

SERFF Tracking Number: AMGN-127361270 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 49573
Company Tracking Number: AGLC100386-2011 AGL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: In-Force Change & Reinstatement App
Project Name/Number: In-Force Change & Reinstatement App/AGLC100386-2011

Filing at a Glance

Company: American General Life Insurance Company

Product Name: In-Force Change & Reinstatement App SERFF Tr Num: AMGN-127361270 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved- Closed State Tr Num: 49573

Sub-TOI: L08.000 Life - Other

Co Tr Num: AGLC100386-2011 State Status: Approved-Closed AGL

Filing Type: Form

Reviewer(s): Linda Bird

Authors: Nancy Smith, Janice Hooey

Disposition Date: 08/18/2011

Date Submitted: 08/16/2011

Disposition Status: Approved-Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: In-Force Change & Reinstatement App

Status of Filing in Domicile: Authorized

Project Number: AGLC100386-2011

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: 08/18/2011

Deemer Date:

State Status Changed: 08/18/2011

Submitted By: Janice Hooey

Created By: Janice Hooey

Corresponding Filing Tracking Number:

AGLC100386-2011

Filing Description:

Re: AGLC100386-2011 – In-Force Change Application

AGLC100440-2011 – Reinstatement Application for Life Insurance

PLEASE NOTE: These same forms are also being submitted to your department on behalf of 2 other companies: The United States Life Insurance Company in the City of New York 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

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changes required will be the same for all companies.

Dear Sir or Madam:

These forms are being submitted for your consideration and approval. They 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 or industry standards.

The In-Force Change application is an application to be used for various policy changes and term insurance conversions of individual life insurance policies.

The Reinstatement application is to be used to apply for reinstatement of individual life insurance policies.

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 type) and color.

These applications have been written in simplified language. The Flesch readability scores are as follows:

Form Number Flesch Score Sentences Words Syllables

AGLC100386-2011 62.87 64 789 1226

AGLC100440-2011 63.22 62 737 1146

If you have any questions, or need additional information, please call me at 800-247-8837, extension 8313194 or you may send an e-mail to Nancy.M.Smith@aglife.com.

Sincerely,

Nancy Smith
Compliance Administrator

Company and Contact

Filing Contact Information

Nancy Smith, Manager
2929 Allen Parkway
Mail Stop A38-40
Houston, TX 77019

nancy.m.smith@aglife.com
713-831-3194 [Phone]
713-342-7550 [FAX]

SERFF Tracking Number: AMGN-127361270 State: Arkansas
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 Product Name: In-Force Change & Reinstatement App
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Filing Company Information

| | | |
|---|-------------------------|--------------------------|
| American General Life Insurance Company | CoCode: 60488 | State of Domicile: Texas |
| 2727-A Allen Parkway | Group Code: 12 | Company Type: |
| Houston, TX 77019 | Group Name: AIG | State ID Number: |
| (713) 831-3508 ext. [Phone] | FEIN Number: 25-0598210 | |

Filing Fees

| | |
|------------------|---------------------|
| Fee Required? | Yes |
| Fee Amount: | \$100.00 |
| Retaliatory? | Yes |
| Fee Explanation: | \$100.00 per filing |
| Per Company: | No |

| COMPANY | AMOUNT | DATE PROCESSED | TRANSACTION # |
|---|----------|----------------|---------------|
| American General Life Insurance Company | \$100.00 | 08/16/2011 | 50673968 |

SERFF Tracking Number: AMGN-127361270 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 49573
Company Tracking Number: AGLC100386-2011 AGL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: In-Force Change & Reinstatement App
Project Name/Number: In-Force Change & Reinstatement App/AGLC100386-2011

Correspondence Summary

Dispositions

| Status | Created By | Created On | Date Submitted |
|-----------------|------------|------------|----------------|
| Approved-Closed | Linda Bird | 08/18/2011 | 08/18/2011 |

SERFF Tracking Number: *AMGN-127361270* *State:* *Arkansas*
Filing Company: *American General Life Insurance Company* *State Tracking Number:* *49573*
Company Tracking Number: *AGLC100386-2011 AGL*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *In-Force Change & Reinstatement App*
Project Name/Number: *In-Force Change & Reinstatement App/AGLC100386-2011*

Disposition

Disposition Date: 08/18/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMGN-127361270 State: Arkansas
 Filing Company: American General Life Insurance Company State Tracking Number: 49573
 Company Tracking Number: AGLC100386-2011 AGL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: In-Force Change & Reinstatement App
 Project Name/Number: In-Force Change & Reinstatement App/AGLC100386-2011

| Schedule | Schedule Item | Schedule Item Status | Public Access |
|---------------------|--|----------------------|---------------|
| Supporting Document | Flesch Certification | | Yes |
| Supporting Document | Application | | No |
| Form | In-Force Change Application | | Yes |
| Form | Reinstatement Application for Life Insurance | | Yes |

SERFF Tracking Number: AMGN-127361270 State: Arkansas
 Filing Company: American General Life Insurance Company State Tracking Number: 49573
 Company Tracking Number: AGLC100386-2011 AGL
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: In-Force Change & Reinstatement App
 Project Name/Number: In-Force Change & Reinstatement App/AGLC100386-2011

Form Schedule

Lead Form Number: AGLC100386

| Schedule Item Status | Form Number | Form Type | Form Name | Action | Action Specific Data | Readability | Attachment |
|----------------------|-----------------|------------------------------|--|---------|----------------------|-------------|---------------------|
| | AGLC100386-2011 | Application/ Enrollment Form | In-Force Change Application | Initial | | 62.870 | AGLC100386-2011.pdf |
| | AGLC100440-2011 | Application/ Enrollment Form | Reinstatement Application for Life Insurance | Initial | | 63.220 | AGLC100440-2011.pdf |

American General

Life Companies

In-Force Change Application

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

P.O. Box 4373 • Houston, TX 77210-4373 • Fax #: 713-831-3028

Some transactions may not be available for all policies for every company listed above. Contact your service center or agent for further details. In this application, "Company" refers to the insurance company whose name is checked above. The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy it may issue. No other company shown is responsible for such obligations or payments.

Use permanent ink when completing this form. Be sure to answer all questions that pertain to your request. Provide details for any questions answered "Yes". Personally sign and date. If a separate page is needed to complete the answers, attach to this form and sign and date the separate page(s). Carefully read the Notices to the Proposed Insured(s) and keep with your policy.

Current Policy Number 12345 **Insured Name** John Doe

- Requested Change:**
- Application for Reduction of Premium Rate/Reversion
 - Increase Specified Amount:
Base Coverage: \$100,000 Supplemental Coverage (if applicable) _____
 - Addition or Increase of Rider &/or Benefit
 - Waiver of Premium
 - Waiver of Monthly Deduction
 - Waiver of Monthly Guarantee Premium
 - Payor Death
 - Payor Disability
 - Accidental Death Benefit: Amount _____
 - Other Insured Rider: Amount _____
 - Guaranteed Insurability Option Rider
 - Child Rider: Amount _____
(Complete all info for the primary insured & each child)
 - Spouse Rider: Amount _____ Plan: _____
(Complete all info for the primary insured & spouse)
 - Term Rider: Amount _____ Plan: _____
Insured _____
 - Other Rider: Amount _____ Explain type: _____
 - Smoker/Tobacco/Nicotine Change: _____

Instructions:
For these changes, please complete the entire application, sign and date page 5.

Instructions: For the changes listed below, complete Section I, sign and date page 5. If a face increase or benefit/rider addition is requested, complete the entire application, sign and date page 5.

- Exercise Guaranteed Insurability Option (GIO)
GIO Amount: _____
Option Date: _____
Dividend Option: _____
- Term Conversion
CONVERSION AMOUNT
Base Coverage: _____
Supplemental Coverage: _____

Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.

Is insured totally disabled? Yes No

- Waiver of Premium/Monthly Deduction
- Accidental Death Benefit
- Guaranteed Insurability Option
- Other _____

Automatic Premium Loan desired (if available)

Yes No

Note: Underwriting class changes are not available on a GIO transaction.

New Policy # _____ **(Office use only)**

Effective Date: _____

New Plan: _____

Dividend Option: _____ *(if applicable)*

Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.

Is insured totally disabled? Yes No

- Waiver of Premium/Monthly Deduction
- Accidental Death Benefit
- Guaranteed Insurability Option
- Other _____

Nonforfeiture Process: ___ETI or ___RPU

Automatic Premium Loan (if available) Yes No

Death Benefit Option: Level Increasing

Level Plus Return of Premium

After the conversion, will there be any remaining coverage on the existing policy? Yes No

Amount remaining after conversion: _____

SECTION I – GENERAL INFORMATION:

A. PRIMARY INSURED

First Name John MI 7 Last Name Doe Social Security # 123456789

Sex M F Birthplace (state, country) Anytown, USA Date of Birth 12/28/1975

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)

CHECK HERE IF NEW ADDRESS

Address 123 Line Street City, State Anytown, USA Zip 56789

Home Phone 555-555-1222 Alternate Phone 555-555-8858 Email john.d@aol.com

Employer Anytown USA Bank Occupation Loan Officer

Personal Earned Income \$ 65,000 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.

B. OTHER INSURED Complete if spouse or additional insured covered under the policy

First Name _____ MI _____ Last Name _____ Social Security # _____

Sex M F Birthplace (state, country) _____ Date of Birth _____

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 _____ City, State _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

Employer _____ Occupation _____

Personal Earned Income \$ _____ Net Worth \$ _____

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.

C. CHILD INFORMATION Complete information for all children covered by child rider

| Child Name | Sex | Date of Birth |
|------------|---|---------------|
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |

D. OWNER INFORMATION Complete if the primary insured is not the owner

First Name _____ MI _____ Last Name _____ Tax ID # _____

CHECK HERE IF NEW ADDRESS

Address _____ City, State _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

If owner is a trust please designate information for the Name, Tax ID, Current Trustee and Date of Trust in the Special Remarks section.

E. PREMIUM PAYMENT ENCLOSED

yes no Amount \$ \$500 Check # 2356

SECTION II:

A. BACKGROUND INFORMATION – For all covered persons

Complete questions 1 through 12 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details. You may be asked to complete and submit an additional form.

- 1. Tobacco Use: Have you ever used any form of tobacco or nicotine products? yes no
If yes, *type and quantity* _____ Are you a current user? yes no
If not a current user, date of last use _____
- 2. Have you ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? yes no
- 3. Have you ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? yes no
- 4. Driver's License State: USA Number: 855-12324-02
In the past five years, have you been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? yes no
- 5. In the past five years, have you participated in, or do you 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
- 6. Do you intend to travel or reside outside of the United States or Canada within the next two years? yes no
- 7. Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability? yes no
- 8. Have you ever filed for bankruptcy? yes no
- 9. Have you 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
- 10. 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
- 11. 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
- 12. 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

Details:

B. MEDICAL INFORMATION

- 1. **Primary Insured:** Height ___ ft ___ in Weight ___ lbs Change of weight in last year? None Gain: ___ lbs Loss: ___ lbs
Other Insured: Height ___ ft ___ in Weight ___ lbs Change of weight in last year? None Gain: ___ lbs Loss: ___ lbs
Child 1: Height ___ ft ___ in Weight ___ lbs Change of weight in last year? None Gain: ___ lbs Loss: ___ lbs
Child 2: Height ___ ft ___ in Weight ___ lbs Change of weight in last year? None Gain: ___ lbs Loss: ___ lbs
- 2. Name and address of personal physician
Primary Insured: _____
Other Insured: _____
Child 1: _____
Child 2: _____
- 3. Date, reason, findings and treatment at last visit
Primary Insured: _____
Other Insured: _____
Child 1: _____
Child 2: _____

B. MEDICAL INFORMATION (continued)

Complete questions 4 through 8 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details such as date of first diagnosis, name and address of doctor, tests performed, test results, medication(s) or recommended treatment.

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

Details: _____

5. Are you currently taking any medication, treatment or therapy or under medical observation? yes no

Details: _____

6. Have you 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

Details: _____

7. Other than previously stated, in the past 10 years have you been advised to have any diagnostic test, hospitalization, or treatment that was NOT completed? yes no

Details: _____

8. Do you have any symptoms or knowledge of any other condition that is NOT disclosed above? yes no

Details: _____

C. EXISTING COVERAGE

1. Does any Proposed Insured have any existing life insurance policies? yes no

2. If question 1 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 # |
|--------------------------|------------------|---------------|-------------|-------------------|----------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Type: i= individual, b= business, g= group

D. SPECIAL REMARKS: Use this space to provide any additional comments or remarks not given in detail above

AUTHORIZATION AND SIGNATURES

**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 application, "Company" refers to the insurance company which was selected on page one.

Authorization to Obtain and Disclose Information and Declaration

I give my consent to all of the entities listed below to give to the Company, its legal representative, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations, treatments or surgeries; hospital confinements for any physical and 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 or changes to 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 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 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.

I have read the above statements 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 shall be the basis for: (1) any policy issued; or (2) changes to the existing policy as requested on this application. I understand that any misrepresentation contained in this application and related forms and relied on by the Company may be used to reduce or deny a claim or void the policy, if it is within its contestable period and if such misrepresentation materially affects the acceptance of the risk. I understand and agree that no insurance will be in effect under this application, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted; the first full modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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).

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.

If this is a full term conversion, please note:

I HEREBY ABSOLUTELY ASSIGN AND TRANSFER TO THE COMPANY IDENTIFIED IN THIS APPLICATION ALL OF MY RIGHTS, TITLE AND INTEREST OF EVERY KIND IN AND TO THE CURRENT POLICY INCLUDING, BUT NOT LIMITED TO THE RIGHT TO SURRENDER, ASSIGN, TRANSFER OR CHANGE THE BENEFICIARY.

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).

Anytown, USA 3/17/2011

Signed at (City and State) **Date**

John T. Doe

Signature of Primary Insured (if under age 15, signature of parent or guardian)

Signature of Other Insured (if under age 15, signature of parent or guardian)

Signature of Owner (if other than insured) **Signature of Officer and Title** (if corporate owned)

Signature of Trustee (if owned by a trust) **Agent Signature** **Date**

Agent Name (Printed) **State License #**

Percentage of Commissions **Agent Telephone #**

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

P.O. Box 4373 • Houston, TX 77210-4373 • Fax #: 713-831-3028

The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy it may issue. No other company shown is responsible for such obligations or payments.

Policy Number(s) 12345

SECTION I – GENERAL INFORMATION:

A. PRIMARY INSURED

First Name John MI 7 Last Name Doe Social Security # 123456789

Sex M F Birthplace (state, country) Anytown, USA Date of Birth 12/28/1975

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)

CHECK HERE IF NEW ADDRESS

Address 123 Line Street City, State Anytown, USA Zip 56789

Home Phone 555-555-1222 Alternate Phone 555-555-8858 Email john@adl.com

Employer Anytown USA Bank Occupation Loan Officer

Personal Earned Income \$ 65,000 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.

B. OTHER INSURED Complete if spouse or additional insured covered under the policy

First Name _____ MI _____ Last Name _____ Social Security # _____

Sex M F Birthplace (state, country) _____ Date of Birth _____

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 _____ City, State _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

Employer _____ Occupation _____

Personal Earned Income \$ _____ Net Worth \$ _____

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.

C. CHILD INFORMATION Complete information for all children covered by child rider

| Child Name | Sex | Date of Birth |
|------------|---|---------------|
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |
| _____ | <input type="checkbox"/> M <input type="checkbox"/> F | _____ |

D. OWNER INFORMATION Complete if the primary insured is not the owner

First Name _____ MI _____ Last Name _____ Tax ID # _____

CHECK HERE IF NEW ADDRESS

Address _____ City, State _____ Zip _____

Home Phone _____ Alternate Phone _____ Email _____

If owner is a trust please designate information for the Name, Tax ID, Current Trustee and Date of Trust in the Special Remarks section.

E. PREMIUM PAYMENT ENCLOSED

yes no Amount \$ \$500 Check # 2356

SECTION II:

A. BACKGROUND INFORMATION – For all covered persons

Complete questions 1 through 12 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details. You may be asked to complete and submit an additional form.

- 1. Tobacco Use: Have you ever used any form of tobacco or nicotine products? yes no
 If yes, type and quantity _____ Are you a current user? yes no
 If not a current user, date of last use _____
- 2. Have you ever used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? yes no
- 3. Have you ever sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? yes no
- 4. Driver's License State: USA Number: 855-12324-02
 In the past five years, have you been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? yes no
- 5. In the past five years, have you participated in, or do you 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
- 6. Do you intend to travel or reside outside of the United States or Canada within the next two years? yes no
- 7. Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability? yes no
- 8. Have you ever filed for bankruptcy? yes no
- 9. Have you 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
- 10. 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
- 11. 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
- 12. 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

Details: _____

B. EXISTING COVERAGE

- 1. Does any Proposed Insured have any existing life insurance policies? yes no
- 2. If question 1 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 # |
|--------------------------|------------------|---------------|-------------|-------------------|----------------------|
| _____ | _____ | _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ | _____ | _____ |

Type: i= individual, b= business, g= group

C. MEDICAL INFORMATION

1. **Primary Insured:** Height ____ft ____in Weight ____ lbs Change of weight in last year? None Gain: ____ lbs Loss: ____ lbs
Other Insured: Height ____ft ____in Weight ____ lbs Change of weight in last year? None Gain: ____ lbs Loss: ____ lbs
2. Name and address of personal physician

Primary Insured: _____

Other Insured: _____

3. Date, reason, findings and treatment at last visit

Primary Insured: _____

Other Insured: _____

Complete questions 4 through 8 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details such as date of first diagnosis, name and address of doctor, tests performed, test results, medication(s) or recommended treatment.

4. Have you ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

- a. heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? yes no
- b. a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? yes no
- c. cancer, tumors, masses, cysts or other such abnormalities? yes no
- d. diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? yes no
- e. colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? yes no
- f. a disorder of the kidneys, bladder, prostate or reproductive organs or protein in the urine? yes no
- g. asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? yes no
- h. seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including anxiety, depression or other psychiatric conditions? yes no
- i. arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? yes no

Details: _____

5. Are you currently taking any medication, treatment or therapy or under medical observation? yes no

Details: _____

6. Have you 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

Details: _____

7. Other than previously stated, in the past 10 years have you been advised to have any diagnostic test, hospitalization, or treatment that was NOT completed? yes no

Details: _____

8. Do you have any symptoms or knowledge of any other condition that is NOT disclosed above? yes no

Details: _____

D. SPECIAL REMARKS: Use this space to provide any additional comments or remarks not given in detail above

AUTHORIZATION AND SIGNATURES

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 application, "Company" refers to the insurance company which was selected on page one.

Authorization to Obtain and Disclose Information and Declaration

I give my consent to all of the entities listed below to give to the Company, its legal representative, American General Life Companies LLC ("AGLC") (an affiliated service company), and affiliated insurers all information they have pertaining to: medical consultations, treatments or surgeries; hospital confinements for any physical and 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 or court records, 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 or changes to 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 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 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.

I have read the above statements 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 shall be the basis for reinstatement of my coverage. I understand that any misrepresentation contained in this application and related forms and relied on by Company may be used to reduce or deny a claim or void the policy, if it is within its contestable period and if such misrepresentation materially affects the acceptance of the risk. I understand and agree that no insurance will be in effect under this application unless or until approved for reinstatement, the full reinstatement premium for the policy has been paid, and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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).

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.

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).

Anytown, USA
Signed at (City and State)

3/17/2011
Date

John T. Doe
Signature of Primary Insured (if under age 15, signature of parent or guardian)

Signature of Other Insured (if under age 15, signature of parent or guardian)

Signature of Owner (if other than insured)

Signature of Officer and Title (if corporate owned)

Signature of Trustee (if owned by a trust)

Jack Johnson
Agent Name (printed)

Jack Johnson
Agent Signature

SERFF Tracking Number: AMGN-127361270 State: Arkansas
Filing Company: American General Life Insurance Company State Tracking Number: 49573
Company Tracking Number: AGLC100386-2011 AGL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: In-Force Change & Reinstatement App
Project Name/Number: In-Force Change & Reinstatement App/AGLC100386-2011

Supporting Document Schedules

Item Status:

**Status
Date:**

Satisfied - Item: Flesch Certification

Comments:

Attachment:

AR Flesch Certification AGL.pdf

Item Status:

**Status
Date:**

Bypassed - Item: Application

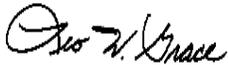
Bypass Reason: Not applicable

Comments:

AMERICAN GENERAL LIFE INSURANCE COMPANY

ARKANSAS FLESCH CERTIFICATION

This is to certify that the attached Form No(s). **AGLC100386-2011 and AGLC100440-2011** (has) achieved Flesch Reading Score of **62.87 and 63.22** 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

August 15, 2011
Date