CriticalCare Plus[SM]
Producer Application Instructions – South Carolina

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.

SOUTH CAROLINA FORMS CHECKLIST

	REQUIRED FORMS		
✓	**Form Name**	**Form Number**	**Action**
✓	Application	AGLC101791-SC	Complete the application information. Obtain applicant signature(s) on page 6. Sign the application and complete and sign the agent report.
✓	Supplemental Application	AGLC100469	The State of South Carolina requires this form to be completed and submitted with the application.
✓	Outline of Coverage	05130-OLC-41	Complete the form with applicable coverage information and present to applicant at time of application.
	HIPAA Authorization	AGLC100633	Complete applicant's name and birth date at the top of the form. Obtain appropriate signatures and submit with application.
✓	Privacy Notice	AGLC100695	Leave with applicant.
✓	HIV Consent	AGLC0335-2001	At the top of the form, select American General Life Insurance Company. Have applicant complete information on page 2 and sign. Submit with application.
✓	Bank Draft Authorization	AGLC102113	The Bank Draft Authorization must be completed, signed by the applicant and submitted with the application.
✓	Shopper' s Guide to Cancer Insurance	AGLC101866	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.
	SUPPLEMENTAL FORMS		
	Credit Card Authorization	AGLC100949	If applicant would prefer to make initial premium payment with a credit card, complete the form and submit with application. Please note that we cannot accept recurring credit card payments for this product, only for the first premium payment.
	Replacement Form	AGLC102640	If this policy is replacing other coverage, please complete and submit this replacement form with the application.
	Critical Care Comparison Form	AGLC102780	Complete and leave with the applicant if this policy is replacing an existing policy.
	Policy Delivery Receipt	AGLC101336	This form is only required by LA, PA, SD, and WV. However, it is a good business practice to have the policyholder sign that they have received their policy when you deliver it to them.

American General
Life Companies

Application for Individual Critical Illness Insurance
South Carolina

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

1. Primary Proposed Insured (Please print full name)
Smithmyer (Last) Shelly (First) (Middle)

2. Address
759 W Georgia St (Street)
Woodruff (City) SC (State) 29388 (Zip Code)
Email shellymyer22@gmail.com
( ) Home Telephone ( ) Business Telephone
Contact Preference: ❑ Home ❑ Business
Driver's License Number State of Issue

3. Social Security No. 247-83-2206

4. Birth Date and Place — Month 3 | Day 6 | Year 1990 | State South Carolina | Country —

5. Age 25

6. Sex ❑ M ☒ F

7. Marital Status
☒ Single ❑ Married ❑ Widowed ❑ Divorced ❑ Separated

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

9. Coverage Period / Proposed Insured(s) / Amounts
- ❑ 10 years
- ❑ 15 years
- ❑ 20 years
- ❑ 30 years
- ☒ Lifetime

Proposed Insured(s):
- ☒ Primary — $50,000.00
- ❑ Spouse — $_____
- ❑ Child(ren) — $_____

10. Riders
- ❑ HIV Rider
  - ❑ Primary ❑ Spouse
- ❑ Benefit Extension Rider
  - ❑ Primary ❑ Primary/Spouse
  - ❑ Primary/Child(ren) ❑ Family
- ❑ ADD Rider/No. of Units (1 – 6) ($25,000 per unit)
  - ❑ Primary _____ ❑ Primary/Spouse _____
  - ❑ Primary/Child(ren) _____ ❑ Family _____
- ❑ Other Riders _____

11. Modal Premium
Primary $ _____ Spouse $ _____
Children $ _____ **Total $** 29.04
Payable
❑ A ❑ S ❑ Q ☒ Bank Draft ❑ Other _____
❑ Add to existing Bank Draft account, policy no. _____
❑ Add to existing Salary Allotment account no. _____
Deduction Frequency _____
Deduction Amount _____

12. Occupation NHC HealthCare, Mauldin Employer NHC HealthCare, Mauldin
Employer Address 850 E Butler Rd (Street) Greenville (City) SC (State) 29607 (Zip Code)
Duties NHC HealthCare, Mauldin Length of Employment 5 years 0 months
If less than 2 years, Previous Employer _____
Personal Income $1 - $20,000 Household Income $1 - $20,000

13. Premium Payor (If other than Primary Proposed Insured)
Name _____ Social Security No. _____
Relationship _____
Address _____ (Street) (City) (State) (Zip Code)

14. Owner (If other than Primary Proposed Insured)

Name _____ Social Security No. _____

Relationship _____ Date of Birth _____

Address _____
Street City State Zip Code

Home Phone _____

Complete if owner is a Trust

Exact Name of Trust _____ Trust Tax ID _____

Current Trustee(s) _____ Date of Trust _____

15. Primary Beneficiary Estate Estate Estate

03/06/1990 Estate
Date of Birth Relationship

Contingent Beneficiary _____

_____
Date of Birth Relationship

16. Spouse (If coverage applied for) _____
Occupation

_____
Birthplace Date of Birth Social Security No Age

Spouse Driver's License Number _____ State of Issue _____

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

17. List Dependent(s) Information:

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

Background	**INSURED**	**SPOUSE**	**DEP #a**	**DEP #b**	**DEP #c**	**DEP #d**
18. In the 90 days immediately prior to the date of this application, has any Proposed Insured been physically incapable of working, or incapable of performing normal daily activities for more than 3 consecutive days?	YES NO ❑ ☒	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑
19. Has any Proposed Insured participated within the last 3 years or have any intention of participating in: (a) flight in any type of aircraft as a pilot, student pilot or crew member, including Ultralight aviation; or (b) extreme sports or other hazardous activity; or (c) parachute jumping, auto, boat or motorcycle racing, hang gliding or scuba diving? If yes, **circle** the applicable activities.	❑ ☒	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑

Background (cont'd)	**INSURED**	**SPOUSE**	**DEP #a**	**DEP #b**	**DEP #c**	**DEP #d**
20. Has any Proposed Insured ever had a life, disability, health or critical illness application modified, rated, declined, postponed, withdrawn, cancelled or refused for renewal?	YES NO ❑ ☒	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑	YES NO ❑ ❑
21. In the past 5 years, has any Proposed Insured been charged with or convicted of: (a) driving while intoxicated, or (b) driving under the influence of alcohol or drugs; or (c) any driving violations? If yes, list Proposed Insured's name, license no., state of issue, specific violation(s), and date. _____ _____	❑ ☒	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
22. Has any Proposed Insured ever been convicted of, pled guilty or no contest to a felony, or do they have any such charge pending against them? If yes, list Proposed Insured's name, date, state and felony. _____ _____	❑ ☒	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑
23. Within the past 12 months, has the Primary Proposed Insured and/or Spouse, if proposed for coverage, used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine?	❑ ☒	❑ ❑				
Primary Proposed Insured: Type _____						
Date of Last Use _____ Amount/Frequency _____						
Spouse: Type _____						
Date of Last Use _____ Amount/Frequency _____						

24. Has any member of any Proposed Insured's immediate family (mother, father, sister, brother) ever been diagnosed as having or been treated for heart disease, stroke, cancer, cerebrovascular disorder, aneurysm or diabetes prior to age 55? ❑ Yes ☒ No
Complete the information that follows if the answer is Yes.

Name of Proposed Insured	Relationship	Condition (from list on question 24)	Age at Diagnosis

HEALTH HISTORY - If yes answer applies to any Proposed Insured, provide details on page 4.	**INSURED**	**SPOUSE**	**DEP #a**	**DEP #b**	**DEP #c**	**DEP #d**
25. Height	5 ft-03 in	_____	_____	_____	_____	_____
26. Weight	150 lbs	_____	_____	_____	_____	_____
27. Has any Proposed Insured ever been diagnosed as having or been treated for, or consulted a legally qualified practitioner of the healing arts for any of the following?	YES NO	YES NO	YES NO	YES NO	YES NO	YES NO
a) Human Immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)	❑ ☒	❑ ❑	❑ ❑	❑ ❑	❑ ❑	❑ ❑

HEALTH HISTORY (cont'd) - If yes answer applies to any Proposed Insured, provide details below.	**INSURED**		**SPOUSE**		**DEP #a**		**DEP #b**		**DEP #c**		**DEP #d**	
b) heart disease, stroke, or Transient Ischemia Attacks (TIA)	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c) glaucoma, macular degeneration, or optic neuritis	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d) disease or disorder of the endocrine system (diabetes, thyroid or other glands), kidney failure, polycystic kidneys, or abnormal kidney function	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e) cancer, leukemia, melanoma, malignant tumor, Hodgkin's Disease or non-Hodgkin's Lymphoma, or familial adenomatous polyposis (Gardener's Syndrome)	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f) need for an organ transplant	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g) liver disease, including Hepatitis B or C	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
h) paralysis, Multiple Sclerosis (MS) or cerebral palsy	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
28. Within the past 10 years, has any Proposed Insured been diagnosed as having or treated for, or consulted a legally qualified practitioner of the healing arts for any of the following?												
a) high blood pressure, rheumatic fever, heart murmur, elevated cholesterol, or disease or disorder of the blood, heart or circulatory system	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b) polycystic ovary; breast tumor(s) or cyst(s); or colon polyp(s)	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c) disease or disorder of the respiratory system	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d) disease or disorder of the spinal cord; or disease or disorder of the musculoskeletal system, including lupus	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e) a disease or disorder of the kidney; disease or disorder of the digestive system; or congenital anomalies	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f) mental illness; seizures; disease or disorder of the nervous system	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g) loss of hearing (requiring the use of a hearing aid), speech or blindness	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
h) a condition related to alcohol or drug use	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
29. Within the past 24 months, has any Proposed Insured experienced unexplained chest pain, shortness of breath, palpitation, weight loss, dizziness, fatigue, numbness or paralysis?	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
30. Within the past 12 months, has any Proposed Insured been advised by a legally qualified practitioner of the healing arts concerning any abnormal diagnostic test results or been advised to have any diagnostic tests (including self-administered), hospitalization, treatment or surgery which was not completed?	❑	☒	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Health History - Details for "Yes" answers.

Identify Question #	Name of Proposed Insured	Nature of Illness/Injury	Date & Duration	Name and Address of Physician or Medical Facility

31. Is any Proposed Insured taking any medications? ❑ Yes ☒ No
Complete the information that follows if the answer is Yes.

Name of Insured	Drug Name	Dosage	Physician Name and Address

32. Existing and Pending Critical Illness Insurance or any other Existing and Pending Insurance being replaced

Name of Proposed Insured	Policy Number	Company Name	Type*	Face Amount	Year Issued	Replace** Yes	Replace** No
						❑	❑
						❑	❑
						❑	❑
						❑	❑
						❑	❑

* Type: I = individual or G =group AND = AC = accident, H = health, C = cancer, CI = critical illness, or DI = disability illness

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

Remarks/Special Instructions

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

X Shelly Smithmyer 3/3/2016

Signature of Proposed Insured Date

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING

I, the Primary Proposed Insured (and any Owner or Spouse signing below), **AGREE** that: (a) **NO insurance** shall begin ***unless*** a policy is issued and the first premium has been paid in full within 31 days of the date of issue; and (b) **No conditional, temporary or interim insurance** of any kind will be in effect from the date of this application until the date a policy, if any, is issued, regardless of whether I paid any premium. Any such premium paid will be refunded if a policy is not issued, and American General Life Insurance Company ("Company") will have no further liability regarding this application; and (c) I am applying for a policy that provides limited benefits for diagnosis of the critical illness or loss of independent living, as defined in the policy, with **No** benefits if manifestation and/or diagnosis of such critical illness or loss of independent living occurs before the end of the applicable waiting period. The waiting period begins on the date a policy, if any, is issued; and (d) The policy I am applying for is **Not** a major medical insurance policy; and (e) All statements and answers in this application are complete and true to the best of my knowledge and belief; and (f) No agent has authority to waive any answer or otherwise modify this application. I **AUTHORIZE** the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this Authorization, I agree that a photocopy will be as valid as the original and that it will be valid for 24 months from the date shown below. I know that I or my representative may request a copy of this Authorization and may revoke this Authorization at any time by written notification to the Company at its Home Office. I **ACKNOWLEDGE** receipt of: (a) NOTICES TO THE PROPOSED INSURED, page 8; and (b) Outline of Coverage. I **UNDERSTAND** that if I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

Any person who, with intent to defraud or knowing that he/she is facilitating a fraud against the Company, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

If an investigative consumer report is prepared in connection with this application, the Proposed Insured elects: ☒ to be interviewed; or ☐ not to be interviewed.

Signed at Woodruff SC 3/3/2016 X Shelly Smithmyer

City State Date Signature of Primary Proposed Insured (If Age 16 or Over)

X Agent Sign: Sean McCloskey Powered By RZD Inc.

Agent

X

Signature of Spouse (Including as a Proposed Insured)

X

Signature of Owner (If other Than Primary Proposed Insured)

AGENT'S REPORT

1. How long have you known any of the Proposed Insured(s)? N/A

2. Are you related to any of the Proposed Insured(s)?
   ❑ Yes ☑ No If "Yes", give details in Remarks section below.

3. Do you have knowledge of any unfavorable information regarding the Proposed Insured(s) which has not been disclosed in the application?
   ❑ Yes ☑ No If "Yes", give details in Remarks section below.

4. Have you given the insured a copy of the Outline of Coverage and obtained a signed HIPAA Privacy Notification?
   ☑ Yes ❑ No

5. Do you have any information indicating that any Proposed Insured may replace any accident and sickness policies with any company, including health, cancer, accident or critical illness insurance, in connection with the insurance being applied for? ❑ Yes ☑ No
   If yes, please provide details in the Remarks section below and attach any replacement notice related forms.

AGENT'S CERTIFICATION

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge, concerning any Proposed Insured.

3/3/2016 Agent Sign: Sean McCloskey Powered By RZD Inc.

Date

Sean McCloskey

Print Agent's Name

4U46A

Agent Number

Agency Code Number

REMARKS

Detach this page and leave it with the Primary Proposed Insured

NOTICES TO THE PRIMARY 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 life insurance or 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 the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

American General Life Insurance Company

DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY COVERAGE
OUTLINE OF COVERAGE

Policy Form 05130-41

Read Your Policy Carefully
This outline of coverage provides a very brief description of the important features of the 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!**

Critical Illness Coverage
The policy you have applied for provides a limited benefit for diagnosis of a defined Critical Illness ONLY. It does NOT provide comprehensive medical or hospital insurance, long-term care insurance or nursing home and home care insurance.

Benefits Of The Policy
We will pay the Critical Illness Maximum Benefit Percentage stated in the Policy Schedule (summarized in the chart on Page 2), subject to all applicable Policy provisions, if a Critical Illness is initially Incurred (or Manifests, as stated in the policy) and Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective, or for Invasive and In Situ Cancer, more than 90 days after the date coverage on the Insured Person becomes effective.

This is NOT A MEDICARE SUPPLEMENT policy. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the Company.

Exclusions
For any Insured Person:

(a) We will pay **NO** benefits for any Critical Illness that is initially Incurred or Manifests, whichever is applicable as stated in the policy, and/or Diagnosed within the first 30 days after the date coverage on the Insured Person becomes effective under the policy, or for Invasive or In-Situ Cancer, within the first 90 days after the date coverage on the Insured Person becomes effective under the policy. However, an Insured Child born after the effective date of the policy or any subsequent reinstatement will be covered from birth for the Critical Illnesses stated in the Policy Schedule.

(b) There is a 180-day waiting period between Diagnosed Critical Illnesses that are medically related. During this period, we will pay NO benefits under the policy if Diagnosed Critical Illnesses are medically related.

(c) We will pay **NO** benefits for any Critical Illness 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 attempt at suicide, or intentional self-inflicted injury or sickness, while sane or insane; or
- (2) the Insured Person’s mental or emotional disorders, alcoholism or drug addiction; or
- (3) the Insured Person's participation in a felony, riot or insurrection; or
- (4) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or
- (5) The Insured Person’s service in the armed forces or units auxiliary thereto.

Limitations
The indicated percentage of the Critical Illness Maximum Benefit Amount payable for a Critical Illness will be reduced by any amount paid or payable for any other benefit provided under the policy. Once 100% of the Critical Illness Maximum Benefit has been paid for an Insured Person, coverage for that Insured Person terminates and no further benefits are payable.

Preexisting Condition Limitation
We will not pay any benefit for Critical Illnesses that are caused by a Preexisting Condition unless the Critical Illness commences after the policy has been in force two years from the Effective Date or most recent reinstatement date.

BENEFITS SCHEDULE

CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

Insured	**$**	50,000.00
Insured Spouse	**$**	
Insured Child	**$**	

CRITICAL ILLNESS DIAGNOSIS BENEFITS*

Coverage may expire prior to the Expiry Date, see the TERMINATION provision for more details.

There is NO coverage for a Critical Illness that is initially Incurred, Manifested and/or Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if an Insured Person initially Incurred and/or was Diagnosed with permanent loss of two or more Activities of Daily Living before the end of the Waiting Period.

The Waiting Period begins on the Effective Date and continues for the number of days stated below:

Waiting Period **30 days for all Critical Illness, except for Invasive Cancer and In Situ Cancer.**
90 days for Invasive Cancer and In Situ Cancer.

CRITICAL ILLNESS DIAGNOSIS	CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE
☐ Invasive Cancer	100%
☐ Heart Attack	100%
☐ Kidney (Renal) Failure	100%
☐ Stroke	100%
☐ Coma	100%
☐ Coronary Artery Bypass ***Any Benefits for Coronary Artery Bypass are payable only once per lifetime, per Insured Person.***	25% of the Maximum Benefit, or $50,000 whichever is less
☐ Major Organ Transplant	100%
☐ Paralysis: ***Any Benefits for the following types of Paralysis/Paralyzed are payable only once per lifetime, per Insured Person.***	
Quadriplegia	100%
Paraplegia	50%
Hemiplegia	50%
☐ Severe Burn	100%
☐ Loss of Sight, Hearing or Speech	100%

☐	In-Situ Cancer ***Any Benefits for In Situ Cancer are payable only once per lifetime, per Insured Person.***	25% of the Maximum Benefit, or $25,000 whichever is less
☐	Loss Of Independent Living Elimination Period – 180 days	100%

PREVENTIVE CARE BENEFIT

Health Screening Tests (As Limited in the policy)	**NOT** to exceed a total of $50.00, per Insured Person, Per Calendar Year. There is no Waiting Period for this Benefit.

RETURN OF PREMIUM UPON THE DEATH OF THE INSURED

Total Premium Paid – less any benefits previously paid under policy

*The policy, if issued, will provide coverage for diagnosis of a defined Critical Illness ONLY, and only for the Critical Illnesses that are checked on the above chart and listed on the Policy Schedule.

DEFINITIONS

Critical Illness means ONLY the following illnesses as defined and limited in the policy:

(a) Invasive Cancer;
(b) Heart Attack;
(c) Kidney (Renal) Failure;
(d) Stroke;
(e) Coma;
(f) Coronary Artery Bypass;
(g) Major Organ Transplant;
(h) Paralysis;
(i) Severe Burn;
(j) Loss of Sight, Speech or Hearing; or
(k) In-Situ Cancer

Activities of Daily Living mean the following self-care functions**:** (1) **bathing**: washing in either a tub or shower, including the task of getting into or out of the tub or shower without the assistance of another person; (2) **dressing**: putting on or taking off all items of clothing and any necessary braces, fasteners or artificial limbs without the assistance of another person; (3) **toileting**: getting on and off the toilet and performing associated personal hygiene without the assistance of other person; (4) **transferring**: moving onto or out of a bed, chair, or wheelchair without the assistance of another person; (5) **continence**: the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel or bladder functions, the ability to perform the associated personal hygiene (including caring for catheter or colostomy bag) without the assistance of another person; or (6) **eating:** feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or a feeding tube, or intravenously without the assistance of another person.

Diagnosis/Diagnosed means a definitive diagnosis made by a physician, licensed and practicing in the United States or its territories and, where applicable, specializing in a particular area of medicine:

(a) based upon the use of diagnostic evaluations, clinical and/or laboratory investigations tests and observations; and the results are documented in and supported by the Insured Person's medical records;
(b) meeting all diagnostic requirements set forth in the policy for the particular Critical Illness being diagnosed.

Elimination Period means the number of days shown on the BENEFITS SCHEDULE during which an Insured Person must be prevented from performing at least two or more Activities of Daily Living. The Elimination Period begins after the end of the Waiting Period.

Expiry Date means the period of time the Insured elects for coverage, subject to the Termination provision.

Incurs/Incurred means an event or incident that:

(a) initially occurs after the date coverage on an Insured Person becomes effective under the policy; and
(b) initially occurs while coverage on an Insured Person under the policy is in force; and
(c) is not excluded by specific description or exclusion stated in the policy.

Insured means the person named as "Insured" in the Policy Data on Page 1 of the policy.

Insured Person means the Insured and any Insured Spouse or Insured Child indicated as an Insured Person in the Policy Data.

Loss of Independent Living means an Insured Person is permanently unable to perform two or more of the six Activities of Daily Living.

Manifests/Manifested/Manifestation means a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment.

Preexisting Condition means:

(a) any condition misrepresented or not revealed in the application; and

(b) any condition for which symptoms existed prior to becoming covered under the policy that would cause an ordinary prudent person to seek diagnosis, care or treatment within the 2 year period before the date coverage on the Insured becomes effective under the policy or for which medical advice or treatment was recommended by or received from a physician.

Waiting Period means the period that begins on the Effective Date and continues for the period shown in the Policy Schedule. There is NO coverage for a sickness that first manifests itself to the Insured during the Waiting Period.

RETURN OF PREMIUM UPON DEATH OF THE INSURED

If the Insured dies while the policy is in force, We will return to the Owner, or to the Owner's Beneficiary if the Owner is deceased or to the Owner's estate if there is no surviving Beneficiary, 100% of all premiums paid for the policy and any attached riders, less any benefits paid under the policy and any attached riders. The premiums to be returned will be calculated without interest and after all pending claims have been settled. If the sum of all benefits paid under the policy and applicable riders is equal to or greater than the sum of the premiums paid, there will be no return of premiums.

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 date that 100% of the Critical Illness Maximum Benefit Amount is paid for that Insured Person; or

(c) the next policy anniversary date following the attainment of age 70, for all benefits, except the Loss of Independent Living; or

(d) the maximum age for an Insured Child, as shown in the Insured Child provision; or

(e) the Expiry Date.

Guaranteed Renewable to The Policy Expiry Date

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

OPTIONAL RIDERS

ACCIDENTAL DEATH AND DISMEMBERMENT RIDER - 05138

MEDICAL PERSONNEL HIV BENEFIT RIDER - 05139

BENEFIT EXTENSION RIDER - 05137

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

Premium Summary

Premiums: Payable Monthly (mode) Until the Expiry Date

Primary	$	
Spouse	$	
Child	$	
Total Premium	$	29.04

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 Insurance Company
A subsidiary of American International Group, Inc.

2727-A Allen Parkway
Houston, TX 77019

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

American General
Life Companies

HIPAA Authorization -
New Business and Inforce Operations

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

Shelly Smithmyer — 3 / 6 / 1990

Name of Patient/Proposed Insured (Please Print) **Date of Birth**

I hereby authorize all of the people and organizations listed below to give American General Life Insurance Company of Delaware, American General Life Insurance Company, The United States Life Insurance Company in the City of New York, and any affiliated services company, (collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities to provide the information outlined above:

- any physician or medical practitioner;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any other American General Life Companies company which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits under any temporary insurance;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect health care fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the insurance companies listed above are subject to federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the American General Life Companies Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P. O. Box 4373, Houston, TX 77210-4373. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the medical information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

usersign Shelly Smithmyer — 3/3/2016

Signature of Proposed Insured or Proposed Insured's Personal Representative — Date

Description of Authority of Personal Representative (if applicable)

BANK DRAFT AUTHORIZATION

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

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

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

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

Automatic Bank Draft Agreement

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

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

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

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

Financial Institution Name: Arthur State Bank

Financial Institution Address: 595 S Main St. City, State: Woodruff, SC ZIP: 29388

Routing Number: ⑆ 0 5 3 2 0 1 0 3 4 ⑆

Account Number: 9 2 0 4 4 7 7 5 ⑈

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

Name of Primary Proposed Insured: Shelly Smithmyer Premium Amount $: 29.04

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

Preferred Withdrawal Date (1st-28th): 3 **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name: Shelly Smithmyer

Signature(s) of Bank Account Owner(s) **X** signbank Shelly Smithmyer

Please attach voided check or deposit slip.

Additional Payment Information

03/03/2016

American General
Life Companies

Credit Card Authorization Form

Form to be used only for the collection of *initial* insurance premium on Term, Whole Life, and Accident & Health Products Only

American General Life Insurance Company

Please read this authorization carefully and complete all requested items.

Type of Insurance/Contract Applied For: _____

Policy Number: YMCE223489

Name of Proposed Insured: Shelly Smithmyer

Proposed Policy Owner: Shelly Smithmyer

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

Cardholder Billing Address: _____

_____

Credit Card Number: _____ Expiration Date: _____

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

Quoted Initial Premium Amount: _____ Mode of ongoing premium payments: _____

Additional Payment Information

By signing below, I, _____, authorize American General Life Insurance Company ("Company") or its representative to charge the credit card, listed above. I also understand and agree that:

1) If there are no changes to the policy/contract as applied for or the frequency of ongoing premium payments, the charge to the account for the Quoted Initial Premium Amount will be processed when the Company places the policy/contract in force.
2) In the event of changes to the policy/contract as applied for or the mode of ongoing premium payments, the new information will be communicated to me. If I accept the change(s), the charge to the account for the new amount will be processed when the Company places the policy/contract in force.

I understand and agree that this transaction is subject to the acceptance by, and the terms and conditions of, the credit card company indicated above. **I understand and agree that this Authorization Form is not a part of the application or policy/contract of insurance applied for and does not modify any terms or conditions contained therein.** I understand and agree that the Company shall incur no liability if the credit card company dishonors any amount charged under this Authorization and may terminate this Authorization immediately if any charges are not paid. I agree to hold the Company harmless against any liability pursuant to this authorization. I understand and agree that payment of the initial premium is one of the conditions required for coverage to be placed into effect. **If the charge is declined for any reason, I understand and agree that coverage will not be placed into effect.**

Signature of Authorized Person on Account: X signcredit _____ Date: 3/3/2016

For Internal Use Only

#: _____ **Date:** _____

Please return this copy with the application.

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RZD eZign Audit Trail

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Agent Name: Sean McCloskey
Agent Email: info@allinsurancecenter.cor
Agent Phone: 888-290-9060
Agent Numbers: 4U46A

Document Signer

Primary Insured: Shelly Smithmyer
Signature: 

Signer Location: 97.93.171.178

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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
** These minimum requirements are subject to change. If these requirements change, you will be asked to re-accept the disclosure. Pre-release (e.g. beta) versions of operating systems and browsers are not supported.

Acknowledging your access and consent to receive materials electronically

To confirm to us that you can access this information electronically, which will be similar to other electronic notices and disclosures that we will provide to you, please verify that you were able to read this electronic disclosure and that you also were able to print on paper or

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