Application for Group Insurance Programs

American General Life Insurance Company*
Houston, Texas
Administrative Office: 3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588, Neptune, NJ 07754-1588

*This company does not solicit business in New York

These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential in accordance with Vermont laws and regulations. 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, MA 02184-8734.

The Company, or its reinsurers, may also release information from 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.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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☐ Change in Family Status ☐ New Coverage ☐ Increasing Coverage ☐ Decreasing Coverage

Please print or type all information requested.

Please complete all sections of the application to avoid delays.

Group Policy Number _____ **Division** _____

Employee's annual salary $_____ **Hire Date**_____

Job Title_____

Actively at Work ___**Yes** ___**No**

1. Name of Employer/Association/Union _____

2. Employee's/Member's full name _____
FIRST *MIDDLE* *LAST*

3. Home Address _____
NUMBER *STREET* *CITY* *STATE* *ZIP* *HOME TELEPHONE NUMBER*

Email Address _____

4. Select coverages with specific amounts for Life, AD&D, LTD, STD and Critical Illness. If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter. * If you had prior Dental coverage with the employer named above, please indicate by checking box and including your prior effective date.

****Wherever the term spouse appears can also read as domestic partner (DP) or party to a civil union throughout the application.**

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
Employee	$ _____ ☐ refused	$ _____ ☐ refused	$ _____ ☐ refused	$ _____ ☐ refused	☐ Prior Coverage * Date / /	☐ refused
Spouse**	$ _____ ☐ refused	$ _____ ☐ refused	(not to exceed maximum benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	☐ refused ☐ Employee ☐ Employee & Spouse** ☐ Employee & Child ☐ Full Family	☐ Employee ☐ Employee & Spouse** ☐ Employee & Child ☐ Full Family
Child(ren):	$ _____ ☐ refused	/ / / / / /				

Hospital Indemnity	Accident	Cancer	Critical Illness Amount
☐ Employee ☐ Employee & Spouse ☐ Employee & Child ☐ Full Family ☐ refused	☐ Employee ☐ Employee & Spouse ☐ Employee & Child ☐ Full Family ☐ refused	☐ Employee ☐ Employee & Spouse ☐ Employee & Child ☐ Full Family ☐ refused	Employee $_____ ☐ refused Spouse $_____ ☐ refused

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4 (a) Do you have any disability insurance in force or pending (including group coverage)? ☐ Yes ☐ No
If YES, please indicate companies and amounts _____

4 (b) Will this coverage applied for, replace any insurance in force now? ☐ Yes ☐ No
If YES, please indicate companies and amounts _____

5. Complete the following for employee/member, spouse/domestic partner/party to a civil union and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security #
EE						ft. in.	lbs.	
SP**						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

If you are eligible for Guaranteed Issue do not complete questions 6, 7, 8 and 9 unless you are applying for more than your group's Guaranteed Issue.

Complete questions 6, 7, 8, and 9 if applying for Life or Disability Coverage.	EMPLOYEE/ MEMBER	SPOUSE**	CHILD
6. Has a licensed physician ever diagnosed you with or treated you for: any disease or disorder of the heart, kidneys, liver; lungs or blood; chest pain; stroke or other neurological disorder; cancer or tumor; diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency; arthritis or other musculoskeletal disease or disorder; or been diagnosed as having or treated by a licensed physician for AIDS (Acquired Immune Deficiency Syndrome); AIDS related complex, or other immune disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution for any reason other than stated above?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
8. Are you presently taking any medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
9. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury? **J**	☐ Yes ☐ No	☐ Yes ☐ No	

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Complete questions 10, 11, 12, and 13 if applying for Accident, Cancer, Critical Illness or Hospital Indemnity Coverage	EMPLOYEE/ MEMBER	SPOUSE**
[10.] Has a licensed physician ever diagnosed any Proposed Insured as having or treated any Proposed Insured for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or for the Human Immunodeficiency Virus (HIV)?	☐Yes ☐ No	☐Yes ☐ No
[11.] In the last 5 years, has any Proposed Insured been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's disease, or non-Hodgkin's lymphoma?	☐Yes ☐ No	☐Yes ☐ No
12. In the past 90 days immediately prior to the date of this application, has any Proposed Insured been physically incapable of working, or incapable of performing normal daily activity excluding pregnancy for more than three 3 consecutive days?	☐Yes ☐ No	☐Yes ☐ No
13. In the last 12 months has any Proposed Insured used any form of tobacco or nicotine product, including a nicotine patch?	☐Yes ☐ No	☐Yes ☐ No
Complete questions 14 and 15 if applying for Critical Illness or Hospital Indemnity Coverage		
14. In the last 5 years, has any Proposed Insured: a. sought or received counseling or treatment by a medical professional for any alcohol and/or drug addictions and/or substance abuse, including abuse of drugs prescribed by a physician? b. used cocaine, marijuana, heroin, controlled substance, or a drug requiring a prescription that was not legally prescribed by a physician? c. been diagnosed as having or been treated for, or consulted a licensed health care provider for disease or disorder of the nervous system (seizure, disorder of the brain or spinal cord or any other nervous system disorder), paralysis; stroke, or transient ischemic attack (TIA); diabetes, disease or disorder of the lung, liver, heart, or blood vessels, heart attack, or uncontrolled high blood pressure, kidney failure, polycystic kidneys or abnormal kidney function, familial adenomatous polyposis Gardener's syndrome or multiple sclerosis? d. had an organ transplant or been advised of the need of an organ transplant?	☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No	☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No ☐Yes ☐ No
15. Does any Proposed Insured have a loss of hearing, requiring the use of a hearing aid or cochlear implant; or a history of glaucoma, optic neuritis or macular degeneration?	☐Yes ☐ No	☐Yes ☐ No

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If "yes" to any part of questions 6 through 15, give details on the following page (not required for child(ren) if employee or spouse is also applying). Use a separate sheet of paper if more space is needed for answers:**

SIGNATURE IS REQUIRED BELOW

Question No.	Does Question Apply to Employee, Spouse** or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

	EMPLOYEE/MEMBER	SPOUSE**
16. Have you used tobacco in any form during the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

If this question is not completed, you will be billed using smoker rates.

AUTHORIZATION

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my health, to give to American General Life Insurance Company of Delaware or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes, information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except MIB, Inc. to give such records or knowledge to any agency employed by American General Life Insurance Company of Delaware to collect and transmit such information. 2. I understand that this information will be used by American General Life Insurance Company of Delaware solely to determine eligibility for insurance. 3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which American General Life Insurance Company of Delaware has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months, if not revoked earlier. 4. I know that I should retain a copy of this authorization for my records. 5. I agree that a photocopy of this authorization is as valid as the original. 6. To the best of my knowledge and belief, all statements made above are true and complete. All statements are representations and not warranties. 7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application. 8. I authorize deductions from earnings for the costs of this insurance. 9. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.

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NOTE: This authorization includes the results of my HIV-related test results to the Company's reinsurers, or to those contractually retained medical personnel, laboratories, insurance support organizations and insurance affiliates, (but not agents or brokers) that are involved in underwriting decisions regarding my application. I understand that if my test result is positive or indeterminate, then the Company may report a code to the MIB provided that a nonspecific test result code is used which does not indicate that I was subjected to HIV-related testing.

THIS AUTHORIZATION EXCLUDES the release of any information relating to previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC by the proposed insured's/applicant's family physician, regular physician, medical practitioner, care giver, or any other person or entity which may possess such information. The proposed insured/applicant is also **NOT AUTHORIZING** the company to forward the results of any new HIV test requested by the company in connection with this application to any outside person, company or entity other than direct affiliates of the company or entities under specific contract with the company to perform underwriting services in connection with this application.

_____ ➢ _____
(DATE SIGNED) *(SIGNATURE OF EMPLOYEE/MEMBER)*

_____ ➢ _____
(DATE SIGNED) *(SIGNATURE OF SPOUSE**, IF APPLYING FOR INSURANCE)*

➢ Witness to above Signature(s): _____

BENEFICIARY DESIGNATION
Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse** and children insurance applied for, and the spouse** named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse** or children and no one is named below, proceeds will be payable to the estate of the insured:

Beneficiary of Employee
and Relationship _____

Beneficiary of Spouse**
and Relationship _____

For Administrative Use Only (if Agent is involved)

_____ _____
Agent Name **License Number**

_____
Agent Signature

IMPORTANT NOTICE – For Hospital Indemnity Plan Applicants

The American General Life Insurance Company ("AGL") believes that the Hospital Indemnity Plan that you are applying for qualifies as a supplemental excepted benefit under the Affordable Care Act ("ACA"), provided that you also maintain major medical or other required minimum essential coverage. It does not qualify as an excepted benefit if you do not maintain major medical or other minimum essential coverage. Therefore, AGL is providing you with this important Disclosure Statement about the Hospital Indemnity Plan.

THE HOSPITAL INDEMNITY POLICY AND THE ASSOCIATED CERTIFICATES ARE SUPPLEMENTAL TO HEALTH INSURANCE AND ARE NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENT OF MINIMUM ESSENTIAL COVERAGE.

_____ _____

Applicant's Signature Date