# Accident Choice Plus℠
# Producer Application Instructions - ALABAMA

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.

## ALABAMA FORMS CHECKLIST

| | REQUIRED FORMS | | |
|---|---|---|---|
| ✓ | **Form Name** | **Form Number** | **Action** |
| ✓ | Application | AGLC105596 | 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-01 | 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 |
| | 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

**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:** Cullie **MI** _____ **Last Name** Johnson

**Date of Birth** (MM/DD/YYYY): 06/03/1960 **Age*:** 55 **Sex:** ☒ **Male (M)** ☐ **Female (F)**

**Address*:** 673 county road 41

**City*:** Mt. Hope **State*:** AL **Zip*:** 35651

**E-Mail Address:** culliejohnson35651@24hourmail.net

**Social Security Number:** 424-02-5418 **Place of birth** (STATE / COUNTRY): _

**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:** _____ **MI** _____ **Last Name** _____

**Date of Birth** (MM/DD/YYYY): _____ **Age:** _____ **Sex:** ☐ **Male (M)** ☐ **Female (F)**

**Social Security Number:** _____ **Place of birth** (STATE / COUNTRY): _____

**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** **$** _____

☐ **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:** $ 48.69

**Accidental Death & Dismemberment Rider:** $ _____

**Critical Illness Rider:** $ 27.65

**Accident Only Disability Income Rider:** $ _____

**Total Periodic Premium:** $ 48.69

**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.

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.

**Signed at** Mt. Hope (**City**) AL (**State**) 3/17/2016 (**Date**)

usersign Cullie Johnson

**X** _____ Cullie Johnson

**Signature of Primary Proposed Insured** (If minor, Signature of Parent or Guardian) — **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: Sean McCloskey Powered By RZD Inc. _____ Sean McCloskey

**Signature of Licensed Agent** — **Printed Name of Agent**

4U46A — **Agent Number**

3/17/2016 — **Date**

# ACCIDENT COVERAGE OUTLINE OF COVERAGE
## Policy Form 11120

### 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.

| | |
|---|---|
| Deductible Amount | $ 500.00 |

| **Benefits** | **Maximum Benefit Amount** |
|---|---|
| Insured | $ 25,000.00 |
| 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.

### 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.

**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. Such exams must be performed within 14 days of 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.

## 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;

(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.

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 taken as prescribed by a Physician) 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 commission of or attempt to commit an assault or felony; or

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

(5) the Insured Person’s voluntary participation in any riot or civil insurrection; 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.

## 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.

**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.

**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 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.

## OPTIONAL RIDERS

### ☐ SPOUSE RIDER (OPTIONAL)

If the Rider is elected, We will pay for the Benefits as listed in the Policy in the event of an Accident (as defined and covered in the Policy) for the Insured Spouse. Payment of benefits is subject to the conditions and limitations as described in the Policy.

## DEFINITIONS

The Definitions of the Policy to which the Rider is attached will be used, along with the terms defined below.

**INSURED PERSON** includes the Insured Spouse covered under the Rider.

**INSURED SPOUSE** means only the spouse designated by You.

**TERMINATION**

Coverage for the Insured Spouse will terminate on the earlier of:

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

(b) the Policy anniversary on or following the date the Insured Spouse reaches age 65; or

(c) the date the Insured's marriage to the Insured Spouse is terminated by a divorce decree.

The Rider will terminate on the earliest of:

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

(b) the date that the Insured Spouse becomes the Insured under the Continuation provision of the Rider;

(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 for the Rider was not paid;

(e) the date the Insured's marriage to the Insured Spouse is terminated by a divorce decree; or

(f) the death of the Insured Spouse.

The termination of coverage on the Insured Spouse will not reduce Our liability for any claim originating prior to the termination of such coverage.

If the Policy and the Rider are in force and the Insured's marriage to the Insured Spouse is terminated by a divorce decree, the Insured Spouse may obtain a separate Accident policy. Coverage provided on any Insured Person by the Policy cannot be continued if the Insured Person is subsequently covered by a separate Accident policy issued by Us. Coverage on any Insured Person provided by the Policy ceases when coverage on such Insured Person becomes effective under a separate Accident policy issued by Us.

**CONTINUATION**

If the Policy and the Rider are in force and the Insured dies, the Insured Spouse may continue the Policy by payment of the required premiums when they are due. The following conditions will apply:

(a) the Insured Spouse will become the Insured under the Policy; and

(b) the premiums will be based on the Insured Spouse's Age on the Effective Date of the Rider.

## ☐ CHILD RIDER (OPTIONAL)

If the Rider is elected, We will pay for the Benefits as listed in the Policy in the event of an Accident (as defined and covered in the Policy) for an Insured Child. Payment of benefits is subject to the conditions and limitations as described in the Policy.

The Maximum Benefit Amount Payable Combined For **ALL** Children shown in the Policy Schedule is the total amount payable per Calendar Year for **ALL** children covered under the Rider – not for each Child.

## DEFINITIONS

The Definitions of the Policy to which the Rider is attached will be used, along with the terms defined below.

**INSURED CHILD** means all of the Insured's biological children, legally adopted children, or stepchildren who are dependent on the Insured, and are:

(a) named by You and are less than 26 years of Age on the Effective Date of the Rider;

(b) born after the Effective Date of the Rider, and the Insured is named as parent on the child's birth certificate; or

(c) legally adopted by the Insured after the Effective Date of the Rider and before the child's 26th birthday.

**INSURED PERSON** includes an Insured Child covered under the Rider.

**TERMINATION**

Coverage on any Insured Child will terminate on the earlier of:

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

(b) the premium due date following the Insured Child's 26th birthday; or

(c) the Date of Issue of a separate policy, which is issued to the Insured Spouse and provides coverage on the Insured Child.

The Rider will terminate on the earliest of:

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

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

(c) the end of the Grace Period following the due date for which a premium for the Rider was not paid.

The termination of an Insured Child's coverage will not reduce Our liability for any claim originating prior to the termination.

**CONTINUATION**

The coverage provided on an Insured Child by the Rider may be continued, so long as the Insured Child is:

(a) legally incapable of self-sustained employment due to mental or physical incapacity; and

(b) dependent upon the Insured for support and maintenance.

## ☐ ACCIDENTAL DEATH AND DISMEMBERMENT RIDER (OPTIONAL)

We will pay the amount shown in the Accidental Death and Dismemberment Benefit provision of the Rider for any one listed loss due to an Accidental Injury incurred by the Insured Person. The loss must be incurred within 90 days of the Accidental Injury. The Rider must be in force on the date of the Accidental Injury. The Insured must have the Rider for the Insured Spouse or Insured Child(ren) to be eligible for the Rider. Benefits are also paid for death while riding as a fare-paying passenger inside a Common Carrier (as defined in the Rider).

Units are $50,000 for the Insured, $25,000 for the Insured Spouse, and $12,500 for Insured Child(ren). The Units purchased for the Insured Spouse or Insured Child(ren) must be the same as the Units for the Insured with a maximum of 5 Units available.

## ☐ ACCIDENT DISABILITY INCOME RIDER (OPTIONAL, AVAILABLE TO THE INSURED ONLY)

The Rider pays a flat monthly benefit due to Total Disability as a result of an Accident as defined and covered in the Policy. This benefit is not payable for disabilities due to Sickness. The Accident Disability Income Benefit Rider provides "24 Hour" coverage (includes on and off the job Accidents). The coverage provided by the Rider does not coordinate with other non-American General Life Insurance Company disability insurance, workers comp, or social security benefits. The Rider is available only for the Insured. The Insured must be at least 18 years old and actively work for at least 30 hours a week to qualify for purchase of the Rider.

In the event of an Accident (as defined and covered in the Policy) that causes the Insured to become Totally Disabled and unable to work, benefits of $500 per month per Unit will be paid after the Elimination Period has been satisfied. The maximum number of Units is 5. The number of months the benefits covered by the Rider are payable is 6 months. The Elimination Period is 14 days.

## ☒ CRITICAL ILNESS 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 Person.

## PREMIUMS

**Premium Summary**

**Premiums:** Payable Monthly (mode) until age 65:

| | | |
|---|---|---|
| **Insured** | **$** | 21.04 |
| **Spouse Rider** | **$** | |
| **Child(ren) Rider** | **$** | |
| **Accidental Death and Dismemberment Rider** | **$** | |
| **Accident Disability Income Rider** | **$** | |
| **Critical Illness Benefit Rider** | **$** | 27.65 |
| **Total Premium** | **$** | 48.69 |

**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<br>2727-A Allen Parkway<br>Houston, Texas 77019<br>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.* |

**American General**
Life Companies

*Effective Date: April 14, 2003*

# NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**
**PLEASE REVIEW IT CAREFULLY.**

**THIS NOTICE IS PROVIDED TO YOU FOR INFORMATIONAL PURPOSES ONLY. YOU ARE NOT REQUIRED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THIS NOTICE.**

This Notice applies to the individual health and long term care insurance business of American General Life Insurance Company, and The United States Life Insurance Company in the City of New York, and any affiliated services company, (collectively the "Companies").

As used in this Notice, "Personal Health Information" means individually identifiable information about you including demographic information (like your name, address and gender) which is collected from you or from members of the health care industry (like doctors or employee benefit plans) and relates to your health, health care provided to you, or payment for health care provided to you.

This Notice will tell you about the ways we use and disclose your Personal Health Information for underwriting, claims administration, plan of care, other payment and health care operations matters, and other circumstances as either required or permitted by law. For purposes of this Notice, "health care operations" means our business operations relating to health and long term care insurance coverage. Please note that not all of the companies listed above necessarily issue both health and long term care insurance policies. To the extent that applicable state law further limits or restricts the uses and disclosures discussed below, we will comply with the more stringent state law. Except as outlined below, we cannot use or disclose your Personal Health Information without your written authorization.

We are required by law to: maintain the privacy of your Personal Health Information, give you this Notice of our legal duties and privacy practices, and abide by the terms of this Notice as long as it remains in effect.

We reserve the right to change any of our privacy practices and the terms of this Notice and to apply our updated privacy practices to all Personal Health Information maintained by us or by those who work on our behalf. In the event of a material change to our Notice, a revised Notice will be sent to all affected policyholders.

## USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

**For Plan of Care:** We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We may also send certain information to doctors for patient safety or other treatment-related issues.

**For Claim Payments and Processing:** We may use and disclose your Personal Health Information as necessary for benefit verification and claim payment purposes. For instance, we may use information regarding services you receive from health care providers (such as physicians) to process and pay claims.

**For Business Operations:** We may use and disclose your Personal Health Information as necessary, and as permitted by law, for our health care operations which include but are not limited to underwriting, premium rating, premium collection, customer service, payment of commissions, reinsurance, compliance, auditing, and other functions related to the administration of your health and/or long term care insurance coverage.

For example:

- **Collection of Information**: To properly underwrite and administer your insurance coverage, we collect medical and non-medical personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, we may also collect or verify information by contacting the following sources: consumer reporting agencies, the Medical Information Bureau Inc., insurance companies to which you have applied for coverage (ncluding the Companies), and medical professionals and facilities which have provided services to you.
- **Business Associates:** Certain services are performed through contracts with outside persons or organizations, such as underwriting support services, actuarial services, legal services, care coordination services, etc. At times it may be necessary for us to disclose your Personal Health Information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately maintain the privacy of your information.
- **Agents:** In order to allow your agent to serve you, we may provide the agent with copies of certain correspondence we send to you, including our declination of your application, our offer of coverage to you at a higher than standard rate, our offer to

accept your application with modifications to the benefits you requested, your replacement of your policy, or your cancellation of your policy. We may also provide certain information to the agent necessary for determining payments to the agent or notify the agent when you submit a claim.

- **Family, Friends and Others Involved in Your Care:** We may from time to time disclose your Personal Health Information to family, friends, and others (such as your designees) who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited Personal Health Information with such individuals. We may also disclose limited Personal Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures.
- **Service-Related Uses and Marketing:** We may contact you to provide information on payment of your claims, or information about health-related benefits and services that may be of interest to you. We will not use your Personal Health Information for marketing non-health products without your authorization.

**Other Uses and Disclosures:** In some circumstances, such as those described below, we may disclose your Personal Health Information to third parties without your authorization:

- We may release your Personal Health Information for any purpose allowed by law;
- We may release your Personal Health Information to law enforcement officials as allowed by law to report wounds, injuries, and crimes;
- We may release your Personal Health Information for public health activities, such as permitted reporting of disease, injury, death, and for required public health investigations;
- We may release your Personal Health Information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- If you are covered under a group plan, we may release your Personal Health Information to your plan sponsor as permitted by the group health plan and as provided for in the group health plan's notice of privacy practices if required. However, prior to any such disclosure the plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment related decisions or in connection with any other benefit or benefit plan of the plan sponsor, or in any other manner not permitted by law;
- We may release your Personal Health Information if allowed by law to a government oversight agency conducting audits, investigations (such as investigations into consumer complaints), or civil or criminal proceedings;
- We may release your Personal Health Information if required to do so by a court or administratively ordered subpoena or discovery request;
- We may release your Personal Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- We may release your Personal Health Information if you are a member of the military as required by armed forces services. We may also release your Personal Health Information if necessary for national security, intelligence activities, disaster relief purposes, to avert a serious threat to health or safety, or for the protection of the President and others;
- We may release your Personal Health Information to workers' compensation agencies if necessary for your workers' compensation benefit determination;
- We may release your Personal Health Information to coroners, medical examiners, and funeral directors if needed, for example, to identify a deceased person. We may also release your Personal Health Information to organ or tissue procurement organizations, consistent with applicable law;
- We may release your Personal Health Information to a correctional institution if you are or become an inmate of a correctional institution;
- We may release your Personal Health Information to non-affiliated organizations or persons such as other insurance institutions, agents, insurance support organizations, or law enforcement and governmental authority as necessary to prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with your coverage or application for coverage; and
- We may release your Personal Health Information to any affiliated company. Such company's use will be limited to use in connection with a compliance audit, market conduct audit, or other compliance or regulatory activity.

## YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

- To copy and/or inspect much of the Personal Health Information that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies and postage and, in certain cases, may deny your request.

- To request that we send communications of Personal Health Information about you by alternative means or to alternative locations, if all or part of that information could endanger you. For example. you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.
- To request in writing that Personal Health Information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.
- To receive a list of certain disclosures made by us of your Personal Health Information. The list will not include our disclosures related to payment or health care operations, disclosures made to you or with your authorization, or certain other disclosures, such as for national security purposes. Your request for a listing of disclosures must be in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. The first accounting in any 12-month period is free. You will be charged a reasonable fee for each subsequent accounting you request within the same 12-month period.
- To request restrictions on certain of our uses and disclosures of your Personal Health Information for plan of care, payment, or health care operations by notifying us of your request for a restriction in writing. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.
- To receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.
- If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance of such authorization, or if other law provides us with the right to contest a claim under the policy itself.

**If you would like to exercise a right discussed in this Notice, or if you believe your privacy rights have been violated, please send your written request or complaint to the address below:**

Chief Privacy Officer
American General Life Insurance Company
2919 Allen Parkway
Houston, TX 77019

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington. D.C., in writing within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

**FOR FURTHER INFORMATION**

If you have questions or need further assistance regarding this Notice, you may contact us at the address below:

American General Life Companies Service Center
P. O. Box 4373
Houston, TX 77210-4373
Telephone: 1-800-231-3655

**Detach this page and leave it with the proposed insured**

# NOTICES TO THE PROPOSED INSURED

**American General Life Insurance Company, Houston, TX**

This notice is provided on behalf of American General Life Insurance Company ("The Company") and American General Life Companies LLC, an affiliated service company.

## FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

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

## MEDICAL INFORMATION BUREAU

Information regarding your insurability will be treated as confidential. The Company, or its reinsurers may, however, make a brief report thereon to MIB, 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 in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of 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 Post Office Box 105, Essex Station Boston, Massachusetts 02112.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or heath insurance, or to whom a claim for benefits may be submitted.

## INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: American General Life Companies LLC, P.O. Box 1931, Houston, TX 77251-1931

## TELEPHONE INTERVIEW INFORMATION

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

## USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

## 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: Bank Independence

Financial Institution Address: 15259 Court St City, State: Moulton, AL ZIP: 35650

Routing Number: ⑆ 0 6 2 2 0 5 7 9 1 ⑆

Account Number: 3 2 4 4 2 5 3 ⑈

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

Name of Primary Proposed Insured: Cullie Johnson Premium Amount $: 48.69

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: Cullie Johnson

Signature(s) of Bank Account Owner(s) **X** signbank Cullie Johnson

**Please attach voided check or deposit slip.**

Additional Payment Information

03/17/2016

**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: YMCE226347

Name of Proposed Insured: Cullie Johnson

Proposed Policy Owner: Cullie Johnson

E-mail Address: culliejohnson35651@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:

☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

Additional Payment Information

_____

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: 3/17/2016

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**RZD eZign Audit Trail**

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Document Unique ID: 73dd7ee0-96d3-4e9d-90df-514903cf1224
Document Signed: 3/17/2016 6:49:45 PM
Document Pages: 23
Audit Pages: 3

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**Document Originator**

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

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**Document Signer**

Primary Insured: Cullie Johnson
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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