

SERFF Tracking Number: AMGN-127361272 State: Arkansas  
Filing Company: The United States Life Insurance Company in the State Tracking Number: 49571  
City of New York  
Company Tracking Number: AGLC100386-2011 USL  
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: The United States Life Insurance Company in the City of New York

Product Name: In-Force Change & Reinstatement App SERFF Tr Num: AMGN-127361272 State: Arkansas

TOI: L08 Life - Other

SERFF Status: Closed-Approved-  
Closed State Tr Num: 49571

Sub-TOI: L08.000 Life - Other

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

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

State Status Changed: 08/18/2011

Deemer Date:

Created By: Janice Hooey

Submitted 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: American General Life Insurance Company and American General Life Insurance Company of Delaware. Please

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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:

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](mailto:Nancy.M.Smith@aglife.com).

Sincerely,

Nancy Smith  
Compliance Administrator

## Company and Contact

### Filing Contact Information

Nancy Smith, Manager	<a href="mailto:nancy.m.smith@aglife.com">nancy.m.smith@aglife.com</a>
2929 Allen Parkway	713-831-3194 [Phone]

SERFF Tracking Number: AMGN-127361272 State: Arkansas  
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Mail Stop A38-40 713-342-7550 [FAX]  
 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]

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**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$100.00  
 Retaliatory? No  
 Fee Explanation: \$50.00 per form x 2 forms = \$100.00  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$100.00	08/16/2011	50674058

SERFF Tracking Number: AMGN-127361272 State: Arkansas  
Filing Company: The United States Life Insurance Company in the State Tracking Number: 49571  
City of New York  
Company Tracking Number: AGLC100386-2011 USL  
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-127361272 State: Arkansas  
Filing Company: The United States Life Insurance Company in the State Tracking Number: 49571  
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TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other  
Product Name: In-Force Change & Reinstatement App  
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## Disposition

Disposition Date: 08/18/2011

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: AMGN-127361272 State: Arkansas  
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 City of New York  
 Company Tracking Number: AGLC100386-2011 USL  
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Yes	Yes
Supporting Document	Application	No	No
Form	In-Force Change Application	Yes	Yes
Form	Reinstatement Application for Life Insurance	Yes	Yes

SERFF Tracking Number: AMGN-127361272 State: Arkansas  
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 49571  
 City of New York  
 Company Tracking Number: AGLC100386-2011 USL  
 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/In-Force Change Enrollment Form	Initial		62.870	AGLC100386-2011.pdf
	AGLC100440-2011	Application/Reinstatement Enrollment Form 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-127361272 State: Arkansas  
Filing Company: The United States Life Insurance Company in the State Tracking Number: 49571  
City of New York  
Company Tracking Number: AGLC100386-2011 USL  
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 USL.pdf

**Item Status:** **Status**  
**Date:**

**Bypassed - Item:** Application

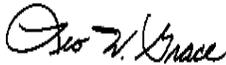
**Bypass Reason:** Not applicable

**Comments:**

**UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK**

**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.



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Leo W. Grace, FLMI  
Vice President

August 15, 2011  
Date