

SERFF Tracking Number: AMGN-126802415 State: Arkansas
Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 46737
Company Tracking Number: COMBO APP 2010
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Application
Project Name/Number: /

Filing at a Glance

Company: American General Life Insurance Company of Delaware

Product Name: Application

SERFF Tr Num: AMGN-126802415 State: Arkansas

TOI: H21 Health - Other

SERFF Status: Closed-Approved-
Closed State Tr Num: 46737

Sub-TOI: H21.000 Health - Other

Co Tr Num: COMBO APP 2010

State Status: Approved-Closed

Filing Type: Form

Author: Cecily Garris

Reviewer(s): Rosalind Minor

Date Submitted: 09/08/2010

Disposition Date: 09/20/2010

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name:

Status of Filing in Domicile: Authorized

Project Number:

Date Approved in Domicile: 08/05/2010

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer, Other

Filing Status Changed: 09/20/2010

Explanation for Other Group Market Type: All
statutorily eligible groups

State Status Changed: 09/20/2010

Deemer Date:

Created By: Cecily Garris

Submitted By: Cecily Garris

Corresponding Filing Tracking Number:

PPACA: Not PPACA-Related

Filing Description:

Enclosed for your review and approval are the attached applications. These are new forms and do not replace any previously approved forms.

The enclosed applications are for use with all of our group programs. The G-APPComb-40040-AR-0210 Master Application for Benefits allows the policyholder to apply for coverage for its employees/members. The G-APPComb-40042 Application for Group Programs is completed individually by the employees/members.

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The forms are in final printed format subject only to changes in font style, margins, page numbers, ink, and paper stock. Printing standards will never be less than those required by law. An Explanation of Variables is attached.

Thank you for your consideration of this filing. Please call me at 732-922-7682 or e-mail me at Cecily.Garris@aglife.com if you have any questions or concerns.

Company and Contact

Filing Contact Information

Cecily Garris, Senior Analyst cecily.garris@aglife.com
 3600 Route 66 732-922-7682 [Phone]
 Neptune, NJ 07754 732-922-5593 [FAX]

Filing Company Information

American General Life Insurance Company of Delaware CoCode: 66842 State of Domicile: Delaware
 600 King Street Group Code: 12 Company Type:
 Wilmington, DE 19801 Group Name: State ID Number:
 (713) 831-3508 ext. [Phone] FEIN Number: 25-1118523

Filing Fees

Fee Required? Yes
 Fee Amount: \$100.00
 Retaliatory? Yes
 Fee Explanation: \$50 per form
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
American General Life Insurance Company of Delaware	\$100.00	09/08/2010	39312586

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/20/2010	09/20/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Master Application for Employee Benefits	Cecily Garris	09/16/2010	09/16/2010
Supporting Document	Explanation of Variables	Cecily Garris	09/16/2010	09/16/2010

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Disposition

Disposition Date: 09/20/2010

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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 Product Name: Application
 Project Name/Number: /

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	PPACA Uniform Compliance Summary	Approved-Closed	Yes
Supporting Document (revised)	Explanation of Variables	Approved-Closed	Yes
Supporting Document	Explanation of Variables	Replaced	Yes
Form (revised)	Master Application for Employee Benefits	Approved-Closed	Yes
Form	Master Application for Employee Benefits	Replaced	Yes
Form	Application for Group Insurance Programs	Approved-Closed	Yes

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 Product Name: Application
 Project Name/Number: /

Amendment Letter

Submitted Date: 09/16/2010

Comments:

We have revised the Master Application to include an Important Notice page.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
G-APPComb-40040F-0210	Application/EMaster nrollment Form	Application for Employee Benefits	Initial				50.000	G-APPComb-40040F-2010.pdf

Supporting Document Schedule Item Changes:

User Added -Name: Explanation of Variables

Comment:

G-APPComb-40042 EOVS (FINAL).pdf
 G-APPComb-40040F-2010 EOVS .pdf

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 Product Name: Application
 Project Name/Number: /

Form Schedule

Lead Form Number: G-APPComb-40040-AR-2010

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 09/20/2010	G-APPComb-40040F-0210	Form	Application/Master Application Enrollment for Employee Benefits	Initial		50.000	G-APPComb-40040F-2010.pdf
Approved-Closed 09/20/2010	G-APPComb-40042	Form	Application/ Application for Group Enrollment Insurance Programs	Initial		50.000	G-APPComb-40042 (FINAL Version).pdf

MASTER APPLICATION FOR [EMPLOYEE] BENEFITS

[LOGO]A

[Program Name]B

American General Life Insurance Company of Delaware*

Wilmington, Delaware

[Administrative Office: 3600 Route 66, P.O. Box 1591, MSN 3D, Neptune, NJ 07754-1591]

* This company does not solicit business in New York

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, [will participate in a Trust, or] C will be issued a group policy.

(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)

Applicant Data

1. Full Name of Applicant [(Company)]: _____

2. Group Contact Name: _____

3. Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Mailing Address (if different) _____ Fax: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ SIC Code: _____

4. Applicant is a: Proprietorship Partnership Corporation Union

Other (Explain): _____

5. Nature of Business: _____ & Number of years in business _____

6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? Yes No

If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	Nature of Business	Full Address	# of Full-Time Employees
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you ever applied for, or been insured for, group insurance with any affiliated American General Companies, including United States Life? Yes No

If yes, give details: Group Policy Number(s) _____

Date Insurance Ended/Declined _____ Effective Date (if still insured) _____

8. Please complete the information below for those coverages being replaced:

Current Coverage		Replacing with the Company's Plans?*		Prior Plan Name & Effective Date	Proposed Termination Date
[Employer]	Employee Pay All				
Life**	<input type="checkbox"/>	Life**	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADD	<input type="checkbox"/>	ADD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental	<input type="checkbox"/>	Dental	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
STD	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LTD	<input type="checkbox"/>	LTD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Critical Illness	<input type="checkbox"/>	Critical Illness	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital Indemnity	<input type="checkbox"/>	Hospital Indemnity	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Accident	<input type="checkbox"/>	Accident	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	JD

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

** Are there other [Employer Sponsored] plans in force which you are not replacing or currently applying for with another carrier? Yes No

If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number: _____	Division Number: _____
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Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least [*30 hours (20 hours for Employee Pay All Life only) per week, or ____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.]E

9. Do you want to exclude any classes of full-time employees from coverage? Yes No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____

_____ Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees _____ months OR First of the month following _____ months*
 Future Employees _____ months OR First of the month following _____ months*

*Only option available for Employee Pay All Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued)....._____
- b. Number of Full-Time Employees **waiving all coverages**_____
12. Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Contribution Data – Not applicable to Employee Pay All Coverages

13. Will the employees be required to contribute toward the cost of the insurance? Yes No
 If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

[NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.]

Coverage	Life	AD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD	Critical Illness	Cancer	Hospital Indemnity	Accident
Employer %													

]F

* The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid: Annually Semi-annually Quarterly Monthly EFT

[Employee]/Dependent Data

15. Are there any [employees] who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? Yes No

If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. [NOTE:

This question does not need to be answered for Life and AD&D groups with more than 50 [employees] insured, Dental coverages, for Disability coverages with ten (10) or more [employees] insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.]G

Name of [Employee]	Date Disability Began	Current Amount of Group Life Insurance in Force	Describe Nature of Injury/Sickness	Date Return to Full-Time Work

Requested Effective Date

I request that the coverage(s) chosen take effect on:

- the date the application is approved in writing by the Company; or
 _____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.
 For [Employer] Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For [Employee] Pay All Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all [employees] applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all [employees] meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all [employees]. Completed waivers are attached for those [employees] and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): _____.
- [5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.]**H**
6. I understand and agree that:
 - no agent may change or waive any of the provisions of this application or of any plan of insurance;
 - any change or waiver may be made only by an officer of the Company; and
 - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
 - If the insurance contract compromises a part of an [employee] benefit plan, the Company is granted ** sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

DATE _____ PRINT NAME & TITLE OF OFFICER, PARTNER, PROPRIETOR _____

WITNESS _____ SIGNATURE OF OFFICER, PARTNER, PROPRIETOR _____

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law

[The Policyholder [Participant Employer] hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.]

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print Producer #	PRODUCING AGENT Tax ID # / SS#	% Commissions split with other agents
Name as Licensed		License #
Mailing Address		
City / State / Zip		
Phone	Fax	E-Mail
Signature	Date	City and State Where Signed

Please Print General Agent #	GENERAL AGENT Name	Tax ID # / SS#
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	Premium Deposit \$	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

[Important Notice

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

The following statement does not apply to an application for life insurance in New York:

For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: 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.]K

[Disclosure Regarding Compensation

Your insurance or benefits advisor can offer you advice and guidance as you select the policy and provider most appropriate for your needs. At American General Life Insurance Company of Delaware we recognize the important role these professionals play in the sale of our products and services and offer them a variety of compensation programs. Your advisor can provide you with information about these programs. We support disclosure of broker compensation so that customers can make an informed buying decision.

Brokers may be eligible to receive Base Commissions and Supplemental Compensation from American General Life Insurance Company of Delaware.

Unless you have agreed in writing to compensate the broker differently, American General Life Insurance Company of Delaware provides Base Commissions to all producers in connection with the sale of an insurance policy. Base Commissions are a fixed percentage of the policy premium, and include a one time, first year flat amount for each policy sold. Base Commissions are paid by American General Life Insurance Company of Delaware to your producer as long as they remain the broker of record on your policy.

A producer may also qualify for Supplemental Compensation paid by American General Life Insurance Company of Delaware. For group insurance products, Supplemental Compensation may be paid in an amount equal to a fixed percentage of total group insurance premiums. The Supplemental Compensation percentage may range from 0% to 7% of total premiums paid. The exact Supplemental Compensation percentage payable to any producer is based upon the total dollar amount of all group insurance premiums or number of policies that the broker had in force with American General Life Insurance Company of Delaware and affiliated American General Companies in the prior calendar year. Supplemental Compensation may be calculated differently for other insurance products. The premium you pay is not impacted whether or not your broker receives Supplemental Compensation.

If you would like additional information about the range of compensation programs our company offers for your group insurance policy or any other American General Benefits Solutions product, you can find more details at [\[www.AmericanGeneral.com/employeebenefits\]](http://www.AmericanGeneral.com/employeebenefits). Should you have other questions not addressed by the website, including Supplemental Compensation, please your Benefits Solutions representative.]]

[CENSUS INFORMATION (This form may be photocopied if additional supply is needed) – Not applicable for Employee Pay All Coverages

For H.O. Use Only Class/Div.	Employee's Soc. Security #	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth M D Y	Date of Hire	Marital Status**	# of dependents	Coverage Election E- Employee S-Spouse, C-Child	Coverage Selected – Please check										
											[Life	LTD	STD	INT. DIS	Dental	Vision	Critical Ill.	Cancer	HIP	Accident]	
1.																					
2.																					
3.																					
4.																					
5.																					
6.																					
7.																					
8.																					
9.																					
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13.																					
14.																					
15.																					
16.																					
17.																					
18.																					
19.																					
20.																					

*Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.

**Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced

***Please state if salary is per hour, per week, per month or per year.]

For H.O. only:
Group Number: _____]

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: [3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588 Neptune, NJ 07754-1588]

*This company does not solicit business in New York

[These Notices must be detached and retained by the applicant]

[MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers 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, MA 02184-8734.]

The Company, or its reinsurers, may also release information from 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.]

[NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.]

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: [3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588 Neptune, NJ 07754-1588]

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Change in Family Status New Coverage Increasing Coverage Decreasing Coverage]E

Please print or type all information requested.

Group Policy Number _____ [Division _____

Please complete all sections of the application to avoid delays.

[Employee's] annual salary \$ _____ Hire Date _____

Job Title _____

Actively at Work ___ Yes ___ No]E

1. Name of [Employer/Association/Union] _____

2. [Employee's/Member's full name] _____
FIRST MIDDLE LAST

3. Home Address _____
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

[Email Address] _____

[4. Select coverages with specific amounts for [Life, AD&D, LTD, STD and Critical Illness]. [If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter.] [* If you had prior Dental coverage with the employer named above, please indicate by checking box and including your prior effective date.]G

[Wherever the term spouse appears can also read as domestic partner (DP) throughout the application .]C**

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
Employee	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	<input type="checkbox"/> Prior Coverage * Date / / <input type="checkbox"/> refused	<input type="checkbox"/> refused
Spouse/DP**	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	(not to exceed maximum benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family
Child(ren):	\$ _____ <input type="checkbox"/> refused	/ / / / / /				

Hospital Care	Accident	Cancer	Critical Illness Amount
<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family <input type="checkbox"/> refused	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family <input type="checkbox"/> refused	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family <input type="checkbox"/> refused	Employee \$ _____ <input type="checkbox"/> refused Spouse \$ _____ <input type="checkbox"/> refused

JF

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: [3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588 Neptune, NJ 07754-1588]

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[4 (a) Do you have any disability insurance in force or pending (including group coverage)? Yes No

If YES, please indicate companies and amounts _____

4 (b) Will this coverage applied for, replace any insurance in force now? Yes No

If YES, please indicate companies and amounts _____]H

5. Complete the following for [employee/member, spouse/domestic partner and dependents]I requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	[Social Security #]
[EE						ft. in.	lbs.	
[SP/DP]						ft. in.	lbs.	
[CH]						ft. in.	lbs.	
[CH]						ft. in.	lbs.	

]I

[If you are eligible for Guaranteed Issue do not complete questions [6, 7, 8 and 9] unless you are applying for more than your group's Guaranteed Issue.]J

[Complete questions [6, 7, 8, and 9] if applying for Life or Disability Coverage.

	[EMPLOYEE/ MEMBER]	[SPOUSE/DP]	[CHILD]
[6.] Have you ever been diagnosed with or treated for: any disease or disorder of the heart, kidneys, liver ; lungs or blood; chest pain; stroke or other neurological disorder; cancer or tumor; AIDS (Acquired Immune Deficiency Syndrome); AIDS related complex, or other immune disorder; diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency; arthritis or other musculoskeletal disease or disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[7.] Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution for any reason other than stated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[8.] Are you presently taking any medications?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[9.] Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?]J	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: [3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588 Neptune, NJ 07754-1588]

*This company does not solicit business in New York

[Complete questions [10, 11, 12, and 13] if applying for Accident, Cancer, Critical Illness or Hospital Care Coverage	[EMPLOYEE/MEMBER]	[SPOUSE]
[10.] Has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[11.] In the last 5 years, has any Proposed Insured been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's disease, or non-Hodgkin's lymphoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[12.] In the past 90 days immediately prior to the date of this application, has any Proposed Insured been physically incapable of working, or incapable of performing normal daily activity [excluding pregnancy] for more than three [3] consecutive days?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[13.] In the last 12 months has any Proposed Insured used any form of tobacco or nicotine product, including a nicotine patch?]K	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
[Complete questions [14 and 15] if applying for Critical Illness or Hospital Care Coverage		
[14.] In the last 5 years, has any Proposed Insured: a. sought or received counseling or treatment by a medical professional for any alcohol and/or drug addictions and/or substance abuse, including abuse of drugs prescribed by a physician? b. used cocaine, marijuana, heroin, controlled substance, or a drug requiring a prescription that was not legally prescribed by a physician? c. been diagnosed as having or been treated for, or consulted a licensed health care provider for disease or disorder of the nervous system (seizure, disorder of the brain or spinal cord or any other nervous system disorder), paralysis; stroke, or transient ischemic attack (TIA); diabetes, disease or disorder of the lung, liver, heart, or blood vessels, heart attack, or uncontrolled high blood pressure, kidney failure, polycystic kidneys or abnormal kidney function, familial adenomatous polyposis [Gardener's syndrome] or multiple sclerosis? d. had an organ transplant or been advised of the need of an organ transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
[15.] Does any Proposed Insured have a loss of hearing, requiring the use of a hearing aid or cochlear implant; or a history of glaucoma, optic neuritis or macular degeneration?]L	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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If "yes" to any part of questions [6 through 15], give details on the following page [(not required for child(ren) if employee] or [spouse] is also applying)] M. Use a separate sheet of paper if more space is needed for answers:

SIGNATURE IS REQUIRED [BELOW]

Question No.	Does Question Apply to [Employee, Spouse/DP or Child]	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

[10. Have you used tobacco in any form during the past [12-36] months?	[EMPLOYEE/MEMBER] <input type="checkbox"/> Yes <input type="checkbox"/> No	[SPOUSE/DP] <input type="checkbox"/> Yes <input type="checkbox"/> No
--	---	---

If this question is not completed, you will be billed using smoker rates.

JN

[AUTHORIZATION

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to American General Life Insurance Company of Delaware or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes, information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by American General Life Insurance Company of Delaware to collect and transmit such information. 2. I understand that this information will be used by American General Life Insurance Company of Delaware solely to determine eligibility for insurance. 3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which American General Life Insurance Company of Delaware has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months, if not revoked earlier. 4. I know that I should retain a copy of this authorization for my records. 5. I agree that a photocopy of this authorization is as valid as the original. 6. To the best of my knowledge and belief, all statements made above are true and complete. All statements are representations and not warranties. 7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insured's; and (b) while there is no change in the insurability or health of such person from that stated in the application. [8. I authorize deductions from earnings for the costs of this insurance.] O [9. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.]P]Q

(DATE SIGNED)

➤ _____
(SIGNATURE OF [EMPLOYEE/MEMBER])

(DATE SIGNED)

➤ _____]R
(SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)

➤ Witness to above Signature(s): _____

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

American General Life Insurance Company of Delaware*

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[BENEFICIARY DESIGNATION

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and children insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Beneficiary of [Employee]
and Relationship _____

Beneficiary of Spouse
and Relationship _____]S

[-----
For Administrative Use Only (if Agent is involved)

Agent Name

License Number

_____]]
Agent Signature

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: [3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588 Neptune, NJ 07754-1588]

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[Important Notice

For residents of Arkansas, Louisiana, Rhode Island and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

For residents of Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

For residents of Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine, Tennessee, Virginia and Washington: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

For residents of Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

The following statement does not apply to an application for life insurance in New York:

For residents of New York: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

For residents of Pennsylvania: 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.]T

SERFF Tracking Number: AMGN-126802415 State: Arkansas
 Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 46737
 Company Tracking Number: COMBO APP 2010
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Application
 Project Name/Number: /

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	09/20/2010
Comments:			
Attachment:			
Flesch Certification.pdf			

		Item Status:	Status Date:
Bypassed - Item:	Application	Approved-Closed	09/20/2010
Bypass Reason:	Filing is for application only.		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Health - Actuarial Justification	Approved-Closed	09/20/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	Outline of Coverage	Approved-Closed	09/20/2010
Bypass Reason:	Not Applicable		
Comments:			

		Item Status:	Status Date:
Bypassed - Item:	PPACA Uniform Compliance Summary	Approved-Closed	09/20/2010
Bypass Reason:	Not Applicable		
Comments:			

SERFF Tracking Number: AMGN-126802415 State: Arkansas
Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 46737
Company Tracking Number: COMBO APP 2010
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Application
Project Name/Number: /

Item Status:

Status

Satisfied - Item: Explanation of Variables

Approved-Closed

Date:

09/20/2010

Comments:

Attachments:

G-APPComb-40042 EOV (FINAL).pdf

G-APPComb-40040F-2010 EOV .pdf

READABILITY CERTIFICATION

AMERICAN GENERAL LIFE INSURANCE COMPANY OF DELAWARE

The company has reviewed the enclosed policy form(s) and certifies that, to the best of its knowledge and belief, each form submitted is consistent and complies with the minimum readability score.

Keith W. Coleman

Signature of an Officer of the Insurer

Keith Coleman

Name (Print)

Assistant Secretary

Title

9/9/2010

Date

American General Life Insurance Company of Delaware

EXPLANATION OF VARIABLE AREAS FORM No. G-APPComb-40042

GENERAL

Where the term “employer” is used, it may be changed to “union”, “association”, “policyholder”, or equivalent term. Where the term “employee” is used, it may be changed to “member”, “associate”, or other term that the policyholder utilizes for the applicants.

The MIB Disclosure Notice and the Notice As Required Under The Fair Credit Reporting Act(s) will be included when the applicant is not eligible for Guaranteed Issue. The disclosures will be updated for regulatory changes or if the telephone numbers, address, or website change.

The addresses provided are variable material and will reflect current addresses as applicable.

EXPLANATION OF VARIABLE AREAS

A: The company logo will be included or omitted. Should the logo of the company change, the logo will be revised to reflect most current company logo.

B: The title of the form will be one of versions shown. The reference to “Voluntary” will be included when the plan is contributory.

[Application for Group [Voluntary] Insurance Programs]

[Application for Group Worksite Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]

C: The reference to “Employee/Spouse/Domestic Partner” will be included or omitted according to client preference. The reference will reflect the potential applicant(s), e.g., when the form is just used for Employee applicants, reference will be made to Employee only. Reference to domestic partner will only be included in states which allow said coverage.

D: A program name may be included according to client preference. For example a marketing name may be included or the client name.

E: Bracketed text will be included, omitted or modified to display information such as current amount of insurance, division, or reason for application.

F: This item may be modified to reflect the coverage(s) elected by the policyholder.

G: If dental coverage is selected, “G” will be included.

H: These questions will be included if LTD/STD coverage is selected.

I: Bracketed text will vary depending on insured class types in this portion of the “application” and throughout the form.

J: Questions will be included or omitted based upon the coverages elected by the policyholder. When questions are deleted, question numbers will be revised accordingly.

K: Questions will be included or omitted based upon the coverages elected by the policyholder. When questions are deleted, question numbers will be revised accordingly.

L: Questions will be included or omitted based upon the coverages elected by the policyholder. When questions are deleted, question numbers will be revised accordingly.

M: Bracketed text will vary based on insured class types.

N: Question will be included when plan design offers smoker/non-smoker rates. If not applicable, question will be omitted. Time period will vary within range displayed.

O: If not applicable, item will be omitted.

P: If not applicable, item will be omitted.

Q: Authorization section will be removed when form is used for enrollment only (when no underwriting questions appear on form).

R: If not applicable, item will be omitted.

S: If not applicable, item will be omitted.

T: Important Notice; bracketed text will be included, omitted or revised according to state regulations.

American General Life Insurance Company of Delaware

EXPLANATION OF VARIABLE AREAS FORM No. G-APPComb-40040F-0210

GENERAL

Where the term “employer” is used, it may be changed to “union”, “association”, “policyholder” or equivalent term. Where the term “employee” is used, it may be changed to “member”, “associate”, or other term that the policyholder utilizes for the applicants.

The addresses provided are variable material and will reflect current addresses as applicable.

EXPLANATION OF VARIABLE AREAS

A: The company logo will be included or omitted. Should the logo of the company change, the logo will be revised to reflect most current company logo.

B: A program name may be included according to client preference. For example a marketing name may be included or the client’s name.

C: Bracketed text will be included or omitted.

D: The coverage categories that appear in item 8 may be modified to show only the coverage(s) being offered.

E: The full-time definition may vary on a case by case basis, but full-time hours will never be greater than permitted by law.

F: This item may be modified to reflect the coverage(s) offered to the policyholder.

G: The number of employees may vary.

H: If not applicable, item will be omitted.

I: If not applicable, item will be omitted.

J: This may be included, deleted if we receive the data electronically from the policyholder, or modified to show only the coverage(s) being offered.

K: Important Notice; bracketed text will be included, omitted or revised according to state regulations

SERFF Tracking Number: AMGN-126802415 State: Arkansas
 Filing Company: American General Life Insurance Company of Delaware State Tracking Number: 46737
 Company Tracking Number: COMBO APP 2010
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Application
 Project Name/Number: /

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
09/07/2010		Supporting Explanation of Variables Document	09/16/2010	G-APPComb-40040-2010 EOV (FINAL).pdf (Superseded) G-APPComb-40042 EOV (FINAL).pdf
09/07/2010	Form	Master Application for Employee Benefits	09/16/2010	G-APPComb-40040-AR-2010.pdf (Superseded)

American General Life Insurance Company of Delaware

**EXPLANATION OF VARIABLE AREAS
FORM No. G-APPComb-40040-0210**

GENERAL

Where the term “employer” is used, it may be changed to “union”, “association”, “policyholder” or equivalent term. Where the term “employee” is used, it may be changed to “member”, “associate”, or other term that the policyholder utilizes for the applicants.

The addresses provided are variable material and will reflect current addresses as applicable.

EXPLANATION OF VARIABLE AREAS

A: The company logo will be included or omitted. Should the logo of the company change, the logo will be revised to reflect most current company logo.

B: A program name may be included according to client preference. For example a marketing name may be included or the client’s name.

C: Bracketed text will be included or omitted.

D: The coverage categories that appear in item 8 may be modified to show only the coverage(s) being offered.

E: The full–time definition may vary on a case by case basis, but full-time hours will never be greater than permitted by law.

F: This item may be modified to reflect the coverage(s) offered to the policyholder.

G: The number of employees may vary.

H: If not applicable, item will be omitted.

I: If not applicable, item will be omitted.

J: This may be included, deleted if we receive the data electronically from the policyholder, or modified to show only the coverage(s) being offered.

MASTER APPLICATION FOR [EMPLOYEE] BENEFITS

[LOGO]A

[Program Name]B

American General Life Insurance Company of Delaware*

Wilmington, Delaware

[Administrative Office: 3600 Route 66, P.O. Box 1591, MSN 3D, Neptune, NJ 07754-1591]

* This company does not solicit business in New York

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, [will participate in a Trust, or] C will be issued a group policy.

(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)

Applicant Data

1. Full Name of Applicant [(Company)]: _____

2. Group Contact Name: _____

3. Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Mailing Address (if different) _____ Fax: _____

City: _____ State: _____ Zip: _____

E-Mail Address: _____ SIC Code: _____

4. Applicant is a: Proprietorship Partnership Corporation Union

Other (Explain): _____

5. Nature of Business: _____ & Number of years in business _____

6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? Yes No

If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	Nature of Business	Full Address	# of Full-Time Employees
_____	_____	_____	_____
_____	_____	_____	_____

7. Have you ever applied for, or been insured for, group insurance with any affiliated American General Companies, including United States Life? Yes No

If yes, give details: Group Policy Number(s) _____

Date Insurance Ended/Declined _____ Effective Date (if still insured) _____

8. Please complete the information below for those coverages being replaced:

Current Coverage		Replacing with the Company's Plans?*		Prior Plan Name & Effective Date	Proposed Termination Date
[Employer]	Employee Pay All				
Life**	<input type="checkbox"/>	Life**	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ADD	<input type="checkbox"/>	ADD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dental	<input type="checkbox"/>	Dental	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Vision	<input type="checkbox"/>	Vision	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
STD	<input type="checkbox"/>	STD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
LTD	<input type="checkbox"/>	LTD	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Critical Illness	<input type="checkbox"/>	Critical Illness	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Cancer	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital Indemnity	<input type="checkbox"/>	Hospital Indemnity	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Accident	<input type="checkbox"/>	Accident	<input type="checkbox"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No	JD

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

** Are there other [Employer Sponsored] plans in force which you are not replacing or currently applying for with another carrier? Yes No

If yes, please indicate the highest benefit amount of each plan.

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number: _____	Division Number: _____
--------------------------	---------------------	------------------------

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least [*30 hours (20 hours for Employee Pay All Life only) per week, or ____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.]E

9. Do you want to exclude any classes of full-time employees from coverage? Yes No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____

_____ Total # of excluded employees _____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees _____ months OR First of the month following _____ months*

Future Employees _____ months OR First of the month following _____ months*

*Only option available for Employee Pay All Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued)....._____

b. Number of Full-Time Employees **waiving all coverages**_____

12. Do you employ 20 or more employees? (Include part-time, union, etc.) Yes No

Contribution Data – Not applicable to Employee Pay All Coverages

13. Will the employees be required to contribute toward the cost of the insurance? Yes No

If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

[NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.]

Coverage	Life	AD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD	Critical Illness	Cancer	Hospital Indemnity	Accident
Employer %													

]F

* The employer must contribute a minimum of 35% of the total dental and vision premiums.

14. Premiums will be paid: Annually Semi-annually Quarterly Monthly EFT

[Employee]/Dependent Data

15. Are there any [employees] who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? Yes No

If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. [NOTE:

This question does not need to be answered for Life and AD&D groups with more than 50 [employees] insured, Dental coverages, for Disability coverages with ten (10) or more [employees] insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.]G

Name of [Employee]	Date Disability Began	Current Amount of Group Life Insurance in Force	Describe Nature of Injury/Sickness	Date Return to Full-Time Work

Requested Effective Date

I request that the coverage(s) chosen take effect on:

- the date the application is approved in writing by the Company; or
 _____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.
 For [Employer] Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For [Employee] Pay All Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all [employees] applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all [employees] meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all [employees]. Completed waivers are attached for those [employees] and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): _____.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy. **JH**
6. I understand and agree that:
 - no agent may change or waive any of the provisions of this application or of any plan of insurance;
 - any change or waiver may be made only by an officer of the Company; and
 - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
 - If the insurance contract compromises a part of an [employee] benefit plan, the Company is granted ** sole discretionary authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

DATE _____ PRINT NAME & TITLE OF OFFICER, PARTNER, PROPRIETOR _____

WITNESS _____ SIGNATURE OF OFFICER, PARTNER, PROPRIETOR _____

* Amount of hours may vary by state law

** May not be applicable in all states, and may vary by state law

[The Policyholder [Participant Employer] hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.]

Note: *If there are any modifications to the statements and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print			PRODUCING AGENT
Producer #	Tax ID # / SS#	% Commissions split with other agents	
Name as Licensed			License #
Mailing Address			
City / State / Zip			
Phone	Fax	E-Mail	
Signature	Date	City and State Where Signed	
Please Print			GENERAL AGENT
General Agent #	Name	Tax ID # / SS#	
Phone	Fax	E-Mail	
HOME OFFICE USE ONLY			
Policy No.	Premium Deposit \$	Underwriter	
Mode	Coverages		
Group Contact	Producer	GA	

[Disclosure Regarding Compensation

Your insurance or benefits advisor can offer you advice and guidance as you select the policy and provider most appropriate for your needs. At American General Life Insurance Company of Delaware we recognize the important role these professionals play in the sale of our products and services and offer them a variety of compensation programs. Your advisor can provide you with information about these programs. We support disclosure of broker compensation so that customers can make an informed buying decision.

Brokers may be eligible to receive Base Commissions and Supplemental Compensation from American General Life Insurance Company of Delaware.

Unless you have agreed in writing to compensate the broker differently, American General Life Insurance Company of Delaware provides Base Commissions to all producers in connection with the sale of an insurance policy. Base Commissions are a fixed percentage of the policy premium, and include a one time, first year flat amount for each policy sold. Base Commissions are paid by American General Life Insurance Company of Delaware to your producer as long as they remain the broker of record on your policy.

A producer may also qualify for Supplemental Compensation paid by American General Life Insurance Company of Delaware. For group insurance products, Supplemental Compensation may be paid in an amount equal to a fixed percentage of total group insurance premiums. The Supplemental Compensation percentage may range from 0% to 7% of total premiums paid. The exact Supplemental Compensation percentage payable to any producer is based upon the total dollar amount of all group insurance premiums or number of policies that the broker had in force with American General Life Insurance Company of Delaware and affiliated American General Companies in the prior calendar year. Supplemental Compensation may be calculated differently for other insurance products. The premium you pay is not impacted whether or not your broker receives Supplemental Compensation.

If you would like additional information about the range of compensation programs our company offers for your group insurance policy or any other American General Benefits Solutions product, you can find more details at [\[www.AmericanGeneral.com/employeebenefits\]](http://www.AmericanGeneral.com/employeebenefits). Should you have other questions not addressed by the website, including Supplemental Compensation, please your Benefits Solutions representative.]]

[CENSUS INFORMATION (This form may be photocopied if additional supply is needed) – Not applicable for Employee Pay All Coverages

For H.O. Use Only Class/Div.	Employee's Soc. Security #	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Date of Birth M D Y	Date of Hire	Marital Status**	# of dependents	Coverage Election E- Employee S-Spouse, C-Child	Coverage Selected – Please check										
											[Life	LTD	STD	INT. DIS	Dental	Vision	Critical Ill.	Cancer	HIP	Accident]	
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*Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.

**Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced

***Please state if salary is per hour, per week, per month or per year.]

For H.O. only: Group Number: _____]
