

SERFF Tracking Number: AMGN-127117526 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 48506
City of New York
Company Tracking Number: AGLC100565-2011 USL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Common Application
Project Name/Number: Common Application/AGLC100565-2011

Filing at a Glance

Company: The United States Life Insurance Company in the City of New York

Product Name: Common Application

SERFF Tr Num: AMGN-127117526 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- State Tr Num: 48506
Closed

Sub-TOI: L08.000 Life - Other

Co Tr Num: AGLC100565-2011 State Status: Approved-Closed
USL

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Nancy Smith, Janice
Hooley

Disposition Date: 04/19/2011

Date Submitted: 04/15/2011

Disposition Status: Approved-
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: Common Application

Status of Filing in Domicile: Authorized

Project Number: AGLC100565-2011

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 04/19/2011

State Status Changed: 04/19/2011

Deemer Date:

Created By: Janice Hooley

Submitted By: Janice Hooley

Corresponding Filing Tracking Number:
AGLC100565-2011

Filing Description:

Re: AGLC100565-2011 - Life Insurance Application- Part A

AGLC100566-2011 - Life Insurance Application - Part B

AGLC100240-2011 – Term Insurance Application - Part A

AGLC100241-2011– Child Rider Attachment

AGLC101431-2011 – Limited Temporary Life Insurance Agreement (LTLIA)

AGLC101432-2011 – Limited Temporary Life Insurance Agreement Receipt (Receipt)

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AGLC102110-2011 – Addendum to Application

PLEASE NOTE: These same forms are also being submitted to your department on behalf of 2 other companies: American General Life Insurance Company and American General Life Insurance Company of Delaware. Please review the forms for all 3 companies at the same time for consistency so that any objections or changes required will be the same for all companies.

Dear Sir or Madam:

We are submitting new applications for life insurance coverage sold by licensed agents and a few other miscellaneous forms for your consideration and approval. These forms are new and will not replace any forms previously approved by your Department.

No part of this filing contains any unusual or possibly controversial items from normal industry standards.

A complete application will always consist of a Part A, Part B and the Child Rider Attachment, if applicable. A separate Part B must be completed for each proposed insured. Appropriate pages from Part A will be photocopied and made a part of each issued policy. The last two pages of Part B will be completed by medical examiners when examining applicants for life insurance. Photocopies of these pages will not be included in the policy, such information being considered confidential. The Child Rider Attachment, if applicable, will also be photocopied and made a part of each issued policy.

Specifically Life Insurance Application Part A and Life Insurance Application Part B will be used with a variety of life insurance policies i.e. whole life, universal life, term life, variable universal life etc. offered by the company. Whereas, the Term Insurance Application Part A is strictly used with term insurance.

In the event the proposed insured requests coverage under a child rider the enclosed Child Rider Attachment will be completed and processed as part of the entire application.

The Limited Temporary Life Insurance Agreement (Agreement) will be used with the above referenced applications as well as other approved life insurance applications. The specific conditions for temporary life insurance coverage are covered in the Agreement. The Agreement must be signed by the owner acknowledging he or she has read the Agreement and agrees to be bound by the terms and conditions of the Agreement and Receipt. The signed Agreement will be left with the applicant.

The Limited Temporary Life Insurance Agreement Receipt (Receipt) will accompany the Agreement. This Receipt must be signed by the owner acknowledging he or she has read the receipt and agrees to be bound by the terms and

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conditions of the Agreement and Receipt. The signed Receipt will be submitted to our home office with the signed application.

The enclosed Addendum to Application form will be used when space allotted on the application is insufficient to provide all details to answers in the application. It will be made a part of the application, photocopied and attached to the policy.

The application may, in some instances, be completed electronically which may also include the use of electronic signatures.

Unless otherwise informed, we reserve the right to alter the layout of the enclosed forms, including sequential ordering of the questions, provisions, and type font, size (but not less than 10 point) and color.

The submitted forms have been written in simplified language. The Flesch readability scores are as follows:

Form #	Flesch Score	Sentences	Words	Syllables
AGLC100565-2011	66.005	73	964	1452
AGLC100566-2011	68.436	21	365	521
AGLC100240-2011	66.103	73	950	1432
AGLC100241-2011	60.8	6	108	163
AGLC101431-2011	59.8	38	771	1152
AGLC101432-2011	60.746	11	280	398
AGLC102110-2011	67.7	1	12	18

If you have any questions, or need additional information, please don't hesitate to call me at 800-247-8837, extension 3194 or you may e-mail me at Nancy.M.Smith@aglife.com.

Sincerely,

Nancy Smith
Compliance Administrator

Company and Contact

Filing Contact Information

Nancy Smith, Manager nancy.m.smith@aglife.com
2929 Allen Parkway 713-831-3194 [Phone]
Mail Stop A38-40 713-342-7550 [FAX]

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Houston, TX 77019

Filing Company Information

The United States Life Insurance Company in CoCode: 70106 State of Domicile: New York
 the City of New York
 830 Third Avenue Group Code: 12 Company Type:
 7th Floor Group Name: AIG State ID Number:
 New York, NY 10022 FEIN Number: 13-5459480
 (713) 831-3508 ext. [Phone]

Filing Fees

Fee Required? Yes
 Fee Amount: \$350.00
 Retaliatory? No
 Fee Explanation: \$50.00 per form x 7 forms = \$350.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$350.00	04/15/2011	46614907

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved- Closed	Linda Bird	04/19/2011	04/19/2011

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Form	Life Insurance Application - Part A		Yes
Form	Life Insurance Application - Part B		Yes
Form	Term Insurance Application		Yes
Form	Child Rider Attachment		Yes
Form	Limited Temporary Life Insurance Agreement (LTLIA)		Yes
Form	Limited Temporary Life Insurance Agreement Receipt (Receipt)		Yes
Form	Addendum to Application		Yes

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Form Schedule

Lead Form Number: AGLC100565-2011

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	AGLC100565-2011	Application/Life Insurance Enrollment Application - Part A Form	Initial		66.005	AGLC100565-2011.pdf
	AGLC100566-2011	Application/Life Insurance Enrollment Application - Part B Form	Initial		68.436	AGLC100566-2011.pdf
	AGLC100240-2011	Application/Term Insurance Enrollment Application Form	Initial		66.103	AGLC100240-2011.pdf
	AGLC100241-2011	Application/Child Rider Enrollment Attachment Form	Initial		60.800	AGLC100241-2011.pdf
	AGLC101431-2011	Application/Limited Temporary Enrollment Life Insurance Form Agreement (LTLIA)	Initial		59.800	AGLC101431-2011.pdf
	AGLC101432-2011	Application/Limited Temporary Enrollment Life Insurance Form Agreement Receipt (Receipt)	Initial		60.746	AGLC101432-2011.pdf
	AGLC102110-2011	Application/Addendum to Enrollment Application Form	Initial		67.700	AGLC102110-2011.pdf

3. Owner

A. Complete if the Primary Proposed Insured is not the Owner (If contingent Owner is required, use Remarks section)

First Name MI Last Name Sex M F
Social Security or Tax ID # Date of Birth
U.S. Citizen yes no If no, Country of Citizenship Date of Entry Visa Type Exp. Date
Address City, State ZIP
Home Phone Relationship to Primary Proposed Insured
Email

B. Complete if Owner is a trust (If trustee is a premium payor, also complete section 13 D)

Exact Name of Trust Trust Tax ID #
Address City, State ZIP
Email
Current Trustee(s) Date of Trust

4. Product Name (Complete appropriate supplemental application if applicable) Elite Universal Life

Amount Applied For: Base Coverage \$ 50,000 Supplemental Coverage (If applicable) \$
Death Benefit Compliance Test Used (If applicable): Guideline Premium Cash Value Accumulation
Automatic Premium Loan (If applicable): yes no Premium Class Quoted
Reason for Insurance family protection

5. Premium Allocation (For Index UL only) (Complete line A, line B or line C based on the selected product)

Indicate how each premium received is to be allocated. Total allocations must equal 100%. Use whole percentage only.
A. 1-Year Index Interest Account % 5-Year Index Interest Account % Declared Interest Account %
B. 1-Year Index Cap Account % Annual Participation Rate Account % Declared Interest Account %
C. 1-Year Index Cap Account % 5-Year Index Interest Account % Declared Interest Account %
Other:

6. Death Benefit Options (For UL & VUL only) Option 1 - Level Option 2 - Increasing Option 3 - Level Plus Return of Premium

7. Riders/Benefits

Child Rider Amount \$ (Complete Child Rider Attachment) or No current children
Waiver of Premium Waiver of Monthly Deduction Waiver of Monthly Guarantee Premium
Maturity Extension Rider - Accumulation Value Maturity Extension Rider - Death Benefit
Terminal Illness Rider
Accidental Death Benefit Amount \$ Other Insured/Spouse Rider Amount \$
Select Income Rider (Complete the following if SI Rider selected) Benefit Duration Monthly Benefit Amt \$
Disability Income Rider (Complete the following if DI Rider selected)
Number of Units (1 unit = \$100): Occupational Class (Please check): 1 2
Other Riders/Benefits #1 Amount/Unit(s)
Other Riders/Benefits #2 Amount/Unit(s)

8. Primary Beneficiary

Name Jane Doe Relationship wife Share 100 % DOB SSN
Name Relationship Share % DOB SSN
Name Relationship Share % DOB SSN
Name Relationship Share % DOB SSN

9. Contingent Beneficiary

Name Relationship Share % DOB SSN
Name Relationship Share % DOB SSN

10. Trust Information (if Beneficiary) Exact Name of Trust

Trust Tax ID # Current Trustee(s) Date of Trust

11. Rider Beneficiaries (Complete if other than Primary Proposed Insured)

Other Insured/Spouse Rider Relationship

12. Business Insurance Details (Complete only if applying for business coverage)

Does any Proposed Insured have an ownership interest in the business? yes no
 If yes, what is the percentage of ownership for the: Primary Proposed Insured _____% Other Proposed Insured _____%
 Net Profit of Business \$ _____ Fair Market Value of Business \$ _____
 If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? yes no
 If no, provide the reason why all partners are not covered _____
 Describe any special circumstances _____

13. Premium Payment Modal \$ 600 Single \$ _____ Additional Initial \$ _____

A. Frequency of modal premium: Annual Semi-annual Quarterly Monthly (Bank Draft only)
B. Method: Direct Billing Bank Draft (Complete Bank Draft Authorization) List Bill: Number _____
 Credit Card - Initial Premium Only (Complete Credit Card Authorization) (Not available for VUL products)
 Other (Please explain) _____

C. Amount submitted with application \$ 600

D. Premium Payor (Complete if other than Owner or if Owner is Trustee)
 First Name _____ MI _____ Last Name _____ Sex M F
 Social Security or Tax ID # _____ Date of Birth _____
 Relationship to Primary Proposed Insured _____
 U.S. Citizen yes no If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ Exp. Date _____
 Address _____ City, State _____ ZIP _____

14. Existing Coverage and Replacements

A. Does any Proposed Insured have any existing or pending annuities or life insurance policies?* yes no
B. If question 14A is answered "yes", please provide the following information:

Name of Proposed Insured	Type (see below)	Year of Issue	Face Amount	Insurance Company	Contract or Policy #	Is Coverage being Replaced?***	1035 Exchange
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes
_____	_____	_____	_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no	<input type="checkbox"/> yes

Type: i= individual, b= business, g= group, p= pending life insurance or annuity
 *If 14A is answered "yes", certain states require completion of replacement-related forms even when existing or pending life insurance or annuities are not being replaced by the life insurance policy being applied for.
 ***"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

C. Disability Coverage (Complete only if Disability Income Rider coverage requested)

Does any Proposed Insured have any existing or pending Disability insurance policies? yes no
 (If yes, complete the following regarding existing and pending disability insurance)

Insurance Company	Benefit Amount	Benefit Period	Elimination Period	Year Issued
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

15. Background Information (Complete questions A through J. If yes answer applies to any Proposed Insured, provide details specified after each question)

- A.** Does any Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? yes no
(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire) _____
- B.** In the past five years, has any Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? yes no
(If yes, complete the Aviation and/or Avocation Questionnaire)
- C.** Has any Proposed Insured:
- 1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application? yes no
(If yes, list company name, amount applied for, purpose of insurance, and if application will be placed) _____
- 2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? yes no
(If yes, list date and reason) _____
- D.** Has any Proposed Insured ever filed for bankruptcy? yes no
(If yes, list chapter filed, date, reason, and discharge date) _____
- E.** In the past five years, has any Proposed Insured been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? yes no
(If yes, list date, state, license #, and specific violation) _____
- F.** Has any Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending? yes no
(If yes, list date, county, state, charge, and current status) _____
- G.** Is any Proposed Insured an active duty service member of the US Armed Forces, a member of the National Guard or an active reservist of the US Armed Forces, or a dependent of an active duty service member of the US Armed Forces? yes no
(If yes, provide Pay Grade, Rank and any known foreign assignments. Complete the applicable Military Disclosure)
- H.** Is there an intention that any party, other than the Owner, will obtain any right, title, or interest in any policy issued on the life of any Proposed Insured as a result of this application? yes no
- I.** Does the Owner or any Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? yes no
- J.** Is the Owner, any Proposed Insured, or any person or entity, being paid (cash, services, etc) as an incentive to enter into this transaction? yes no
(If yes, describe the incentive) _____

Remarks

16. Details and Explanations

The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Limited Temporary Life Insurance Agreement ("LTLIA") – If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the questions regarding any Proposed Insured's health and age in section 3 of the LTLIA; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. Check if you wish to be interviewed.

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

Owner signed at (city, state) Anytown, USA On (date) 3/17/2011

Owner Signature X John Doe Title (If Corporate Officer or Trustee)

Primary Proposed Insured Signature (if other than Owner) X _____
(If under age 15, signature of parent or guardian)

Other Proposed Insured Signature (if other than Owner) X _____
(If under age 15, signature of parent or guardian)

Agent(s) Signature(s)

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name (please print) John Smith Writing Agent # 5678

Writing Agent Signature X John Smith Countersigned _____
(Licensed resident agent if state required)

Agent's Report

1. Statements

- A.** Does any Proposed Insured have any existing or pending annuities or life insurance policies? yes no
(If yes, certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for - please attach such forms)
- B.** If yes to question 1 A., do you have any information that any Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? yes no
(If yes, please provide details in the Remarks section below and attach replacement-related forms)
- C.** Number of years you have known Primary Proposed Insured: 10 years
Other Proposed Insured: _____
- D.** Are you aware of any other information that would adversely affect any Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance)* yes no
- E.** Did you provide the Owner with a Limited Temporary Life Insurance Agreement? yes no

2. Remarks, Details and Explanations *(Please include information on any collateral assignment, etc)*

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

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

4. Agent Agreement and Signature

I understand and agree that if I am made aware of any changes to any of the answers contained in any of the forms I will notify the company of the changes.

Writing Agent Name *(Please print)* John Smith Date 3/17/2011

Writing Agent Signature **X** John Smith

State License # _____ Phone # _____

Email _____ Fax # _____

For Home Office use

Processing Center _____ Contact Person _____ Phone # _____

Servicing Agent (if other than writing agent) send policy/delivery requirements to _____

5. Personal Health History

- A.** Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a licensed health care provider for:
- 1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? yes no
 - 2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? yes no
 - 3) cancer, tumors, masses, cysts or other such abnormalities? yes no
 - 4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? yes no
 - 5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? yes no
 - 6) a disorder of the kidneys, bladder, prostate or reproductive organs or protein in the urine? yes no
 - 7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? yes no
 - 8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including anxiety, depression or other psychiatric conditions? yes no
 - 9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? yes no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details _____

- B.** Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation? yes no
(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)

Details _____

- C.** Has the Proposed Insured in the **past three years** had but NOT sought treatment for:
- 1) fainting spells, nervous disorder, headaches, convulsions or paralysis? yes no
 - 2) any pain or discomfort in the chest or shortness of breath? yes no
 - 3) disorders of the stomach, intestines or rectum, or blood in the urine? yes no

(If yes, list condition such as: date of first occurrence; symptoms; and how treated)

Details _____

- D.** Has the Proposed Insured **ever**:
- 1) sought or received medical advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? yes no
 - 2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? yes no

(If yes answered to D1 or D2, please provide details below)

Type of drug(s)/alcohol product(s) _____ Date last used _____
Frequency of use: Daily Weekly Monthly Amount usually used: _____

Name(s) of doctor/facility _____ Phone () _____

Address _____ City, State _____ ZIP _____

Treatment Dates _____

Support group(s) _____ Last date attended _____

- Was treatment or support group attendance court ordered? yes no

Details of any drug or alcohol related arrests _____

5. Personal Health History (continued)

E. Has the Proposed Insured **ever** been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? yes no
(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)
Details _____

F. Other than previously stated, in the **past 10 years**, has the Proposed Insured:
1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? yes no
(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)
Details _____

2) been advised to have any diagnostic test, hospitalization or treatment that was NOT completed? yes no
(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; recommended tests, medications or treatment)
Details _____

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? yes no
(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)
Details _____

G. Has the Proposed Insured had any emergency room or emergency clinic visits during the **past 5 years**? yes no
(If yes, provide name and address of hospital or emergency clinic, reason for visit(s), and resolution of condition)
Details _____

H. Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above? yes no
(If yes, provide details such as: date of first diagnosis; name, address, and phone # of doctor; tests performed; test results; medications or recommended treatment)
Details _____

Agreement and Signatures

I, the Proposed Insured signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

Fraud

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.

SIGNATURE OF PROPOSED INSURED

Signed at (city, state) Anytown, USA On (date) 3/17/2011

John Doe
Proposed Insured (If under age 15, signature of parent or guardian)

SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

If Agent recorded information

John Agent 223344 3/17/2011
Writing Agent Name (Please print) Writing Agent # Date

John Agent
Writing Agent Signature Countersigned (Licensed resident agent if state required)

If Tele-interviewer recorded information

Name (Please print) Company Date

If Paramedical Examiner/Medical Doctor recorded information

Examiner Address _____ **Paramed: Use company stamp below.**

Examiner Phone # () _____

Examiner Name _____

Examiner Signature _____

_____ Date _____

Physical Measurements

1. Proposed Insured

- A. Name _____
- B. Build: Measured Height (*in shoes*) _____ ft _____ in Weight (*clothed*) _____ lbs (*Please weigh insured*)
 If unable to obtain accurate weight, please provide reason _____
- C. Blood Pressure (*three readings required*): If blood pressure exceeds 140/90, repeat reading at end of examination.*
 Select cuff size: Standard BP cuff Large BP cuff

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th Phase BP				
Pulse Rate				
Irregularities Per Min.				

- D. Did you weigh Proposed Insured? yes no
- E. Have any of the following been completed in conjunction with this exam?
 Blood Urine EKG Stress Test
- F. Is appearance unhealthy or older than stated age? yes no
- G. Do you have any pertinent information not disclosed previously? yes no
(Details of yes answers to questions F and G)

- H. Are you related to the Proposed Insured by blood or marriage or do you have any business or professional relationship with the Proposed Insured? (*If yes, explain*) yes no

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart

- a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? _____ yes no
- b. Is heart enlarged? (*If yes, describe*) _____ yes no
- c. Is murmur present? (*If yes, complete 1d*) _____ yes no
- d. Before exercise, murmur is:
 Constant Transmitted to where? _____
 Inconstant Localized at: Apex Base Elsewhere
 Systolic (*Give details*) _____
 Diastolic Murmur grade: (*Please circle*) 1/6 2/6 3/6 4/6 5/6 6/6
 After valsalva, murmur is:
 Unchanged Decreased Increased Absent

Your impression _____

Report by Examining Medical Doctor (continued)

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction)* yes no

Details _____

b) Endocrine system *(including thyroid)?* yes no

Details _____

c) Nervous system *(including reflexes, gait, paralysis)?* yes no

Details _____

d) Respiratory system? yes no

Details _____

e) Abdomen *(including scars)?* yes no

Details _____

f) Genito-urinary system? yes no

Details _____

g) Skin *(including scars)*, lymph nodes, blood vessels *(including varicose veins)?* yes no

Details _____

h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* yes no

Details _____

Signature

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____ day of _____, 20_____, at _____ am pm

Location of Exam _____ **Paramed: Use company stamp below.**

Examiner Address _____

Examiner Phone # () _____

Examiner Name _____

Examiner Signature **X** _____

(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion)

American General

Life Companies

Term Insurance Application Part A

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- American General Life Insurance Company of Delaware, Wilmington, DE

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

1. Primary Proposed Insured

First Name John MI Last Name Doe Social Security # 123-45-6789
 Sex M F Birthplace* (state, country) Anytown, USA Date of Birth 12/28/75 Current Age 35

Tobacco Use Have you ever used any form of tobacco or nicotine products? yes no Type and quantity used

If yes, are you a current user? yes no If no, date of last use

Driver's License yes no License State Number

U.S. Citizen or Permanent Resident (Green Card holder) yes no

If no, Country of Citizenship Date of Entry Visa Type (Copy of Visa Required)

Address 123 Main Street City, State Anytown, USA ZIP 77704

Home Phone (713) 123-4567 Alternate Phone (713) 345-6789 Email Jdoe aol.com

Employer Steel Industries Occupation Machine Operator Length of Employment 5 years

Employer Address 123 West Road City, State Anytown, USA ZIP 77704

Duties Operate machines, Supervise other operators

Personal Earned Income \$ 50,000 Household Income \$ 50,000 Net Worth \$ 100,000

Personal Earned Income means salary, wages, commissions, fees, or other earned income received during the last 12 months, reduced by regular business expenses, but before all other deductions.

If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force on any of the following: Spouse \$ Father \$ Mother \$ Siblings \$

2. Owner

A. Complete if the Primary Proposed Insured is not the Owner (If contingent Owner is required, use Remarks section)

First Name MI Last Name Sex M F

Social Security or Tax ID # Date of Birth

U.S. Citizen yes no If no, Country of Citizenship Date of Entry Visa Type Exp. Date

Address City, State ZIP

Home Phone () Relationship to Primary Proposed Insured

Email

B. Complete if Owner is a trust (If trustee is premium payor also complete section 8 D)

Exact Name of Trust Trust Tax ID #

Address City, State ZIP

Email

Current Trustee(s) Date of Trust

3. Plan of Insurance

Product Name Elite Term Life Term Duration 20 years Amount Applied For \$ 50,000

Premium Class Quoted Reason for Insurance family protection

Riders/Benefits

Child Rider Amount \$ (Complete Child Rider Attachment) or No current children

Waiver of Premium Accidental Death Benefit Amount \$ Terminal Illness Rider

Select Income Rider (Complete the following if SI Rider selected) Benefit Duration Monthly Benefit Amt \$

Disability Income Rider (Complete the following if DI Rider selected)

Number of Units (1 unit = \$100): Occupational Class (Please check): 1 2

Other Riders/Benefits #1 Amount/Unit(s)

Other Riders/Benefits #2 Amount/Unit(s)

*for identification purposes only

4. Primary Beneficiary

Name Jane Doe Relationship wife Share 100 % DOB _____ SSN _____
Name _____ Relationship _____ Share _____ % DOB _____ SSN _____
Name _____ Relationship _____ Share _____ % DOB _____ SSN _____

5. Contingent Beneficiary

Name _____ Relationship _____ Share _____ % DOB _____ SSN _____
Name _____ Relationship _____ Share _____ % DOB _____ SSN _____

6. Trust Information (if Beneficiary) Exact Name of Trust _____

Trust Tax ID # _____ Current Trustee(s) _____ Date of Trust _____

7. Business Insurance Details (Complete only if applying for business coverage)

Does the Primary Proposed Insured have an ownership interest in the business? yes no
If yes, what is the percentage of ownership for the Primary Proposed Insured? _____ %
Net Profit of Business \$ _____ Fair Market Value of Business \$ _____
If buy-sell, stock redemption, or key person insurance, will all partners or key people be covered? yes no
If no, provide the reason why all partners are not covered _____
Describe any special circumstances _____

8. Premium Payment Modal \$ 600

A. Frequency of modal premium: Annual Semi-annual Quarterly Monthly (Bank Draft only)

B. Method: Direct Billing Bank Draft (Complete Bank Draft Authorization) List Bill: Number _____
 Credit Card - Initial Premium Only (Complete Credit Card Authorization)
 Other (Please explain) _____

C. Amount submitted with application \$ 600

D. Premium Payor (Complete if other than Owner or if Owner is Trustee)

First Name _____ MI _____ Last Name _____ Sex M F
Social Security or Tax ID # _____ Date of Birth _____
Relationship to Primary Proposed Insured _____
U.S. Citizen yes no If no, Country of Citizenship _____ Date of Entry _____ Visa Type _____ Exp. Date _____
Address _____ City, State _____ ZIP _____

9. Existing Coverage and Replacements

A. Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies?* yes no

B. If question 9A is answered "yes", please provide the following information:

Type (see below)	Year of Issue	Face Amount	Insurance Company	Contract or Policy #	Is Coverage being Replaced?***
_____	_____	_____	_____	_____	<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

Type: i= individual, b= business, g= group, p= pending life insurance or annuity

*If 9A is answered "yes", certain states require completion of replacement-related forms even when existing or pending life insurance or annuities are not being replaced by the life insurance policy being applied for.

***"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

C. Disability Coverage (Complete only if Disability Income Rider coverage requested)

Does the Primary Proposed Insured have any existing or pending Disability insurance policies? yes no

(If yes, complete the following regarding existing or pending disability insurance)

Insurance Company	Benefit Amount	Benefit Period	Elimination Period	Year Issued
_____	_____	_____	_____	_____

10. Background Information (Complete questions A through J. If yes answer applies to the Primary Proposed Insured, provide details specified after each question)

A. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? yes no
(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire) _____

B. In the past five years, has the Primary Proposed Insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? yes no
(If yes, complete the Aviation and/or Avocation Questionnaire)

C. Has the Primary Proposed Insured:
1) During the past 90 days submitted an application for life insurance to any company or begun the process of filling out an application? yes no
(If yes, list company name, amount applied for, purpose of insurance, and if application will be placed) _____

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? yes no
(If yes, list date and reason) _____

D. Has the Primary Proposed Insured ever filed for bankruptcy? yes no
(If yes, list chapter filed, date, reason, and discharge date) _____

E. In the past five years, has the Proposed Insured been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? yes no
(If yes, list date, state, license #, and specific violation) _____

F. Has the Primary Proposed Insured ever been convicted of or pled guilty or no contest to a criminal offense or currently have any felony or misdemeanor charge pending? yes no
(If yes, list date, county, state, charge, and current status) _____

G. Is the Proposed Insured an active duty service member of the US Armed Forces, a member of the National Guard or an active reservist of the US Armed Forces, or a dependent of an active duty service member of the US Armed Forces? yes no
(If yes, provide Pay Grade, Rank and any known foreign assignments. Complete the applicable Military Disclosure) _____

H. Is there an intention that any party, other than the Owner, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application? yes no

I. Does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? yes no

J. Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, etc) as an incentive to enter into this transaction? yes no
(If yes, describe the incentive) _____

Remarks

11. Details and Explanations

The above listed life insurance company ("Company") as selected on page one of this application is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured and Owner signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

Limited Temporary Life Insurance Agreement ("LTLIA") – If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy and only if the following four conditions are met: (1) the full first modal premium is submitted with this application and paid; and (2) only "no" answers have been truthfully given to the questions regarding the Primary Proposed Insured's health and age in section 3 of the LTLIA; and (3) Part A and Part B of the application must be completed, signed and dated; and (4) all medical exam requirements must be satisfied. I understand and agree that such insurance is not available with any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

I give my consent to all of the entities listed below to give to the Company, its legal representatives, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information for me, my spouse or my minor children. Other information could include items such as: personal finances; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc. I give my consent for the information outlined above to be provided by: any physician or medical practitioner; any hospital, clinic or other health care facility; pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine: (1) eligibility for insurance; and (2) eligibility for benefits under an existing policy. Any information gathered during the evaluation of my application may be disclosed to: reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize AGLC or affiliated insurers to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. Check if you wish to be interviewed.

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

Owner signed at (city, state) Anytown, USA On (date) 3/17/2011

Owner Signature X John Doe Title (If Corporate Officer or Trustee)

Primary Proposed Insured Signature (if other than Owner) X _____
(If under age 15, signature of parent or guardian)

Agent Signature

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name (please print) John Smith Writing Agent # 5678

Writing Agent Signature X John Smith Countersigned _____
(Licensed resident agent if state required)

Agent's Report

1. Statements

- A.** Does the Primary Proposed Insured have any existing or pending annuities or life insurance policies? yes no
(If yes, certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for - please attach such forms)
- B.** If yes to question 1A., do you have any information that the Primary Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? yes no
(If yes, please provide details in the Remarks section below and attach replacement-related forms)
- C.** Number of years you have known the Primary Proposed Insured: 10 years
- D.** Are you aware of any other information that would adversely affect the Primary Proposed Insured's eligibility, acceptability, or insurability? *(If yes, please provide details in the Remarks section below, and do not provide limited temporary life insurance)* yes no
- E.** Did you provide the Owner with a Limited Temporary Life Insurance Agreement? yes no

2. Remarks, Details and Explanations *(Please include information on any collateral assignment, etc)*

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

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

4. Agent Agreement and Signature

I understand and agree that if I am made aware of any changes to any of the answers contained in any of the forms I will notify the company of the changes.

Writing Agent Name *(Please print)* John Smith Date 3/17/2011

Writing Agent Signature **X** John Smith

State License # _____ Phone # _____

Email _____ Fax # _____

For Home Office use

Processing Center _____ Contact Person _____ Phone # _____

Servicing Agent (if other than writing agent) send policy/delivery requirements to _____

LEAVE COMPLETED AND SIGNED FORM WITH THE OWNER

Limited Temporary Life Insurance Agreement (Agreement)

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.

1. Check appropriate Company:

- American General Life Insurance Company, Houston, TX
 The United States Life Insurance Company in the City of New York, New York, NY
 American General Life Insurance Company of Delaware, Wilmington, DE

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

2. Complete the following: (please print)

Primary Proposed Insured _____ *John Doe* _____

Other Proposed Insured _____
 (applicable only for a joint life or survivorship policy)

Owner (if other than Primary Proposed Insured) _____

Modal Premium Amount Received _____ *\$2,000* _____

Date of Policy Application _____ *3/17/2011* _____

3. Answer the following questions:

	Yes	No
a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Is any Proposed Insured age 71 or above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STOP If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

A. Eligibility for Coverage: If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

B. When Coverage Will Begin:

COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

SUBMIT COMPLETED FORM WITH SIGNED APPLICATION

Limited Temporary Life Insurance Agreement Receipt

1. Check appropriate Company:

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- American General Life Insurance Company of Delaware, Wilmington, DE

In this Receipt, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable. The "Agreement" refers to the Limited Temporary Life Insurance Agreement.

2. Complete the following: (please print)

Primary Proposed Insured _____	<i>John Doe</i>
Other Proposed Insured _____	
<i>(applicable only for a joint life or survivorship policy)</i>	
Owner (if other than Primary Proposed Insured) _____	
Modal Premium Amount Received _____	\$2,000

3. Answer the following questions:

Yes No

a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b. Is any Proposed Insured age 71 or above?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

STOP If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under the Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under the Agreement.

The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under the Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under the Agreement have been met.

The total death benefit amount pursuant to the Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- \$500,000 plus the amount of any premium paid for coverage in excess of \$500,000.

If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

4. Complete and sign this section:

Any misrepresentation contained in the Agreement or this Receipt and relied on by the Company may be used to deny a claim or to void the Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of the Agreement or this Receipt.

I, the Owner, have received and read the Agreement and this Receipt or they were read to me and agree to be bound by the terms and conditions stated therein.

Signature of Owner _____	Date <u>3/17/2011</u>
Signature of Primary Proposed Insured _____	Date <u>3/17/2011</u>
<i>(If under age 15, signature of parent or guardian)</i>	
Signature of Other Proposed Insured (if applicable) _____	Date _____
<i>(If under age 15, signature of parent or guardian)</i>	
Writing Agent Name (please print) _____	Writing Agent # <u>12345</u>
Jim Smith	

American General

Life Companies

Addendum to Application

American General Life
Insurance Company,
Houston, TX

The United States Life Insurance Company
in the City of New York,
New York, NY

American General Life
Insurance Company of
Delaware, Wilmington, DE

The insurance company ("Company") checked above is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

This addendum is part of the application to which it is attached. (Part A, Part B, etc.)

Addendum to: Life Insurance Application Part A Policy Number: 123456

Proposed Insured:

First Name John MI _____ Last Name Doe Social Security # 123-45-6789

Owner:

First Name _____ MI _____ Last Name _____

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient. Provide an appropriate reference to the specific questions for which answers and details are included below.)

1. *Additional Duties: Performs routine maintenance on machines as needed.
Orders machine parts and overseas inventory control.*

Primary Proposed Insured Signature X John Doe Date 3/17/2011

Other Proposed Insured Signature X _____ Date _____

Owner Signature X _____ Date _____

(If other than Primary Proposed Insured)

SERFF Tracking Number: AMGN-127117526 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 48506
City of New York
Company Tracking Number: AGLC100565-2011 USL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Common Application
Project Name/Number: Common Application/AGLC100565-2011

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

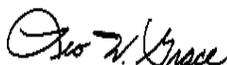
Attachment:

AR Flesch Certification USL.pdf

UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK

ARKANSAS FLESCH CERTIFICATION

This is to certify that the attached Form No(s). **AGLC100565-2011, AGLC100566-2011, AGLC100240-2011, AGLC100241-2011, AGLC101431-2011, AGLC101432-2011, and AGLC102110-2011** (has) achieved Flesch Reading Score of **66.005, 68.436, 66.103, 60.8, 59.8, 60.746, and 67.7** and comply (ies) with the requirements of Arkansas Stat. Ann. §66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.



Leo W. Grace, FLMI
Vice President

April 15, 2011
Date