b>	123-12-1234

**Background Information**

For any person who will be scheduled for a medical examination, please complete Question 11. Questions 12 - 28 are only for persons proposed for insurance who are NOT expected to be subject to a Medical Examination. All applicants may, nevertheless, be subject to a Medical Examination at the Company's option.

1. Does any proposed insured have a life, health, long-term care, or disability insurance policy or an annuity contract in force or have any pending application for such coverage with this Company or any other company? YES

Name	Company Name	Amount / Type	Policy No.
JOHN Q DOE	SOME INSURANCE COMPANY	\$5,000.00 / INFORCE LIFE	23456781234A

2. Will any existing insurance coverage or annuity contract be replaced or changed if any policy applied for is issued? YES

Name	Company Name	Amount / Type	Policy No.
JOE Q DOE	OTHER INSURANCE COMPANY	\$5,000.00 / LIFE	23456781234A

3. Within the past 5 years, has any proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? YES

Name	Type	Date of Last Use	Frequency / Amount
JOHN Q DOE	Cigars	06-2008	DAILY / 2 Cigars
JOE S DOE	Cigarettes	06-2008	DAILY / 40 Cigarettes

4. Has any proposed insured ever had an application for insurance modified, rated, declined, postponed, or withdrawn? YES

Name	Type / Details	Date
JANE R DOE	LIFE / 45 OVERWEIGHT	12-2007

5. Within the past 5 years, has any proposed insured been convicted of, paid a fine/ticket or pled guilty to reckless driving, driving while intoxicated, or had a driver's license revoked or suspended, or, within the past 3 years, had any moving traffic violations? YES

Name	Type / Details	State	Date / Duration
JOHN Q DOE	Driving while intoxicated / .093 BAC	AR	12-2007 / 1 DAY(S)

6. Has any proposed insured ever been convicted of, pled guilty to, or pled no contest to a felony, or is any such charge pending against him/her? YES

Name	Details	Date	Disposition
JOE S DOE	TN CASE NO 345987 WILLIAMSON COUNTY, TN	02-1992	Convicted

7. Does any proposed insured intend to travel or reside outside of the United States within the next year? YES

Name	Details	Date / Duration	Non-Urban Area
JOHN Q DOE	PARIS ALL OTHER FOREIGN, Vacation, 1 TIME PER YEAR, NO TRIPS OUTSIDE OF THE US IN PRIOR TWO YEARS	08-2010 / 2 WEEK(S)	No
JANE R DOE	HONG KONG ALL OTHER FOREIGN, Vacation, 2 TIMES PER YEAR, WENT TO PUERTO RICO 03-2009	06-2010 / 1 WEEK(S)	No

8. Is any proposed insured NOT a citizen of the United States? YES

Name	Details	Type Visa	Date of Entry
JOHN Q DOE	I AM A CITIZEN OF MEXICO. I HAVE A PERMANENT RESIDENT CARD A999888777. I DO OWN A HOME IN THE US AT 123 MAIN ST, LITTLE ROCK AR 37250. BROTHER IS A US CITIZEN.	Other	06-1966

9. Within the past 5 years, has any proposed insured flown as a pilot, student pilot or crew member

of any aircraft, or does any proposed insured have any intention to do so in the next 2 years?			YES
<b>Name</b>	<b>Type / Details</b>	<b>Date / Duration</b>	
JOE S DOE	Pilot / OWNS PRIVATE PLANE. OVER 1000 HOURS RECORDED FLIGHT TIME.	06-2008 / 4 YEAR(S)	
10. Within the past 5 years, has any proposed insured engaged in motor sports events or racing (auto, truck, cycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning)?			YES
<b>Name</b>	<b>Type / Details</b>	<b>Date / Duration</b>	
JOHN Q DOE	Skin or scuba diving / CERTIFIED SCUBA DIVING	02-2008 / 3 YEAR(S)	
11. Within the past 5 years, has any proposed insured been diagnosed as having or been treated for alcoholism, cancer or malignancy, HIV, heart attack, angina, kidney failure, Type 1 diabetes, emphysema, organ transplant or stroke, or been advised to have any diagnostic test or surgery not yet performed?			YES
<b>Name</b>	JOHN Q DOE		
12. Has any proposed insured had a change in weight of 10 or more pounds in the past year?			YES
<b>Name</b>	<b>Details</b>		
JANE R DOE	Lost 30 pounds by not eating fried foods or drinking sodas		
13. Is any proposed insured currently taking any medication or under medical observation, treatment, or therapy?			YES
<b>Name</b>	<b>Type / Details</b>	<b>Doctor / Hospital Information</b>	
JANE R DOE	Taking medication / TAKE PRILOSEC FOR HEARTBURN	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001	
14. Within the past 5 years, has any proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility, or gone to a hospital emergency room or walk-in or similar clinic for medical care or consultation?			YES
<b>Name</b>	<b>Type / Details</b>	<b>Date / Duration</b>	<b>Doctor / Hospital Information</b>
JANE R DOE	Emergency room / TORN LABRUM	04-2009 / 1 DAY(S)	LAKEVIEW HOSPITAL 125 MAIN ST LITTLE ROCK, AR 37250-0001
15. In the immediate family of any proposed insured, is there a history of high blood pressure, heart disease prior to age 60, kidney disease, stroke, diabetes prior to age 55, sickle cell anemia, cerebrovascular disorder, aneurysm, or cancer?			YES
<b>Name</b>	<b>Type / Details</b>	<b>Relationship</b>	
JANE R DOE	Cancer / LUNG CANCER	BROTHER	
16. Does any proposed insured have a history of high blood pressure?			YES
<b>Name</b>	<b>Details</b>	<b>Doctor / Hospital Information</b>	
JANE R DOE	DATE OF DIAGNOSIS: 02/2007 TREATMENT: ATENOLOL 25MB. LAST BLOOD PRESSURE READING 120/80 ON 03/2010. HIGHEST BLOOD PRESSURE READING IN LAST 12 MONTHS: 128/93. AVERAGE BLOOD PRESSURE READING: 120/80.	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001	
17. Does any proposed insured have diabetes?			YES
<b>Name</b>	<b>Details</b>	<b>Doctor / Hospital Information</b>	
JOE S DOE	DATE OF DIAGNOSIS: 09/2007 TREATMENT: METFORMIN 500 MG. NO DISABILITIES RELATED TO DIABETES. LAST BLOOD SUGAR OR HA1C READING: 102 ON 04/2010. HAVE NOT EXPERIENCED DIABETIC	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001	

COMA, OR VASCULAR, KIDNEY, HEART, EYE OR OTHER PROBLEMS RELATED TO DIABETES.

18. Within the past 5 years, has any proposed insured consumed alcoholic beverages? YES

Name	Details
JANE R DOE	I consume 15-24 drinks per week. The maximum # of alcoholic beverages I consume per day is 3. I consume Beer. The date of last use was 04-2010.

19. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Used prescription medication other than as prescribed / XANEX	10-2000 / 1 DAY(S)	DR BARNEY JOONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

20. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)? YES

Name	Details	Doctor / Hospital Information
JOE S DOE	AIDS	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

21. Within the past 12 months, has any proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness, or paralysis for which the cause is not known and for which a doctor has not been consulted? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Dizziness / WAS GETTING DIZZY WHEN I GOT OUT OF BED	04-2010 / 3 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

22. In the past 24 months, has any proposed insured been advised by a member of the medical profession concerning any abnormal diagnostic test results, or been advised to have any diagnostic tests (including self-administered), treatment or surgery which was not completed or does any proposed insured have test results pending [except those tests related to the Human Immunodeficiency Virus (AIDS virus)]? YES

Name	Type / Details	Date	Doctor / Hospital Information
JOE S DOE	Abnormal diagnostic test results / BLOOD SUGAR LEVEL WAS HIGH	04-2009	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

23. Does any proposed insured have a pending appointment with any physician or other medical professional or have the intent to make such appointment within the next 60 days? YES

Name	Type / Details	Date	Doctor / Hospital Information
JANE R DOE	Pending Appointment / NEED TO HAVE MY SHOULDER CHECKED AGAIN	05-2010	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

24. Is any proposed insured currently a patient in or been advised to enter a hospital, nursing home, hospice or assisted living facility? YES

Name	Type / Details
JANE R DOE	Advised to enter an Assisted Living Facility / DR TOLD ME I NEEDED TO LOOK INTO MOVING INTO AN ASSISTED LIVING FACILITY DUE TO MY SHOULDER

25. Has any proposed insured made claim for or received disability (other than for routine pregnancy)

## or Worker's Compensation benefits in the past 5 years?

YES

Name	Type / Details	Date / Duration
JANE R DOE	Disability Claim / HURT SHOULDER WHILE CARRYING BOXES AT WORK	06-2007 / 3 YEAR(S)

## 26a. Within the past 24 months, has any proposed insured experienced fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath?

YES

Name	Type / Details	Date	Doctor / Hospital Information
JOE S DOE	Shortness of Breath / WAS HAVING TROUBLE CATCHING MY BREATH	02-2009	LAKEVIEW HOSPITAL 125 MAIN ST LITTLE ROCK, AR 37250-0001

## 26b. Within the past 24 months, has any proposed insured received home health care services, physical therapy or rehabilitation therapy?

YES

Name	Type / Details	Date	Doctor / Hospital Information
JANE R DOE	Physical Therapy / RECEIVED ULTRASOUND TREATMENT FOR SHOULDER	04-2009	STAG PHYSICAL THERAPY 9081 MEDICAL DR FRANKLIN, AR 37067-0001

## 26c. Within the past 24 months, has any proposed insured resided in senior citizen's housing or a retirement or assisted living community?

YES

Name	Type / Details	Date	Doctor / Hospital Information
JANE R DOE	Assisted Living Community / LIVED THERE WHILE I HAD SHOULDER PROBLEMS	04-2009	CRESTVIEW REHAB 45 S WEBB ST LITTLE ROCK, AR 37250-0001

## 26d. Within the past 24 months, has any proposed insured required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)?

YES

Name	Type / Details	Date	Doctor / Hospital Information
JANE R DOE	Bathing / COULDN'T LOVER MYSELF INTO THE BATHTUB DUE TO SHOULDER PROBLEM	04-2009	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

## 26e. Within the past 24 months, has any proposed insured required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?

YES

Name	Type / Details	Date	Doctor / Hospital Information
JANE R DOE	Driving a car / COULDN'T DRIVE DUE TO SHOULDER PROBLEM	04-2009	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

## 27a. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart?

YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Heart Attack / HAD A HEART ATTACK WHILE MOWING THE YARD	07-2001 / 1 DAY(S)	LAKEVIEW HOSPITAL 125 MAIN ST LITTLE ROCK, AR 37250-0001

## 27b. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins?

YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Stroke / HAD A STROKE WHILE WORKING OUT	07-2001 / 1 DAY(S)	LAKEVIEW HOSPITAL 125 MAIN ST LITTLE ROCK, AR 37250-0001

27c. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JOE S DOE	Cancer / SPOT ON MY FOREHEAD WAS CANCEROUS	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27d. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Disease or disorder of the immune system / MULTIPLE MYELOMA	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27e. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Disease or disorder of the stomach / IBD	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27f. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or protein in the urine? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Polycystic kidneys / BLOOD IN MY URINE	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27g. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the respiratory system, or asthma, chronic bronchitis, chronic obstructive pulmonary disease (COPD), emphysema, sleep apnea, or other lung disease? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Asthma / WHEEZING	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27h. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Seizures / WILL HAVE MILD SEIZURE EPISODES WHEN I GET HOT	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27i. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for anxiety, depression or other mental disorder? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Anxiety / GET ANXIOUS IN LARGE GROUPS OF PEOPLE	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27j. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for Alzheimer's disease or dementia? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Alzheimer's disease / STARTING TO	07-2001 / 1 DAY(S)	DR BARNEY JONES

FORGET BASIC ROUTINES

706 3RD AVE  
LITTLE ROCK, AR 37250-0001

27k. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for glaucoma, macular degeneration, optic neuritis? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Glaucoma / STARTING TO LOSE MY EYESIGHT	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27l. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the blood, or anemia, hemophilia, sickle cell anemia? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Hemophilia / BRUISE EASILY	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27m. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the muscles or bones, including but not limited to the back or joints? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Disease or disorder of the muscles / OSTEOPOROSIS	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

27n. Has any proposed insured ever been diagnosed as having, or been treated for or consulted a licensed health care provider for a disease or disorder of the reproductive system? YES

Name	Type / Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Disease or disorder of the reproductive system / CYSTS ON MY OVARIES	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

28. Does any proposed insured have any symptoms or knowledge of any other condition that is NOT disclosed in previous questions? YES

Name	Details	Date / Duration	Doctor / Hospital Information
JANE R DOE	Infection from tattoo removal	07-2001 / 1 DAY(S)	DR BARNEY JONES 706 3RD AVE LITTLE ROCK, AR 37250-0001

### Acknowledgement - Agreement - Authorization - Notice

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

» Acknowledge that, if a Conditional Receipt was issued to me as a result of this application, I have read, or have been given the opportunity to read or to have read to me, all terms and provisions of such Conditional Receipt.

» Agree that, under the Conditional Receipt, if any, given to me as the result of this application and under any additional pending application for other life, accident and/or health insurance coverage from American General Life and Accident Insurance Company ("the Company"), the aggregate liability on account of all coverages applied for with the Company will be the amount of coverage applied for or \$250,000, whichever is less.

» Agree that any temporary insurance arising under the terms of any Conditional Receipt given to me as a result of this application shall become effective only if and when such Conditional Receipt is delivered to the Owner.

» Agree that all statements and answers in this application are complete and true to the best of my knowledge and belief and are the basis for any policy issued by the Company and agree that no information shall be

deemed to have been given to the Company unless it is set forth in this application or in any supplemental application.

» Agree that, except as stated in any Conditional Receipt, if such Conditional Receipt was given to me as a result of this application, the insurance will take effect on the Policy Date shown in the Policy if (a) the Policy has been delivered to me; (b) the first full modal premium for the issued Policy has been paid while each proposed insured is alive; and (c) there has been no change in the health of any proposed insured that would change the answer to any question in this or any supplemental application before the conditions in items (a) and (b) above are met.

» Agree that no agent of the Company or Medical Examiner has authority to waive any answer or otherwise modify this or any supplemental application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

» AUTHORIZE:

(a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, other persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for insurance policy, and (3) the duration of a claim for benefits.

» ACKNOWLEDGE receipt of the following notices:

- (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; and (c) Investigative Consumer Report.

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

» NOTICE: If a proposed insured's answers on this application are incorrect or untrue, the Company may have the right to deny benefits and/or rescind coverage.

Primary Proposed Insured:

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

Additional Proposed Insured:

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

Signed at: Little Rock, City

AR 08/09/2010 8:49:54 AM X John Q. Doe  
State Date / Time JOHN Q DOE, Primary Proposed Insured

08/09/2010 8:49:54 AM X Jackson Doe  
Date / Time Witness

08/09/2010 8:49:54 AM X James T. Doe  
Date / Time JAMES T DOE, Owner

08/09/2010 8:49:54 AM X Jackson Doe  
Date / Time Witness

08/09/2010 8:49:54 AM X Jane R. Doe  
Date / Time JANE R DOE, Additional Proposed Insured

08/09/2010 8:49:54 AM X Jackson Doe  
Date / Time Witness

Name of Minor Child(ren): JOE S DOE

**Consent to Insurance on Life of Minor Primary Proposed Insured**

» I hereby consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor Primary Proposed Insured.

08/09/2010 8:49:54 AM X James J. Doe  
Date / Time Biological/Adoptive Father or Mother or of Legal Guardian

08/09/2010 8:49:54 AM X Jane R. Doe  
Date / Time Biological/Adoptive Father or Mother or of Legal Guardian

**Consent to Children's Term Rider on Life of Minor Stepchild of Primary Proposed Insured**

» I hereby consent to the insurance plan and amount shown on this application as to any biological and adopted child(ren) of mine listed in this application. I understand that the beneficiary of such applied-for coverage on such child(ren) will be the Owner of the policy. I affirm the answers to the health questions on this application as to such child(ren).

08/09/2010 8:49:54 AM X John Q. Doe  
Date / Time Biological/Adoptive Father or Mother

**SECONDARY ADDRESSEE FOR CHRONIC ILLNESS ACCELERATED BENEFIT RIDER II  
(not applicable to any other coverage)**

Name and address of person to receive notice of lapse or termination of the applied-for coverage (in addition to the payer of the Policy):

Name: DONNA H DOE  
Street/Box: 456 PINE AVE  
City, State, Zip: LITTLE ROCK, AR 37250

Protection Against Unintended Lapse: I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of this accelerated death benefit rider for nonpayment of cost of insurance. I understand that notice will not be given until thirty (30) days after cost of insurance is due and unpaid. By not providing a name and address, I signify that I elect NOT to designate any person to receive such notice.

**Agent's Certification - Confirmation**

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

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

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

08/09/2010 8:49:54 AM X Joseph Turner  
Date / Time JOSEPH TURNER, Licensed Agent

**AGENT'S REPORT**

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

<b>Contact Source:</b>	REFERRAL-FRIEND
<b>Application Origination:</b>	INSURANCE REVIEW
<b>Household Annual Earned Income:</b>	\$98,000
<b>What is your relationship to the Proposed Insured(s)?</b>	NO RELATIONSHIP
<b>Is more than one application being submitted at this time or pending for the proposed insured, family members or business associates?</b>	YES
<i>LIFE APPLICATION PENDING FOR JOHN Q DOE</i>	
<b>For Any Associated Plan or Stand-alone Policy:</b>	
<b>Proposed Insured and Plan:</b>	JOHN Q DOE      20 YR AGLAFLEX
<i>TERM</i>	
<b>Policy number or name of insured on the qualified policy if the application is pending?</b>	210000001
<b>Efficiency Discount:</b>	FT1
<b>Did you personally see all proposed insured(s) when the application was written?</b>	YES
<b>Do you have any knowledge of any unfavorable information regarding the proposed insured(s) which has not been fully disclosed in the application?</b>	YES
<i>INSURED KNOWN TO ASSOCIATE WITH DRUG DEALERS</i>	
<b>Agent: To the best of your knowledge, is the insurance applied for intended to replace any existing insurance?</b>	YES
<b>Is there to be any split commission with another agent?</b>	YES
<b>Agent's Name:</b>	JOHN R ABERCROMBIE
<b>Agent's ID:</b>	R005566
<b>Percentage of split:</b>	78%
<b>Agent's Name:</b>	WANDA G ROBINSON
<b>Agent's ID:</b>	R005566
<b>Percentage of split:</b>	22%
<b>Did you give the Owner a Conditional Receipt?</b>	YES
<b>Did you bring the conditions and limitations of any conditional receipt to the attention of the Owner?</b>	YES
<b>Will the insurance contemplated by this application be premium financed, other than under a split-dollar agreement? If "Yes", provide explanation in the REMARKS section below. If "No", I certify, to the best of my information and belief, that none of the premiums for the policy(ies) sought with the application(s) for life insurance referenced herein will be financed other than under a split-dollar agreement.</b>	NO
<b>Agent's daytime phone number:</b>	(615)749-3000
<b>Agent's e-mail address:</b>	agent01@gmail.com

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

**Juvenile Section**

<b>What is the total amount of existing life insurance in force with this Company and any other company on this juvenile proposed insured?</b>	\$5,000
<b>What is the total amount of life insurance in force on the head of household in residence of the child?</b>	FATHER \$50,000
<b>What is the total amount of life insurance on each of the other members (include siblings) of the household?</b>	BROTHER \$50,000
<i>SISTER \$25,000 MOTHER \$50,000</i>	

What is the total family income where juvenile resides?	\$98,000
If juvenile insurance exceeds Company guidelines, provide explanation:	
Explanation for Missing 2nd Parent Consent for Minor Signature:	MOM IS IN PRISON
If Accidental Death is applied for, what is the total amount of accident coverage applied for and in force on the juvenile proposed insured?	\$20,000
If greater than \$25,000, explain need for accident coverage:	
<b>Case Summary Section</b>	
How was amount of insurance determined:	FINANCIAL REVIEW
Coverage Purpose:	INCOME REPLACEMENT
Coverage Purpose:	ESTATE PRESERVATION
Estate Preservation Net Worth:	\$1,350,000
Coverage Purpose:	CREDIT COVERAGE
Credit Coverage Loan Institute:	SATURN CREDIT UNION
Credit Coverage Loan Amount:	\$400,000
Credit Coverage Loan Duration:	360 month(s)
Coverage Purpose:	KEYMAN
Insureds Contribution to the Company:	BOARD OF DIRECTORS
Complete Value of Compensation Package:	\$1,300,000
Time With the Company:	5 year(s), 3 month(s)
Amount of Experience in the industry:	12 year(s), 0 month(s)
Coverage Purpose:	BUY SELL
First Buy Sell Partner Name:	JOHN DOE
First Buy Sell Partner Ownership Percentage:	15%
First Buy Sell Partner Insurance Amount:	\$400,000
Second Buy Sell Partner Name:	RANDALL ROBINSON
Second Buy Sell Partner Ownership Percentage:	34%
Second Buy Sell Partner Insurance Amount:	\$1,200,000
Third Buy Sell Partner Name:	EMILY JOHNSON
Third Buy Sell Partner Ownership Percentage:	12%
Third Buy Sell Partner Insurance Amount:	\$500,000
Fourth Buy Sell Partner Name:	RAJU ARMASTAD
Fourth Buy Sell Partner Ownership Percentage:	10%
Fourth Buy Sell Partner Insurance Amount:	\$750,000
Coverage Purpose:	CHARITABLE GIVING
History of Charitable Organization:	CREATED IN 1925 AS A
COMMUNITY SERVICE PROJECT	
Purpose of Charitable Organization:	RAISE MONEY FOR MEDICAL
CARE OF CHILDREN DIAGNOSED WITH SERIOUS ILLNESSES	
How long has charity been in business:	83 year(s)
Total Amount of insurance inforce:	\$2,200,000
Purpose of insurance inforce:	INCOME REPLACEMENT
Coverage Purpose:	EXECUTIVE BONUS
Coverage Purpose:	OTHER
Other Details:	CROSS PURCHASE
Beneficiary Financial Interest Explanation:	SPOUSE OF PRIMARY INSURED

**Special Handling Instructions:**  
*AT THE SAME TIME*

*ISSUE ALL BUSINESS PARTNERS*

**Multiple Apps Submitted to AGLA:**

*0208001002 JOHN DOE*

**Multiple Apps Submitted to Other Companies:**  
*STATE LIFE COMPANY*

*LIFE APP FOR \$200,000 TO*

**Multiple Apps Submitted to Other Companies Purposes:**  
*COMPETITIVE RATE*

*LOOKING FOR MOST*

**Home Office Special Information:**  
*INTERNATIONAL COMPANY WHICH HAS BEEN IN OPERATION  
SINCE 1970*

*PROPOSED INSURED IS CEO OF*

**Remarks:**  
*THE COMMUNITY AND FUNDRAISING VENTURES*

*MR DOE IS ALSO A FIXTURE IN*

08/09/2010 8:49:54 AM X  
Date / Time

*Joseph Turner*

JOSEPH TURNER, Licensed Agent  
AR540278

**APPLICATION TO AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY  
(To be Completed By the Medical Examiner)**

**PART 1M**

Name of Proposed Insured \_\_\_\_\_ Birth Date \_\_\_\_\_ Age \_\_\_\_\_  
Month Day Year

1. Name, address and telephone number of the proposed insured's primary physician. (If no primary physician, provide the name, address and telephone number of physician last seen.)  
 \_\_\_\_\_  
 Date, reason, findings and treatment at last visit \_\_\_\_\_

2. Is the proposed insured currently taking any medication or under medical observation, treatment, or therapy? .....  Yes  No  
 If "Yes," give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.  
 \_\_\_\_\_

3. Has the proposed insured had a change in weight of 10 or more pounds in the past year? .....  Yes  No

4. Within the past 5 years, has the proposed insured consulted a doctor or been a patient in a hospital, clinic or treatment facility or gone to a hospital emergency room, walk in clinic, or similar clinic for medical care or consultation? .....  Yes  No

Family History:	Age If Living	Age at Death	Cause of Death	History of Heart Disease	History of Cancer
Father					
Mother					
Brothers					
Sisters					

6. Does the proposed insured have a history of high blood pressure? .....  Yes  No  
 If "Yes," Date of diagnosis \_\_\_\_\_ Describe Treatment \_\_\_\_\_  
 Last blood pressure reading and date \_\_\_\_\_ Highest blood pressure reading in past 12 months \_\_\_\_\_  
 Average blood pressure reading \_\_\_\_\_  
 Name and address of physician treating high blood pressure.  
 \_\_\_\_\_

7. Does the proposed insured have diabetes? .....  Yes  No  
 If "Yes," Date of diagnosis \_\_\_\_\_ Describe treatment \_\_\_\_\_  
 List any disability related to diabetes \_\_\_\_\_ Last blood sugar or HA1C reading and date \_\_\_\_\_  
 Has the proposed insured experienced diabetic coma or vascular, kidney, heart, eye or other problems related to diabetes? .....  Yes  No  
 Name and address of physician treating diabetes.  
 \_\_\_\_\_

8. Does the proposed insured have a history of nervous disorder including anxiety or depression? .....  Yes  No  
 If "Yes," Diagnosis \_\_\_\_\_ Date of diagnosis \_\_\_\_\_  
 Describe treatment \_\_\_\_\_  
 What factors lead to the diagnosis? \_\_\_\_\_ List any disability related to the diagnosis \_\_\_\_\_  
 Has the proposed insured been hospitalized related to the diagnosis? .....  Yes  No  
 If "Yes," provide date and details \_\_\_\_\_  
 How many attacks or occurrences in the past 12 months? \_\_\_\_\_ How often do symptoms occur? \_\_\_\_\_  
 Name and address of physician treating nervous disorder.  
 \_\_\_\_\_

9. Does the proposed insured have a history of sleep apnea, asthma, chronic bronchitis or chronic obstructive pulmonary disease (COPD)? .....  Yes  No  
 If "Yes," Diagnosis \_\_\_\_\_ Date of diagnosis \_\_\_\_\_  
 Describe treatment \_\_\_\_\_ Date of last treatment \_\_\_\_\_  
 Describe symptoms (when & how often do they occur?) \_\_\_\_\_  
 List any disability related to the diagnosis \_\_\_\_\_  
 Name and address of physician treating diagnosis.  
 \_\_\_\_\_

10. Within the past 5 years, has the proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches nicotine gum or any other form of nicotine? .....  Yes  No  
 If "Yes," Type \_\_\_\_\_ Date of Last Use \_\_\_\_\_ Frequency/Amount \_\_\_\_\_

11. Within the past 5 years, has the proposed insured used alcoholic beverages? .....  Yes  No  
 If "Yes," Average No. of drinks per week \_\_\_\_\_ Maximum No. of drinks per day \_\_\_\_\_  
 Type (Beer, Wine, Liquor) \_\_\_\_\_ Date of last use \_\_\_\_\_

12. Has the proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has the proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician? Yes No

13. Within the past 10 years, has the proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS), or tested positive for the Human Immunodeficiency Virus (HIV)? Yes No

14. Within the past 12 months, has the proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness or paralysis for which the cause is not known and for which a doctor has not been consulted? Yes No

15. In the past 24 months, has the proposed insured been advised by a member of the medical profession concerning any abnormal diagnostic test results, or been advised to have any diagnostic tests (including self-administered), treatment or surgery which was not completed or does the proposed insured have test results pending? [except those tests related to the Human Immunodeficiency Virus (AIDS virus)] Yes No

16. Does the proposed insured have a pending appointment with any physician or other medical professional or have the intent to make such appointment within the next 60 days? Yes No

17. Has the proposed insured been advised to enter a hospital, nursing home, hospice or assisted living facility? Yes No

18. Has the proposed insured made claim for or received disability (other than for routine pregnancy) or Worker's Compensation benefits in the past 5 years? Yes No

19. Within the past 24 months, has the proposed insured: (a) experienced fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath? (b) received home health care services, physical therapy or rehabilitation therapy? (c) resided in senior citizen's housing or a retirement or assisted living community? (d) required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? (e) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?

20. Has the proposed insured ever been diagnosed as having or been treated for or consulted a licensed health care provider for any of the following? (If "Yes," check applicable boxes below.) (a) heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart? (b) a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins? (c) cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities? (d) a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system? (e) a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder? (f) a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or protein in the urine? (g) a disease or disorder of the respiratory system, or emphysema, or other lung disorder? (h) a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures? (i) Alzheimer's disease or dementia? (j) glaucoma, macular degeneration, optic neuritis? (k) a disease or disorder of the blood, or anemia, hemophilia, sickle cell anemia? (l) a disease or disorder of the muscles or bones, including but not limited to the back or joints? (m) a disease or disorder of the reproductive system?

21. Does the proposed insured have any symptoms or knowledge of any other condition that is NOT disclosed above? Yes No

If answered "Yes" to question 12-21, provide appropriate details such as: diagnosis; date of diagnosis; name, address and telephone number of physician; tests performed; test results; medications or recommended treatment.

Blank lines for providing details for question 21.

I agree that all statements and answers in this application are complete and true to the best of my knowledge and belief. I agree that this application will become a part of the policy applied for and any policy will be issued on the basis of my answers and statements. I agree that no agent of the Company or the Medical Examiner has authority to waive any answer or otherwise modify this application or bind the Company in any way by making any promise or representation which is not set out in writing in this application. Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Dated at \_\_\_\_\_ Signature of Proposed Insured

this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_

Witnessed by \_\_\_\_\_ (Medical Examiner) Signature of Parent or Guardian required if Proposed Insured has not reached his sixteenth birthday.

**MEDICAL EXAMINER'S REPORT**

22. a. Height (in shoes)		Males Only:			Details of "Yes" answers. (Identify item.)
		Chest (Full Inspiration)	Chest (Forced Expiration)	Abdomen, at Umbilicus	
ft. in.	Weight (Clothed) lbs.	in.	in.	in.	

b. Did you weigh?  Yes  No      Did you measure?  Yes  No

23. Blood Pressure (If pressure over 140/90 give additional readings)

Systolic			
Diastolic 5th phase			

24. Pulse:

At Rest	After Exercise	3 Minutes Later
Rate		
Irregularities per min.		

25. Heart: Is there any:

Enlargement <input type="checkbox"/> Yes <input type="checkbox"/> No	Dyspnea <input type="checkbox"/> Yes <input type="checkbox"/> No
Murmur(s) <input type="checkbox"/> Yes <input type="checkbox"/> No	Edema <input type="checkbox"/> Yes <input type="checkbox"/> No

(describe below—if more than one, describe separately)

	Murmur #1	Murmur #2		
Location			Indicate:	
Constant	<input type="checkbox"/>	<input type="checkbox"/>	Apex by	
Inconstant	<input type="checkbox"/>	<input type="checkbox"/>		
Transmitted	<input type="checkbox"/>	<input type="checkbox"/>	Murmur area by	
Localized	<input type="checkbox"/>	<input type="checkbox"/>		
Systolic	<input type="checkbox"/>	<input type="checkbox"/>	Point of greatest intensity by	
Presystolic	<input type="checkbox"/>	<input type="checkbox"/>		
Diastolic	<input type="checkbox"/>	<input type="checkbox"/>	Transmission by	
Soft (Gr. 1-2)	<input type="checkbox"/>	<input type="checkbox"/>		
Mod. (Gr. 3-4)	<input type="checkbox"/>	<input type="checkbox"/>		
Loud (Gr. 5-6)	<input type="checkbox"/>	<input type="checkbox"/>		
After exercise:				
Increased	<input type="checkbox"/>	<input type="checkbox"/>		
Absent	<input type="checkbox"/>	<input type="checkbox"/>		
Unchanged	<input type="checkbox"/>	<input type="checkbox"/>		
Decreased	<input type="checkbox"/>	<input type="checkbox"/>		

For comments and your impression.

**Examiner's Observation and Remarks**

	Yes	No
a. Does the applicant appear to be stated age? .....	<input type="checkbox"/>	<input type="checkbox"/>
If "No," explain _____		
b. Are there any obvious physical abnormalities? .....	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," explain _____		
c. Does applicant use any devices to aid in locomotion (i.e., cane, walker, wheelchair)? .....	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," explain _____		
d. Does applicant seem alert, oriented to time and place? .....	<input type="checkbox"/>	<input type="checkbox"/>
If "No," explain _____		
e. Does applicant have any speech difficulties? .....	<input type="checkbox"/>	<input type="checkbox"/>
If "Yes," explain _____		

<b>URINALYSIS</b> ➤	Are you satisfied it is authentic? <input type="checkbox"/> Yes <input type="checkbox"/> No	Specific Gravity	Albumin (even a trace)	Sugar (even a trace)	Occult blood?	Are you mailing specimen to Home Office? (See Instructions below.) <input type="checkbox"/> Yes <input type="checkbox"/> No
---------------------	--	------------------	------------------------	----------------------	---------------	--

**NOTICE-FORWARD Specimen to Lab, if**

- a. Albumin or sugar is found, or there is any history or presence of hypertension (blood pressure exceeds 150/90), heart or genito-urinary disorder.
- b. Amount of insurance (listed above) is **\$100,000** or more through age 55; **\$50,000** or more ages 56 and over.
- c. Agent requests it when examination arranged.

I certify that the proposed insured was examined by me in private at  my office  applicant's home  applicant's place of work  
this \_\_\_\_\_ day of \_\_\_\_\_, \_\_\_\_\_ at \_\_\_\_\_ o'clock \_\_\_\_\_ A.M. / P.M.

Signature of Examiner \_\_\_\_\_ Address \_\_\_\_\_

This report should be returned to our Company address shown above.

SERFF Tracking Number: AGLA-126780757 State: Arkansas  
Filing Company: American General Life and Accident Insurance State Tracking Number: 46570  
Company  
Company Tracking Number: AGLA1000-AR (0510), ETAL  
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: AGLA1000-AR (0510) Application for Life Insurance, etal  
Project Name/Number: AGLA1000-AR (0510) Application for Life Insurance, etal/AGLA1000-AR (0510)

## Supporting Document Schedules

Item Status:

Status

Date:

**Satisfied - Item:** Flesch Certification

**Comments:**

**Attachments:**

87-1.pdf

AGLA120Z49 REV0807.pdf

ARCERT2.pdf

ARCert5.pdf

Item Status:

Status

Date:

**Satisfied - Item:** Statements of Variability

**Comments:**

**Attachments:**

statement of Variability forAGLA1000 (0510).pdf

Statement of Variability for AGLA1000E (0510).pdf

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

Service for the attached policy will be provided by:

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

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

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

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

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

### **DISCLAIMER**

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

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

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

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

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

(please turn to back of page)

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

## **COVERAGE**

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

## **EXCLUSIONS FROM COVERAGE**

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

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

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

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

## LIMITS ON AMOUNT OF COVERAGE

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

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### American General Life and Accident Insurance Company

*A member company of American International Group, Inc.*  
American General Center • Nashville, Tennessee 37250-0001





American General Life and Accident Insurance Company

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

ARKANSAS CERTIFICATION

Subject: AGLA1000-AR (0510)	Application for Life Insurance
AGLA1000E-AR (0510)	Application for Life Insurance
AGLA2001-XAR REV0510	Medical Examiner's Report

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

*Grace D. Harvey*

Grace D. Harvey, ASA, MAAA  
Vice President and Actuary

DATE: August 23, 2010



American General Life and Accident Insurance Company

AMERICAN GENERAL LIFE AND ACCIDENT INSURANCE COMPANY

ARKANSAS CERTIFICATION

Subject: AGLA1000-AR (0510)	Application for Life Insurance
AGLA1000E-AR (0510)	Application for Life Insurance
AGLA2001-XAR REV0510	Medical Examiner's Report

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

*Grace D. Harvey*

Grace D. Harvey, ASA, MAAA  
Vice President and Actuary

DATE: August 23, 2010

**Statement of Variability for Application AGLA1000 (0510)**

<b>Variable Field</b>	<b>Explanation</b>
Accelerated Benefit Rider 2 Initial Defined Benefit- Primary Proposed Insured - 5% 10% Other	This rider option will print in the question 6 b if the Accelerated Benefit Rider is approved for sale to Primary Proposed Insured. This rider will be submitted as a separate filing to the Compact. If the Accelerated Benefit Rider is not approved for sale to the Primary Proposed Insured, this option will not appear on the application.
Accelerated Benefit Rider 2 Initial Defined Benefit- Additional Proposed Insured – 5% 10% Other	This rider option will print in the question 6 b if the Accelerated Benefit Rider is approved for sale to Additional Proposed Insured. This rider will be submitted as a separate filing to the Compact. If the Accelerated Benefit Rider is not approved for sale to the Additional Proposed Insured, this option will not appear on the application

**Statement of Variability for Application AGLA1000E (0510)**

<b>Variable Field</b>	<b>Explanation</b>
Accelerated Benefit Rider 2 Initial Defined Benefit- Primary Proposed Insured - 5% 10% Other	This rider option will print if the Accelerated Benefit Rider is approved for sale to Primary Proposed Insured. This rider will be submitted as a separate filing to the Compact. If the Accelerated Benefit Rider is not approved for sale to the Primary Proposed Insured, this option will not appear on the application.
Accelerated Benefit Rider 2 Initial Defined Benefit- Additional Proposed Insured – 5% 10% Other	This rider option will print in the question 6 b if the Accelerated Benefit Rider is approved for sale to Additional Proposed Insured. This rider will be submitted as a separate filing to the Compact. If the Accelerated Benefit Rider is not approved for sale to the Additional Proposed Insured, this option will not appear on the application