AIG

AIG Benefit Solutions

Underwritten by
American General Life Insurance Company*
Houston, Texas
The United States Life Insurance Company In the City of New York
New York, New York
National Union Fire Insurance Company of Pittsburgh, Pa
New York, New York
*This company does not solicit business in New York

Application to Reinstate Group Insurance

Administrative Office: Client Services P. O. Box 15250, Amarillo, TX 79105-5250
Phone: 1-877-672-1648 Fax: 713-521-6047

Application for Reinstatement applies only if your group policy was terminated due to non-payment of premium.

NOTE: American General Life Insurance Company will only review this application IF THE EMPLOYER:

1. Completes all the information requested below, and
2. Remits a premium payment equal to the amount which:

☐ Was due on the date insurance ended, PLUS
☐ Would have been due from the date insurance ended to the date this application is signed.

Please print or type all information requested.

EMPLOYER DATA

1. Name of Employer: _____

2. Group Policy No.: _____ 3. Amount Remitted: $ _____

CLAIMS DATA

4. Since the date insurance ended, has any eligible person:

	YES	NO		YES	NO
a. become disabled?	☐	☐	b. incurred dental/vision expenses?	☐	☐
c. been hospitalized or died?	☐	☐	d. incurred medical expenses?	☐	☐

If "yes" to any part of this question, give details below (included names, dates and causes): _____

_____

_____

EMPLOYEE ELIGIBILITY

A FULL TIME EMPLOYEE IS ONE WHO: ☐ Works at least 30* hours per week ☐ Works your regular work schedule, and ☐ Performs his job for full pay ☐ Works at your place of business

5. How many full-time employees do you have? _____
6. How many full-time employees are eligible for coverage? _____
7. What class(es) of employees are excluded from coverage? _____
8. For which coverage(s) do the employees pay part of the cost?

	YES	NO		YES	NO
Life	☐	☐	Employee Health	☐	☐
Disability	☐	☐	Dependent Health	☐	☐

*Amount of hours may vary by state law or employee's administrative practice.

EMPLOYER'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers in this application are true.
2. I understand that if American General Life Insurance Company accepts this application, the group's insurance will be reinstated on the date in writing by American General Life Insurance Company.
3. I understand that reinstatement, if approved, applies only to coverages that are insured and administered by American General Life Insurance Company. Requests to reinstate coverages that are insured and administered by another insurance company, if applicable, should be directed to that carrier.

_____ _____
Date Print Name of Officer, Partner or Proprietor

_____ _____
Witness Signature of Officer, Partner or Proprietor