Accident Expense Plus[SM]
Producer Application Instructions - Georgia

Follow the checklist and instructions below to ensure that all application forms are properly completed and transmitted. All state required disclosure information must be presented to your client at the time of application.

GEORGIA FORMS CHECKLIST

	REQUIRED FORMS		
✓	**Form Name**	**Form Number**	**Action**
✓	Application	AGLC102438-GA	Complete the application information. Obtain applicant signatures on page 3. Sign the application verifying the information is correct.
✓	Bank Draft Authorization	AGLC102113	The Bank Draft Authorization must be completed, signed by the applicant and submitted with the application.
✓	Notice to Proposed Insured	AGLC102339-2006	Leave with applicant.
✓	Outline of Coverage	07120-OLC-11	Complete Benefits Schedule information on page 1. Check Critical Illness Rider on page 4 if applying for the CI Rider. Complete the Premiums section on page 5. Present to applicant at time of application.
✓	HIPAA Privacy Notice	AGLC100605	Leave with applicant.
	SUPPLEMENTAL FORMS		
	Credit Card Authorization	AGLC106248	If applicant would prefer to make recurring payments with a credit card complete the form and submit with application.
	Shopper' s Guide to Cancer Insurance	AGLC101866	If applying for the Critical Illness Rider, present this guide to the applicant at time of application.
	Acknowledgement of Receipt of Cancer Insurance Shopper's Guide	AGLC101775	If Shopper's Guide to Cancer Insurance is presented to applicant, have them sign this acknowledgement and submit with application.
	Policy Delivery Receipt	AGLC101336	This form is only required by LA, PA, SD, and WV. However, it is a good business practice to have the policyholder sign that they have received their policy when you deliver it to them.

7705691197 NancyCockerham30005@2

American General
Life Companies

Application for Accident and Health Insurance
Georgia Version

American General Life Insurance Company
A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

"Proposed Insured" refers to primary, spouse, and children proposed for coverage in this application.

1. Primary Proposed Insured
Cockerham (Last) Nancy (First) (Middle)

2. Address
242 Churchill Heights (Street)
Alpharetta (City) GA (State) 30005 (Zip Code)

3. Social Security No.
254-96-8281

4. Birth Date and Place
Month: 6 | Day: 20 | Year: 1955 | State: Georgia | Country:

5. Age 60

6. Sex ❑ M ☒ F

7. U.S. Citizen ☒ Yes ❑ No
If no, date of entry _____ visa type _____

8. Spouse (if coverage applied for) Sex ❑ M ❑ F
Name _____ (Last) (First) (Middle)
Month | Day | Year | State | Country
Birth Date and Place | Social Security No. | Age

9. Primary Proposed Insured Height 6.1 Weight 155

10. Spouse Height _____ Weight _____

11. Beneficiary
Name Estate (Last) Estate (First) (Middle)
Social Security No. | 01/01/2011 (Date of Birth) | Estate (Relationship)

12. Primary Proposed Insured Driver's License
100000001 State of Issue GA

13. List Dependent(s) Information:

Full Name	Age	Relationship	Birth Date Mo. Day Yr.	Sex M	Sex F
a.				❑	❑
b.				❑	❑
c.				❑	❑
d.				❑	❑
e.				❑	❑

Insurance Plan

❑ **Accident**

Coverage Level
☒ Primary Proposed Insured
❑ Primary Proposed Insured/Spouse
❑ Family
❑ Primary Proposed Insured/Children

Deductible Amount: $ 500.00

Benefit Payable per Calender Year, per Insured: $ 15,000.00

❑ **Critical Illness Benefit Rider**

Coverage Level
❑ Primary Proposed Insured
❑ Primary Proposed Insured/Spouse
❑ Family
❑ Primary Proposed Insured/Children

Benefit Payable per Lifetime, per Insured:
Primary Proposed Insured $ _____
Spouse $ _____
Children $ _____

Questions 14-17 are only applicable if applying for the Critical Illness Benefit Rider.

14. Additional Information – In the past 1 year, had any Proposed Insured used tobacco (cigarette, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? ❑Yes ❑No

For a "Yes" answer, please indicate Primary Proposed Insured and/or Spouse. ❑Primary Proposed Insured ❑Spouse

Health Questions	Yes	No
15. Within the past 10 years has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑	❑
16. 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?	❑	❑
17. In the last 5 years, has any Proposed Insured been diagnosed as having or been treated for or consulted a licensed health care provider for:		
a. Stroke or transient ischemic attack (TIA)?	❑	❑
b. Diabetes?	❑	❑
c. Disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	❑	❑
d. Kidney failure or abnormal kidney function?	❑	❑
e. An organ transplant or been advised of the need of an organ transplant?	❑	❑

Health History—Details For Any "Yes" Answers

Question #	Name of Proposed Insured	Relationship: Primary Proposed Insured	Relationship: Spouse	Relationship: Child	Description
		☐	☐	☐	
		☐	☐	☐	
		☐	☐	☐	

All Coverage—Existing or Pending Insurance Question

Does any Proposed Insured have any existing or pending accident or sickness insurance?
(If yes, complete section following)

Name of Proposed Insured	Company Name	Type*	Face Amount	Replace** Yes	Replace** No
				❑	❑
				❑	❑
				❑	❑

* Type A = accident, CI = critical illness, or O = other

** Replace means that the insurance policy being applied for replaces any accident and sickness policy pending or presently in force including health, accident, critical illness, disability or cancer insurance. If replacement may be involved, complete and submit any state-required replacement forms.

Modal Premiums

Frequency of modal premium: ❑Annual ❑Semi-annual ❑Quarterly ☒Monthly (Bank Draft only)

Method: ❑Direct Billing ☒Bank Draft (Complete Bank Draft Authorization.) ❑List Bill: Number _____

❑Credit Card – Initial Premium Only (Complete Credit Card Authorization.)

Accident	Critical Illness Benefit Rider	Total Modal Premium
$ 22.94	$	$ 22.94

AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT – UNDERSTANDING

between Proposed Insured ("You or Your") and the Company and its affiliates ("We" or "Us")

Agreement.

Your insurance will not begin until: (a) We have issued Your policy and (b) received Your first premium in full. You must pay your first premium in full within 45 days of the date Your policy is issued. Even if You pay Your premium in advance, there will be no coverage until the day Your policy is issued. If Your policy is not issued for any reason, We will (a) refund Your premium, and (b) have no liability regarding this application.

The policy You are applying for is NOT major medical insurance. It is a limited benefit policy. This means that it pays benefits only as defined in the policy. Benefits payable are subject to the conditions, limits, reductions and exclusions in the policy.

All statements and answers are complete and true to the best of Your knowledge and belief. No agent can: (a) waive any answer, (b) modify this application, (c) bind Us or (d) make any promise or representation not contained in this application.

Authorization.

By signing the application, You authorize Us to release the information obtained in the application in these circumstances only: (a) to reinsurers or other persons or entities performing business or legal services in connection with this application or claims, (b) as may be lawfully required, or (c) as You may further authorize.

A photocopy is as valid as an original. This Authorization will be valid for 24 months of the date signed below.

You or Your representative may request a copy. You also may revoke this Authorization at any time by written notification to Us at our Home Office.

Acknowledgement.

By signing this application, you acknowledge receipt of the Outline of Coverage, Notice to the Primary Proposed Insured and the HIPAA Privacy Notice. If you are completing this application using voice signature, you acknowledge that you already have a copy of the Outline of Coverage and the HIPAA Privacy Notice, and that Notices to the Primary Proposed Insured have either been read to you or provided to you.

Understanding.

If You are receiving Medicaid payments, benefits under the policy may reduce those payments or any Medicaid benefits otherwise payable.

Anyone 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; (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).

Signed at Alpharetta (City) GA (State) 4/15/2016 (Date)

X usersign Nancy Cockerham
Signature of Primary Proposed Insured

X ownersign
Signature of Owner (if other than Primary Proposed Insured)

Information Sharing (Optional)

By signing below, You further authorize Us to use and/or share the demographic information in this application to provide You with information about other products and/or service offered by Us.

X _____
Signature of Primary Proposed Insured

Agent Section.

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge concerning any Proposed Insured. I also have provided the required Outlines of Coverage and the HIPAA Privacy Notice.

X Agent Sign: Sean McCloskey Powered By RZD Inc. _____

Sean McCloskey
Printed Name of Agent

4U46A
Agent Number

ACCIDENT COVERAGE OUTLINE OF COVERAGE
Policy Form 07120-11

Read Your Policy Carefully

This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

ACCIDENT ONLY COVERAGE

Accident only coverage is designed to provide Insured Persons with coverage for certain losses resulting from a covered accident ONLY, subject to any exclusions contained in the policy. Coverage is not provided for any loss due to sickness. Coverage is not provided for basic hospital, basic medical surgical or major medical expenses.

BENEFITS SCHEDULE

Maximum Amount per Insured, per Calendar Year $15,000.00

Deductible Amount $500.00

BENEFITS

When We receive due written proof that expenses incurred due to an Accident satisfy the Deductible Amount, as shown in the Benefit Schedule, We will pay for the following listed benefits, less any adjustment or discounts, up to the Maximum Amount, per Insured, per Calendar Year as shown in the Benefit Schedule.

ACCIDENTAL EMERGENCY CARE BENEFIT
(Within 72 hours following Accidental Injury)

ACCIDENT FOLLOW UP CARE BENEFIT
Follow up treatments must occur within 30 Days of the Accidental Injury or discharge from the hospital, and must be furnished by a Physician in a Physician's Office or in a Hospital on an outpatient basis. Benefit will not be payable for the same visit that the Physical Therapy Benefit is payable or on the same day for which the Accidental Emergency Care Benefit is payable.

AMBULANCE BENEFIT
(Benefit only payable if Accidental Emergency Treatment Benefit is payable.)

DRUG BENEFIT
(Benefits for drugs administered in a Hospital or Urgent Care Center)

FRACTURE BENEFIT
Diagnosis of the Fracture must be within 14 Days of the Accidental Injury.

MAJOR DIAGNOSTIC EXAMINATIONS
Benefit is limited to one Major Diagnostic Exam per Year for each Insured Person.

Major Diagnostic Exams are limited to the following: CT (computerized tomography) scan, MRI (magnetic resonance imaging) and EEG (electroencephalogram).

PHYSICAL THERAPY BENEFIT
Physical Therapy must begin within 30 days of the Accidental Injury or discharge from the Hospital and must be completed within six months after the Accidental Injury. Benefit is limited to one Physical Therapy treatment per day, up to a maximum of ten treatments for each Accidental Injury.

PROSTHESIS BENEFIT
Benefit limited to a maximum of one Prosthetic Device received within one year of the Accidental Injury.

X-RAY BENEFIT
The x-ray or set of x-rays must be performed within 14 days of the Accidental Injury.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for an Accident is subject to the following conditions:

(a) The Accidental Injury and Care occurs while the coverage on an Insured Person is effective under the policy;
(b) The initial Care must begin within 72 hours of the Accidental Injury;
(c) The benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any condition precedent stated in the policy; and
(d) Care for the Accidental Injury is received within the United States.

We reserve the right to request that a Physician of our choice review any Diagnosis in the event of a dispute or disagreement regarding the appropriateness or correctness of a Diagnosis. We also reserve the right to require that an Insured Person submit to an examination to confirm a disputed Accidental Injury. We reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed Diagnosis. We will pay for any such requested examination or review.

EXCLUSIONS

For any Insured Person:

(a) We will pay NO benefits under the policy if covered services provided are not related to a covered Accident.
(b) We will pay NO benefits for any Accident or any loss caused in whole or in part by, or resulting in whole or in part from the following:
  i) the Insured Person's suicide or attempt at suicide, or intentional self-inflicted injury or sickness, or any attempt at intentional self-inflicted injury or sickness while sane or insane;
  ii) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic; or any other drug or intoxicant including those prescribed by a Physician that are misused by the Insured Person;
  iii) the Insured Person's commission of or attempt to commit an assault or felony;
  iv) the Insured Person engaging in an illegal activity or occupation;
  v) the Insured Person's voluntary participation in any riot or civil insurrection;
  vi) declared or undeclared war, or any act of declared or undeclared war;
  vii) the Insured Person's operating, learning to operate, serving as a crew member of, or jumping, parachuting, or falling from an aircraft or hot air balloon, including those which are not motor driven;
  viii) the Insured Person's engaging in hang gliding, bungee jumping, parachuting, sailgliding, parasailing or parakiting or any similar activity;
  ix) the Insured Person's riding in or driving any motor driven vehicle in a race, stunt show or speed test;
  x) the Insured Person practicing for or participating in any semi-professional or professional competitive athletic contest for which such Insured Person receives any compensation or remuneration;
  xi) the Insured Person's operating any type of land, water, or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the Accidental Injury occurred; and
  xii) any illness, loss, or condition specifically excluded from the definition of any Accident.

DEFINITIONS

ACCIDENT means the unforeseen occurrence of an event, which results in Accidental Injury to an Insured Person wholly independent of disease, bodily infirmity, illness, infection or any other physical condition.

ACCIDENTAL INJURY means bodily injury to an Insured Person as the result of an Accident, after coverage under the Policy takes effect and while the Policy is in force, which results in Care within 72 hours after the injury is sustained.

AMBULANCE means a specially equipped vehicle, licensed and used to transport the sick or injured.

CALENDAR YEAR means the period from January 1st to December 31st.

CARE means medical treatment or attention received in an Emergency Room, Hospital, Urgent Care Center, or Physician's office. Such Care must be within 72 hours of the Accidental Injury. Care does not include any psychiatric treatment.

DEDUCTIBLE AMOUNT means the dollar amount shown in the Benefit Schedule above which must be incurred under the policy by an Insured Person each Calendar Year before benefits are payable under the policy. If the Insured elects to cover a spouse and/or child(ren), the Deductible Amount will be satisfied when the total of all dollar amounts incurred by the family unit are equal to two (2) times the Deductible Amount.

DIAGNOSIS/DIAGNOSED means a definitive Diagnosis made by a Physician, licensed and practicing in the United States and its territories and, where applicable, specializing in a particular field of medicine, which:

(a) is based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the Insured Person's medical records; and
(b) meets all diagnostic requirements stated in the policy for the particular Accident being Diagnosed.

EMERGENCY ROOM means a specified area within a Hospital that is designated for the emergency Care of accidental injuries. This area must:

(a) be staffed and equipped to handle trauma;
(b) be supervised and provide Care by a Physician; and
(c) provide Care seven days per week, 24 hours per day.

HOSPITAL means an institution that:

(a) is operated pursuant to law and is licensed as a Hospital by the responsible state agency;
(b) is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of duly licensed Physicians, medical, diagnostic and major surgical facilities for the Care of sick or injured persons on an inpatient basis for which a charge is made; and
(c) provides 24-hour nursing service by or under the supervision of registered graduate professional nurses (RNs).

It does NOT mean or include:

(a) convalescent, assisted living, extended care, hospice, rest or nursing facilities; or
(b) facilities primarily affording custodial, educational or rehabilitative care; or facilities primarily for the aged or for substance abusers; or
(c) a private monitored room.

INSURED means the person named as "Insured" in the Policy Data (or the Insured Spouse, if one is indicated as an "Insured Person" in the Policy Data and such Insured Spouse becomes the Insured upon the death of the person named as "Insured" in the Policy Data).

INSURED PERSON means all persons who are indicated as an "Insured Person" in the Policy Data as being covered by the policy.

PHYSICIAN means a person who:

(a) is a legally qualified-practitioner of the healing arts and is licensed in the United States or its territories;
(b) practices within the scope of his or her license;
(c) is not the Insured Person;
(d) is not related to the Insured Person as a spouse, parent, child or sibling; and
(e) does not customarily reside in the same household as the Insured Person.

PHYSICAL THERAPY means a branch of rehabilitative health care that uses specially designed exercises and equipment to help patients regain or improve their physical abilities.

PROSTHETIC DEVICE means a removable artificial substitute or replacement of a part of the body.

It does NOT mean or include:

(a) dental aids, including false teeth;
(b) eye glasses;
(c) cosmetic prosthesis such as hair wigs;
(d) other types of prosthetic devices that are permanently implanted, such as an artificial hip or tooth;
(e) any experimental prostheses; or
(f) an auditory prosthesis (a device that substitutes for or enhances the ability to hear).

SURGERY means a surgical operation or procedure, especially one involving the repair or removal of an organ or tissue due to an Accidental Injury.

UNITED STATES means the 50 states, plus the District of Columbia, and includes Guam, the U.S. Virgin Islands and Puerto Rico.

URGENT CARE CENTER means a facility operated pursuant to law and licensed by the responsible state agency. Such center is dedicated to the delivery of unscheduled, walk-in care outside of a Hospital Emergency Room. The center must be under the supervision of a duly licensed Physician.

GUARANTEED RENEWABLE TO AGE 65

Your policy may be continued by paying the appropriate premiums when they are due. A Grace Period of 31 days will be granted for each premium payment after the first. The Company retains no right to restrict your benefits after the policy has been issued. The premiums can be changed on a class basis only. Any such change will be based on the Insured's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

TERMINATION DATE

Coverage under the policy for each Insured Person will terminate on the policy anniversary on or next following the date that Insured Person reaches the maximum coverage age. The maximum coverage age for the Insured and Insured Spouse is age 65. The maximum coverage age for an Insured Child is explained in the policy. The policy can be continued for the remaining Insured Person after coverage has been terminated for an Insured Person due to reaching the maximum coverage age.

The policy will terminate:

(a) on the policy anniversary on or next following the date that the last Insured Person reaches their maximum coverage age;
(b) on any premium due date requested by you in writing;
(c) at the end of the Grace Period, if any renewal premium is not paid prior to that time; or
(d) at the end of the month In which the Insured dies.

OPTIONAL RIDER

☐ **CRITICAL ILLNESS BENEFIT RIDER (OPTIONAL)**

If the Critical Illness Benefit Rider is selected, the plan pays for the following Critical Illnesses – Invasive Cancer, Heart Attack and Stroke, subject to the Waiting Period and the Benefit Payable Per Lifetime, Per Insured.

PREMIUMS

Plan: ☐ **Individual** ☐ **Individual & Spouse** ☐ **Parent & Children** ☐ **Family**

Premium Summary

Premiums: Payable Monthly (mode) until age 65:

Primary $ _____

Spouse $ _____

Child $ _____

Total Premium $ _____

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED; THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

American General
Life Companies

American General Life Insurance Company
A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

The underwriting risks, financial obligations and support functions associated with the products issued by American General Life Insurance Company are solely its responsibility. American General Life Insurance Company is responsible for its own financial condition and contractual obligations.

BANK DRAFT AUTHORIZATION

☑ **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**

The company checked above ("Company") will withdraw the premiums from the specified account. "You", "your", "I", and "me" refer to the bank account Owner whose name appears below.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Automatic Bank Draft Agreement

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason.

This must be dated and signed by the bank account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name: Suntrust Bank

Financial Institution Address: 4105 Old Milton Pkwy City, State: Alpharetta, GA ZIP: 30005

Routing Number: ⑆ 0 6 1 0 0 0 1 0 4 ⑆

Account Number: 8 8 1 0 4 0 9 9 4 9 ⑈

Type of Account: ☒ Checking ☐ Savings Credit Union: ☐ yes ☒ no

Name of Primary Proposed Insured: Nancy Cockerham Premium Amount $: 22.94

Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Monthly

Preferred Withdrawal Date (1st-28th) _____ **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name: Nancy Cockerham

Signature(s) of Bank Account Owner(s) **X** signature: Nancy Cockerham

Please attach voided check or deposit slip.

Additional Payment Information
04/15/2016

American General
Life Companies

Recurring Credit Card Authorization Form

Form to be used for the collection of Recurring Credit Card information on authorized plans.

Please read this authorization carefully and complete all requested items.

Policy Number: YMCE231728

Name of Proposed Insured: Nancy Cockerham

Proposed Policy Owner: Nancy Cockerham

E-mail Address: NancyCockerham30005@24hourmail.net

(Note: A valid e-mail address is necessary in order for us to notify you of your recurring credit card set up, charges, and declines. Without a valid e-mail address, we will not be able to set up your recurring credit card request at this time. Should you not have an e-mail address we will need to ask that you select a different method of payment.)

Cardholder Name (exactly as it appears on the card): _____

Cardholder Billing Address: _____

_____

Credit Card Number: _____ Expiration Date: _____

Card Type: ☐ American Express® ☐ MasterCard® ☐ Visa®

Premium Amount: _____

Payment frequency of ongoing premium payments:

Additional Payment Information

☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

By signing below, I, _____, authorize American General Life Insurance Company or The United States Life Insurance Company in the City of New York (the ''Company'') or its representative to charge my debit/credit card for the amount indicated above on a recurring basis as premiums become due.

I understand and agree that this transaction is subject to the acceptance by, and the terms and conditions of, the credit card company/bank indicated. I also understand this Authorization is not a part of the policy/contract of insurance, and that if premiums are not paid within the applicable grace period, the coverage will lapse. I further understand and agree that the Company shall incur no liability if the bank/credit card company dishonors any amount charged under this Authorization. I also agree that this Authorization may be terminated at any time and for any reason by either myself or the Company upon notice to the other party. Upon termination of this Authorization, the Company will bill me directly for any premium amount due.

I understand that I will be provided with confirmation of the recurring charge amount ; however, the initial charge to my account will include all currently due and past due premiums.

Signature of Authorized Person on Account:

signcredit

X _____ Date: 4/15/2016

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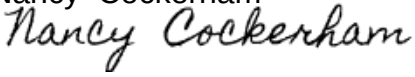
RZD eZign Audit Trail

Document Unique ID: d855e9a0-f7e7-4541-870b-92674f18b169
Document Signed: 4/15/2016 12:29:46 PM
Document Pages: 10
Audit Pages: 3

Document Originator

Agency: E Broker Center Inc.
Agent Name: Sean McCloskey
Agent Email: info@allinsurancecenter.cor
Agent Phone: 888-290-9060
Agent Numbers: 4U46A

Document Signer

Primary Insured: Nancy Cockerham
Signature: 

Signer Location: 97.93.171.178

ELECTRONIC RECORD AND SIGNATURE DISCLOSURE

On occasion, E Broker Center Inc. (we, us or Company) may be required by law to provide to you certain written notices or disclosures. Below the terms and conditions are described for providing to you such notices and disclosures electronically through the RZD, Inc. (RZD eZign) electronic signing system. Read the information below and if you can access this information electronically to your satisfaction and agree to the terms and conditions, please confirm your agreement by clicking the 'I agree' check box on Step 3 of the online enrollment process.

Getting paper copies

You may request from us a paper copy of any record provided or made available electronically to you by us. You will also have the ability to download and print documents we send to you through the RZD eZign system during and immediately after signing session for a limited period of time (usually 7 days) after the applications are first sent to you. After that time, if you wish for us to receive any such documents must be received directly from the carrier.
You may request delivery of such paper copies by contacting your agent directly.

All notices and disclosures will be sent to you electronically

Unless you tell us otherwise in accordance with the procedures described herein, we will provide electronically to you through the RZD eZign system all required notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to you during the course of our relationship with you. To reduce the chance of you inadvertently not receiving any notice or disclosure, we prefer to provide all of the required notices and disclosures to you by the same method and to the same address that you have given us. Thus, you can receive all the disclosures and notices electronically or in paper format through the paper mail delivery system. If you do not agree with this process, please let us know as described below. Please also see the paragraph immediately above that describes the consequences of your electing not to receive delivery of the notices and disclosures electronically from us.

Required hardware and software

Operating Systems: Windows® 2000, Windows® XP, Windows Vista®; Mac OS® X
Browsers: Final release versions of Internet Explorer® 6.0 or above (Windows only); Mozilla Firefox 2.0 or above (Windows and Mac); Safari™ 3.0 or above (Mac only)
PDF Reader: Acrobat® or similar software may be required to view and print PDF files
Screen Resolution: 800 x 600 minimum
Enabled Security Settings: Allow per session cookies
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