Accident Choice Plus℠
Producer Application Instructions – UTAH

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.

UTAH FORMS CHECKLIST

	REQUIRED FORMS		
✓	**Form Name**	**Form Number**	**Action**
✓	Application	AGLC105596-UT	Complete the application information. Obtain applicant signatures on page 3. Sign the application verifying the information is correct.
✓	Bank Draft Authorization	AGLC102113-2011 REV0113	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	11120-OLC-45	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 REV0313	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.
	Transmittal Form and Checklist	AGLC101371	Use for transmittal form for submitting into New Business
	Replacement Form	AGLC100625	Complete when replacing an existing A&H policy
	Salary Allotment	D-B813-A REV0409	Complete when signing up the policy as payroll deduction

American General
Life Companies

Application for Accident Insurance
ACCIDENT CHOICE PLUS
Utah Version

American General Life Insurance Company
2727-A Allen Parkway, Houston, TX 77019

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

Primary Proposed Insured Information

First Name: Kim **MI** _____ **Last Name** Dalton

Date of Birth (MM/DD/YYYY): 01/07/1961 **Age*:** 55 **Sex:** ☒ **Male (M)** ☐ **Female (F)**

Address*: 250 E 100 N

City*: Monroe **State*:** UT **Zip*:** 84754

E-Mail Address: howdyall30@hotmail.com

Social Security Number: 529-88-6408 **Place of birth** (STATE / COUNTRY): Utah

U.S. Citizen: ☒ **Yes** ☐ **No** **If no, date of entry:** _____ **Visa Type:** _____

*If Primary Proposed Insured is a minor, please provide the Address information of the Parent or Guardian above and their full name below.

Parent or Guardian's First Name: _____ **MI** _____ **Last Name** _____

Spouse Information *(if coverage applied for)*

First Name: Pamela **MI** _____ **Last Name** Dalton

Date of Birth (MM/DD/YYYY): 12/07/1975 **Age:** 41 **Sex:** ☐ **Male (M)** ☒ **Female (F)**

Social Security Number: 528-71-4913 **Place of birth** (STATE / COUNTRY): Utah

U.S. Citizen: ☒ **Yes** ☐ **No** **If no, date of entry:** _____ **Visa Type:** _____

Dependent(s) Information *(Only if Child(ren) coverage applied for)*

Full Name: _____ **Relationship:** _____ **Date of Birth / Age:** _____ **Sex:** ☐ **M** ☐ **F**

Full Name: _____ **Relationship:** _____ **Date of Birth / Age:** _____ **Sex:** ☐ **M** ☐ **F**

Full Name: _____ **Relationship:** _____ **Date of Birth / Age:** _____ **Sex:** ☐ **M** ☐ **F**

Full Name: _____ **Relationship:** _____ **Date of Birth / Age:** _____ **Sex:** ☐ **M** ☐ **F**

Coverage Applied for

I. Accident (Base Coverage)

(Check all that apply) ☒ **Primary;** ☒ **Spouse;** ☐ **Child(ren);**

Spouse and Child coverage only available if Primary Insured selects coverage

Deductible (Check One): ☒ $100, ☐ $300, ☐ $500

Maximum Benefit Payable per Calendar year (Check One):

☐ $5,000 ☒ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000

II. Accidental Death & Dismemberment Rider (Optional Coverage)

(Available only to applicants selecting Accident Base Coverage in section I above)

(Check all that apply) ☐ **Primary;** ☐ **Spouse;** ☐ **Child(ren);**

Spouse and child coverage only available if Primary Insured selects coverage

Coverage Amount **per Unit**: • Primary = $50,000 **Number of Units [1-5]:** _____
(Per Selected Insured) • Spouse = $25,000 (Applies to all selected Insured(s))
• Child = $12,500

Beneficiary(s) for Accidental Death and Dismemberment Rider

Beneficiary 1: **Name** (LAST, FIRST): _____

Relationship _____ % Share _____

Beneficiary 2: **Name** (LAST, FIRST): _____

Relationship _____ % Share _____

III. Critical Illness Benefit Rider (Optional Coverage)

(Available only to applicants selecting Accident Base Coverage in section I on previous page)

Proposed Insured(s) ***(check all that apply)***

Coverage Amount Benefit Payable per Lifetime, per Insured: $5,000-$50,000 in $5,000 increments

☒ **Primary** **$** 15,000.00

☒ **Spouse** **$** 15,000.00

☐ **Child(ren)** **$** _____

(Amount of coverage on Spouse and Child(ren) cannot Exceed that of the Primary Insured)

If applying for the Critical Illness Benefit Rider, please answer for each Proposed Insured:

1) Have all Proposed Insured(s) been seen by any member of the medical profession for a routine examination within the past 5 Years? ☒ Yes ☐ No

If No, please list those insured's who have not seen a medical professional in the past 5 Years

Name: _____ **Relationship:** _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____ **Date of Birth:** _____

Name: _____ **Relationship:** _____ **Date of Birth:** _____

2) In the past 2 years, 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

3) Within the past 5 Years Has any proposed insured been seen by any member of the medical profession with any:
   a. Medical or Diagnostic Tests recommended but not yet completed or ☐ Yes ☒ No
   b. Medical or Diagnostic Tests completed with results not yet available or currently unknown to the proposed insured? ☐ Yes ☒ No

4) 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)? ☐ Yes ☒ No

5) 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

6) In the last 5 years, has any proposed insured been diagnosed as having or been treated for or consulted with a licensed health care provider for:
   a. Stroke or Transient Ischemic Attack (TIA)? ☐ Yes ☒ No
   b. Diabetes? ☐ Yes ☒ No
   c. Disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure / hypertension? ☐ Yes ☒ No
   d. Kidney failure, or abnormal kidney function? ☐ Yes ☒ No
   e. An organ transplant or been advised of the need of an organ transplant? ☐ Yes ☒ No

If Yes to questions (2-6), Please Provide Details

Question #	Name of Proposed Insured	Relationship (Primary/Spouse/Child)

IV. Accident Only Disability Income Rider (Optional Coverage)

(Available only to the Primary Insured)

Occupation: _____

Please locate your Gross Monthly Income in the table below and select from the available Monthly Maximum Benefit to the right of your income.

Gross Monthly Income	Available Monthly Maximum Benefit
Less than $800	Rider Not Available
$800 - $1,699	☐ $500
$1,700 - $2,499	☐ $500 ☐ $1,000 (Check One)
$2,500 - $3,349	☐ $500 ☐ $1,000 ☐ $1,500 (Check One)
$3,350 - $4,199	☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 (Check One)
$4,200 or Greater	☐ $500 ☐ $1,000 ☐ $1,500 ☐ $2,000 ☐ $2,500 (Check One)

If applying for the Accident Only Disability Income Rider, please answer the following questions.

1) Does the Primary proposed Insured actively work a minimum of 30 hours per week at their current occupation? ..... ☐ Yes ☐ No

2) Does the Primary Proposed Insured's employment or work duties involve any of the following activities? ..... ☐ Yes ☐ No

- Actor Musician, Performers, Entertainers, or Athletes
- Pilot
- Bartending
- Movers
- Police, Security Guard, Firefighter, Military
- Logging Industry
- Railroad worker
- Route and Door-to-Door Sales
- Agricultural work or farm labor
- Commercial driver (truck, taxi, bus, etc.)
- Excavating
- Fishing and Marine industry
- Custodians, Janitors, Window Washers
- Mining or Mineral exploration and Excavation
- Postal Services including mail carrier
- Domestic Worker (Butler, Housekeeper, Lawn Care, Private Child Care, etc.)

3) Within the past 5 years, has the Primary Proposed Insured had a reckless driving charge, had a driving while intoxicated charge, had a driver's license revoked or suspended, or within the last 3 years had multiple (3 or more) moving violations in any vehicle(s) operated by the Primary Proposed Insured? ..... ☐ Yes ☐ No

All Coverage – Existing or Pending Insurance Questions

Does any Proposed Insured have any existing or pending Accident or Sickness; Accidental Death and Dismemberment; Critical Illness; or Disability Income Insurance? (If yes, complete the following)

Proposed Insured Name	Company Name	Type*	Benefit Amount	Replace***
				☐ Yes** ☐ No
				☐ Yes** ☐ No
				☐ Yes** ☐ No
				☐ Yes** ☐ No

*Type: I = Individual or G = Group AND AS = Accident or Sickness; AD = Accidental Death and Dismemberment; CI = Critical Illness; DI = Disability Income.

** If replacement is indicated complete and submit any state-required replacement forms.

*** Replace means that the insurance policy being applied for replaces and indicated policy pending or presently in force including health, accident, critical illness, disability or cancer insurance.

Periodic Premiums

Frequency of periodic payment: ☐ Annual ☐ Semi-Annual ☐ Quarterly
☒ Monthly (Bank Draft or Recurring Credit Card Only)

Method of Payment: ☒ Bank Draft (complete Bank Draft Authorization)
☐ Recurring Credit Card
☐ List Bill: Number _____
☐ Direct Bill
☐ Other _____

Periodic Premium Amounts

Base Policy: $ 88.34

Accidental Death & Dismemberment Rider: $ _____

Critical Illness Rider: $ 41.46

Accident Only Disability Income Rider: $ _____

Total Periodic Premium: $ 88.34

Agreement – Authorization – Acknowledgement – Understanding
Between Proposed Insured ("You" or "Your") and the Company and its affiliated ("We" or "Us")

Agreement
Your insurance will not begin until the policy is issued and we have received your first premium in full.

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 conditions, limits, reductions and exclusions in the policy.

You agree that all statements and answers are complete and true to the best of Your knowledge and belief. No agent can: (a) waive any question, (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, except that this Authorization will be valid for 180 days with regard to the results of a Human Immunodeficiency Virus (HIV) antibody test.

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
You acknowledge that you are receiving the Outline of Coverage, Notice to the Primary Proposed Insured and the HIPAA Privacy Notice along with this application or they have been read 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.

The policy provides limited benefits. Review your policy carefully.

Signed at Monroe (**City**) UT (**State**) 12/21/2016 (**Date**)

X Primary Kim Dalton Voice Verified at 12/21/2016 10:44 AM
Signature of Primary Proposed Insured
(If minor, Signature of Parent or Guardian)

Kim Dalton
Printed Name of Primary Proposed Insured
(If minor, Printed name of Parent or Guardian)

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 the Proposed Insured(s). I have also provided the required Outline of Coverage and the HIPAA Privacy Notice.

X Agent Sign Lisa Jackson Powered by SignRequest
Signature of Licensed Agent

Lisa Jackson
Printed Name of Agent

5V619
Agent Number

12/21/2016
Date

American General Life Insurance Company

Home Office: 2727-A Allen Parkway, Houston, Texas 77019

ACCIDENT ONLY COVERAGE
THIS POLICY PROVIDES LIMITED BENEFITS. BENEFITS PROVIDED ARE SUPPLEMENTAL AND NOT INTENDED TO COVER ALL MEDICAL EXPENSES
Policy Form 11120

OUTLINE OF COVERAGE

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 is designed to provide, Insured Persons, coverage for certain losses resulting from a covered Accident ONLY, subject to any limitations contained in the Policy. Coverage is not provided for basic hospital, basic medical-surgical or major medical expenses.

Deductible Amount	$ 100.00

Benefits	**Maximum Benefit Amount**
Insured	$ 10,000.00
Spouse Rider	$
Child Rider (Maximum Benefit Amount Payable Combined For **ALL** Children)	$
Accidental Death and Dismemberment Rider	$
Accident Disability Income Rider	$
Critical Illness Benefit Rider	$

BENEFITS

When We receive due written proof that expenses incurred due to an Accident satisfy the Deductible Amount, as shown in the Policy Schedule, We will pay for the following listed benefits, less any adjustment or discounts, up to the Maximum Benefit Amount per Calendar Year as shown in the Policy Schedule. For any of the following benefits to be payable, the initial Care must begin within 72 hours of the Accidental Injury. All expenses must be incurred within 45 days of the Accidental Injury, unless otherwise specified in the Policy. The Policy will not pay benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

If outlying circumstances do not permit You to seek treatment within 72 hours or incur expenses within 45 days of the Accidental Injury, such Care must begin or such expenses must be incurred as soon as reasonably possible after the Accidental Injury.

ACCIDENT EMERGENCY CARE BENEFIT

We will, for each Accidental Injury sustained, pay benefits for emergency Care. Such emergency Care must be received from a Physician, in a Hospital, including an Emergency Room, or an Urgent Care Center in the United States. Such Care can include Surgery.

ACCIDENT FOLLOW-UP CARE BENEFIT

If an Insured Person receives emergency Care within 72 hours after an Accident Injury and later requires additional Care, We will pay benefits for such follow-up Care. This benefit is limited to one follow-up visit per day, up to a maximum of three follow-up visits, per Insured Person for each Accidental Injury. It must be furnished by a Physician in a Physician's office or in a Hospital on an outpatient basis and can include Surgery. Benefits will not be payable for the same visit that the Physical Therapy Benefit is payable or on the same day for which the Accident Emergency Care Benefit is payable.

AMBULANCE BENEFIT

We will, for each Accidental Injury sustained as the result of a covered Accident, pay for transportation of an Insured Person in an Ambulance from the scene of the Accident to a Hospital by a licensed ambulance company. This benefit is only payable for transportation to a Hospital resulting from an Accidental Injury for which an Accident Emergency Care Benefit is payable under the Policy.

FRACTURE BENEFIT

We will pay for a Fracture sustained by an Insured Person as the result of an Accident. The Fracture must be Diagnosed within 14 days of the Accidental Injury or as soon as reasonably possible if outlying circumstances do not allow for such Fracture to be Diagnosed within 14 days of the Accidental Injury.

INPATIENT DRUG BENEFIT

We will pay for drugs that are administered in a Hospital or Urgent Care Center during the Care of an Accidental Injury. There is no payment for a drug prescribed to be taken or used after the initial Care.

MAJOR DIAGNOSTIC EXAMS BENEFIT

We will pay benefits, if an Insured Person requires one of the exams listed below for injuries sustained in an Accident. This benefit is limited to one Major Diagnostic Exam per Accidental Injury. If outlying circumstances do not permit such exams to be performed within 14 days of the Accidental Injury, such exams must be performed as soon as reasonably possible after the Accidental Injury. Major Diagnostic Exams are limited to the following:

(a) CT (computerized tomography) scan;

(b) MRI (magnetic resonance imaging); and

(c) EEG (electroencephalogram).

PHYSICAL THERAPY BENEFIT

We will pay benefits if an Insured Person is advised by a Physician to seek and subsequently receives Physical Therapy as the result of an Accident. All Physical Therapy visits must be prescribed by a Physician, rendered by a physical therapist, and performed in an office or Hospital on an inpatient or outpatient basis. The Physical Therapy must begin within 45 days of the Accidental Injury or discharge from the Hospital and must be completed within six months after the Accidental Injury. Benefits are limited to one Physical Therapy visit per day, up to a maximum of 10 visits for each Accidental Injury.

PROSTHESIS BENEFIT

We will pay benefits if any Insured Person receives a Prosthetic Device prescribed by a Physician for functional purposes when such Insured Person suffers the dismemberment of a hand, foot, arm, leg or sight due to an Accident. This benefit is limited to one Prosthetic Device received within one year of the Accidental Injury.

X-RAY BENEFIT

We will pay benefits if an Insured Person requires an x-ray or a set of x-rays due to an Accidental Injury. Such x-rays(s) must be performed in a Hospital, a Physician's office, or an Urgent Care Facility within 14 days of the Accidental Injury or as soon as reasonably possible if outlying circumstances do not allow for x-rays to 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 or as soon as reasonably possible if outlying circumstances do not permit You to seek treatment 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;

(d) Care for the Accidental Injury is received within the United States; and

(e) All expenses must be incurred within 45 days of the Accidental Injury, unless otherwise specified in the Policy or as soon as reasonably possible if outlying circumstances do not allow for expenses to be incurred within 45 days of the Accidental Injury.

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:

(1) 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; or

(2) the Insured Person's being under the influence of a controlled substance (unless administered by a Physician and taken according to the Physician's instructions) or illegal drugs or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the Accident occurred); or

(3) the Insured Person's voluntary commission of or attempt to commit an assault or felony; or

(4) the Insured Person voluntarily engaging in an illegal activity or occupation; or

(5) the Insured Person's voluntary participation in any riot; or

(6) declared or undeclared war, or any act of declared or undeclared war; or

(7) 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; or

(8) the Insured Person's engaging in hang gliding, bungee jumping, parachuting, sailgliding, parasailing or parakiting, or any similar activity; or

(9) the Insured Person's riding in or driving any motor driven vehicle in a race, stunt show or speed test; or

(10) the Insured Person's practicing for or participating in any semi-professional or professional competitive athletic contest, including officiating, coaching or umpiring, for which such Insured Person receives any compensation or remuneration; or

(11) 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; or

(12) charges for services ordered, directed or performed by a Physician or supplies purchased from a provider who is an Insured Person; an Insured Person's Immediate Family Member; employed or retained by an Insured Person; an employer of an Insured Person; or ordinarily resides with an Insured Person; or

(13) hernia of any kind; or

(14) bacterial infection that was not caused by an Accidental cut or wound; or

(15) the Insured Person's driving any taxi for wage, compensation, or profit; or

(16) the Insured Person's engaging in mountaineering using ropes and/or other equipment or any similar activity; or

(17) charges for treatment, services, drugs, medicines or supplies used to treat a Sickness; or

(18) any illness, loss, or condition specifically excluded from the definition of any Accident.

(c) We will pay NO benefits for injuries received prior to the Effective Date of coverage that are aggravated or re-injured by any event that occurs after the Effective Date.

PRE-EXISTING CONDITION LIMITATION

We will pay NO benefits for an Accidental Injury that is caused by a Pre-Existing Condition unless the Accidental Injury commences after the Policy has been in force for two (2) years from the Effective Date or from the most recent date of reinstatement.

DEFINITIONS

ACCIDENT OR ACCIDENTAL means a sudden, intervening, unforeseen, unusual and unexpected event which results in an Accidental Injury to the Insured Person and meets all of the following requirements:

1. It is the direct cause of a loss, and is wholly independent of Sickness, bodily infirmity or any other cause, including any physical condition.

2. It is definite as to time and place.

3. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.

4. It is sustained on or after the Insured Person's Effective Date of coverage under the Policy and while the Policy is in force.

5. It directly produces at the time objective findings of an injury which is more than simply a gradual deterioration or progressive degeneration.

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. If outlying circumstances do not permit You to seek treatment within 72 hours such Care must begin as soon as reasonably possible after the Accidental Injury.

AGE means the attained age as of the Insured Person's last birthday.

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

AMBULATORY SURGICAL CENTER means a facility which meets these tests:

(a) Its primary purpose is to provide Surgical Care;

(b) Patients are admitted to and discharged from this facility within the same 24-hour period;

(c) It is not part of a Hospital;

(d) It is not a facility for performing termination of pregnancy;

(e) It is not an office maintained by a Physician for the practice of medicine or dentistry.

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. Initial Care must be within 72 hours of the Accidental Injury. Care does not include any psychiatric treatment. If outlying circumstances do not permit You to seek treatment within 72 hours such Care must begin as soon as reasonably possible after the Accidental Injury.

CLOSED REDUCTION means a manipulative repair of a Fracture.

DEDUCTIBLE AMOUNT means the dollar amount shown in the Policy Schedule which must be incurred under the Policy by an Insured Person each Calendar Year before benefits are payable under the Policy. If a Spouse Rider and/or a Child Rider are attached to the Policy, the Deductible Amount will be satisfied when the total of all dollar amounts incurred is 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.

FRACTURE means a break, rupture, or crack, in a bone that can be Diagnosed by x-ray. The Fracture must be Diagnosed by a Physician within 14 days after the date of the Accidental Injury or as soon as reasonably possible if outlying circumstances do not allow for such Fracture to be Diagnosed within 14 days of the Accidental Injury and must require correction by a Physician through either Open or Closed Reduction**.**

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).

Hospital 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.

IMMEDIATE FAMILY MEMBER means a person who is related to the Insured Person in any of the following ways: spouse; child (including a legally adopted child, stepchild, son-in-law, and daughter-in-law); parents, (includes stepparent, mother-in-law, and father-in-law); or brother or sister (including stepbrother, or stepsister, brother-in-law, and sister-in-law).

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.

OPEN REDUCTION means the Surgical repair of a Fracture.

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.

PRE-EXISTING CONDITION means:

(a) an existing condition or symptom that would cause an ordinarily prudent person to seek diagnosis, medical advice, care, attention or treatment within the two (2) year period before the Effective Date; or

(b) a condition or symptom for which medical advice, care, attention or treatment was recommended by a Physician, or received from a Physician within the two (2) year period before the Effective Date.

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).

SICKNESS means a disease, bodily infirmity, illness, infection or any other physical condition that affects the Insured Person, and is wholly independent of an Accident.

SURGERY means a Surgical operation or procedure involving the repair or removal of an organ or tissue due to an Accidental Injury. Eligible Charges include all services and expenses related to the Surgery, including but not limited to the surgeon, assistant surgeon, second opinion, anesthesia, supplies, and surgery facility charges. The Surgery must be necessary as a result of the Accidental Injury. Surgeries can be performed in either a Hospital or an Ambulatory Surgical Center.

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 – SUBJECT TO CHANGE IN PREMIUM BY CLASS

You may continue the coverage on each Insured Person provided by the Policy, until the Policy anniversary on or following the Insured Person's 65th birthday, subject to the Policy's Termination provision, by paying all premiums when they are due. We will not add any restrictive riders or endorsements while the Policy is in force. We reserve the right to change the premium charged for the Policy. Any change in premium will be made on a class basis only, as We determine, and will be based on the Insured Person's Age on the Effective Date. No change in premium will become effective until 40 days after We deliver to You, or mail to Your last known address, a written notice of premium change.

TERMINATION

Coverage for each Insured Person will terminate on the earlier of:

(a) the date on which the Policy lapses or terminates; or

(b) the Policy anniversary on or following the date the Insured Person reaches the maximum coverage age. The maximum coverage age for the Insured is Age 65.

The Policy will terminate on the earliest of:

(a) the date on which the Policy lapses or terminates;

(b) the Policy anniversary on or next following the date that the Insured Person reaches their maximum coverage age;

(c) any premium due date requested by You in writing;

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Insured.

PREMIUMS

Premium Summary

Premiums: Payable Monthly (mode) until age 65:

Insured	**$** 46.87
Spouse Rider	**$**
Child(ren) Rider	**$**
Accidental Death and Dismemberment Rider	**$**
Accident Disability Income Rider	**$**
Critical Illness Benefit Rider	**$** 41.46
Total Premium	**$** 88.34

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 2727-A Allen Parkway Houston, Texas 77019 1-800-811-2696	*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**

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: Utah Independent Bank

Financial Institution Address: 55 S State St, Salina, UT 84654 City, State: Monroe, UT ZIP: 84754

Routing Number: ⑆ 1 2 4 3 0 2 4 6 4 ⑆

Account Number: 4 0 0 5 6 7 3 9 ⑈

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

Name of Primary Proposed Insured: Kim Dalton Premium Amount $: 88.34

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: Kim Dalton

Signature(s) of Bank Account Owner(s) **X** Payer Kim Dalton Voice Verified at 12/21/2016 10:44 AM

Please attach voided check or deposit slip.

Additional Payment Information

12/21/2016

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: YMCE287659

Name of Proposed Insured: Kim Dalton

Proposed Policy Owner: Kim Dalton

E-mail Address: howdyall30@hotmail.com

(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:

X signcredit _____ Date: 12/21/2016

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RZD Voice Verification Audit Trail

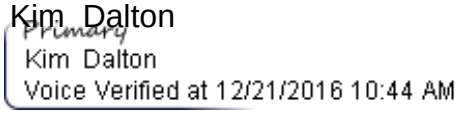
Voice Verified at:
Document Signed: 12/21/2016 10:44:32 AM
Document Pages: 16
Audit Pages: 1

Document Originator

Agency: AIFC, Inc
Agent Name: Lisa Jackson
Agent Email: info@insurtainty.com
Agent Phone: 844-711-8989
Agent Numbers: 5V619

Document Signer

Primary Insured: Kim Dalton
Signature:

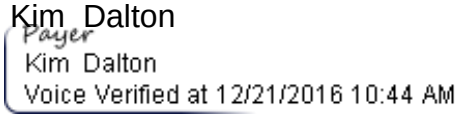


Signer Location:

Spouse/Domestic Partner Insured: Pamela Dalton
Signature:

Signer Location:

Premium Payer: Kim Dalton
Payer Signature:



Signer Location:

This document was voice verifed by AIFC, Inc in accordance to all requirements given by Insurance Carriers legal and product distribution requirements.