

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)
Subsidiaries of American International Group, Inc.
P.O. Box 4373 • Houston, TX 77210-4373

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 attached Notice of Information Practices and keep with your policy.

Policy Number _____ **Insured Name** _____

Reinstatement or **Reduction of Premium Rate**

SECTION I – GENERAL INFORMATION:

A. PRIMARY INSURED

Name _____ Social Security # _____ Sex M F
Birthplace (state, country) _____ Date of Birth _____ Age _____
U.S. citizen Yes No If no, date of entry _____ Visa Type _____
Address _____ City, State _____ Zip _____
Home Phone _____ Work Phone _____
Email address _____
Employer _____ Occupation _____
Length of Employment _____ Duties _____
Personal Income \$ _____ Household Income \$ _____ Net Worth \$ _____

B. OWNER INFORMATION

Primary Insured Other Insured Trust Someone other than an insured or trust
Complete if other than the primary insured is owner (If contingent owner is required, use Special Remarks section.)
Name _____ Tax ID # _____

Check here if new address

Address _____ City, State _____ Zip _____
Home Phone _____ Work Phone _____
If owner is a trust please designate information for the Name, Tax ID, Current Trustee and Date of Trust in the Special Remarks section.

C. OTHER INSURED(S): Please add information for all additional insureds.

Name _____ Social Security # _____ Sex M F
Birthplace (state, country) _____ Date of Birth _____ Age _____
U.S. citizen Yes No If no, date of entry _____ Visa Type _____
Address _____ City, State _____ Zip _____
Home Phone _____ Work Phone _____
Email address _____
Employer _____ Occupation _____
Length of Employment _____ Duties _____
Personal Income \$ _____ Household Income \$ _____ Net Worth \$ _____

D. CHILD INFORMATION (Complete information for all children covered by child rider.)

Child Name	Sex	Birthplace (state, country)	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	_____	_____

E. BILLING

Frequency: Annual Semi Annual Quarterly Monthly Other
Method: Direct List bill Automatic bank draft Other _____
Payment Enclosed: Yes No Amount _____ Check # _____
Effective date (if applicable): _____

Secondary addressee

Name _____ Social Security # _____ Home Phone _____
Address _____ City, State _____ Zip _____

F. BENEFICIARY – The beneficiary at the time the policy was last in force will be continued or reinstated. To change the beneficiary please attach your signed request.

SECTION II:

A. BACKGROUND INFORMATION – For all covered persons

Complete questions 1 through 7 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details.

1. Tobacco Use: Have you ever used ANY form of tobacco or nicotine products? Yes No
If yes, date of last use _____
If yes, *type* and *quantity* of tobacco or nicotine products used _____
2. Have you ever used cocaine, marijuana, heroin or controlled substances, 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 No.: _____ State: _____
In the past five years, have you been convicted of driving under the influence of alcohol or drugs or had any driving violations? Yes No
5. In the past five years, have you participated in or within the next 12 months do you intend to participate in any flights as a trainee, pilot or crew member? If yes, submit appropriate questionnaire. Yes No
6. In the past five years, have you participated in or within the next 12 months do you intend to participate in: scuba diving, skydiving, parachuting, ultralight aviation, auto racing, cave exploration, hang gliding, boat racing or mountaineering? Yes No
If yes, submit appropriate questionnaire.
7. Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability? Yes No

Details: _____

B. NON MEDICAL INFORMATION

1. Height ____Ft. ____In. 2. Weight ____ lbs. Change of weight in last year? None Gain: ____ lbs. Loss: ____ lbs.
3. Name and address of your personal physician. (Write *none* if you do not have one.)

4. Date, reason, findings and treatment at last visit. _____

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**

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 (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; 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, 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; 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 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 of the Notice of Information Practices.

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).

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

Special Circumstances- Corporate Ownership: The signature of one officer followed by the officer's title is required. The request must be submitted on: (1) corporate letterhead; (2) or paper with the corporate seal signed by that officer. Partnership: Provide the full name of the partnership followed by the signatures of all partner(s), other than the Insured. Trust: If the contract is owned by or assigned to a Trustee, Trustee(s) signature are required as instructed by the trust agreement. Validation of Trustee(s) signature may be required.

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

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 #**

NOTICE OF INFORMATION PRACTICES**American General Life Insurance Company, Houston, TX****The United States Life Insurance Company in the City of New York, New York, NY**

You have applied for life insurance with one of the insurance companies identified above. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies (AGLC), (a company providing services to affiliated life insurance companies that are members of American International Group Inc.)

Fair Credit Reporting Act

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living. This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P. O. Box 1931

Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

Medical Information Bureau

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

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

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

Insurance Information Practices

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization, as permitted or required by law. You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding. Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information. If you desire additional information on insurance information practices, you should direct your requests to the Company at:

P. O. Box 1931

Houston, TX 77251-1931

Telephone Interview Information

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

*** PLEASE READ AND KEEP WITH YOUR POLICY***

**HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information**

Name of Patient/Proposed Insured (Please Print)

_____/_____/_____
Date of Birth

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service company), (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life Companies company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

Description of Authority of Personal Representative
(if applicable)