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

INDIVIDUAL TERM LIFE INSURANCE APPLICATION FORM

Proposed Insured and Owner: [John Doe]
Address: [123 Any St.]
[Anytown, US 12345]

Reference Policy No. [123456789]

[**Phone** 555-1212] [**Email** Johndoe@aol.com]

Beneficiary: Please print the name of your beneficiary here:

☑ **Primary Beneficiary**

Height 6 ft 0 in **Weight** 150 lbs

Name Jane Doe [Address 123 Any Street, AT, US] Relationship: wife

[SSN 123-45-6789] Date of Birth 1 / 1 /50 Email janedoe@aol.com Phone # 555-1212]

❑ **Primary** ❑ **Contingent Beneficiary**

Name _____ [Address _____] Relationship: _____

[SSN _____ Date of Birth ___/___/___ Email _____ Phone # _____]

I wish to apply for [$25,000] of [15] year Term Life Insurance issued by American General Life Insurance Company ("Company"). I understand that the premium for this coverage is [$25.00/month].

Qualifying Medical Questions:

1. In the past five years, has a licensed health care professional diagnosed you with or treated you for any of the conditions listed below:..... ❑Yes ☑No
   a. Chronic obstructive pulmonary disease (COPD), emphysema, or chronic bronchitis?
   b. Chronic liver disease, hepatitis, cirrhosis of the liver, or chronic kidney disease (not including kidney stones)?
   c. Heart attack (myocardial infarction), coronary artery or heart disease, congestive heart failure, heart valve disease, arrhythmia, arteriosclerosis, atherosclerosis, enlarged heart or embolism (blood clots)?
   d. Sleep apnea, or do you currently use a continuous positive airway pressure (CPAP) machine or supplemental oxygen?
   e. Stroke, transient ischemic attack (TIA), disease of the heart or blood vessels, dementia or Alzheimer's disease?
   f. Diabetes mellitus or high blood sugar; ulcerative colitis, Crohn's disease (ileitis or regional enteritis), systemic lupus erythematosis, or scleroderma?
   g. AIDS (Acquired Immunodeficiency Syndrome), infection with HIV (Human Immunodeficiency Virus) or other immune system disease?
   h. Alcohol, drug, or substance abuse, or has such treatment been recommended; Mental or nervous system disorder for which inpatient treatment or confinement in an inpatient or residential facility was recommended or completed; Major Depression, or bipolar disorder (manic depression)?
2. In the past five years has a licensed health care professional recommended that you have any tests that have not yet been performed, except those tests related to the Human Immunodeficiency Virus (AIDS virus); such as chest x-ray, stress electrocardiogram, echocardiogram, stress echocardiogram, colonoscopy, cardiac catheterization, blood test or biopsy?..... ❑Yes ☑No
3. In the past five years, has a licensed health care professional diagnosed you with or treated you for any cancer of the internal organs or blood or melanoma?..... ❑Yes ☑No
4. Has a physician or licensed health care professional recommended or scheduled you for surgery that has not been performed?..... ❑Yes ☑No
5. In the past 12 months, have you smoked or used tobacco or nicotine products in any form... ❑Yes ☑No

Non-Medical Questions:

1. Within the next two years, will you reside outside of the US or Canada, or will you travel outside of the US or Canada for more than nine weeks?..... ❑Yes ☑No
2. In the past five years, have you participated in, or in the next two years, do you intend to participate in: any flights as a trainee, pilot or crew member, scuba diving, skydiving or parachuting, ultra light aviation, auto racing, cave exploration, hang gliding, boat racing, or mountaineering?..... ❑Yes ☑No
3. In the past five years, have you plead guilty or been convicted of driving under the influence of alcohol or drugs or had more than two driving violations?..... ❑Yes ☑No
4. In the past five years have you been convicted of, or pled guilty or no contest to a felony, or do you have any such charge pending against you?..... ❑Yes ☑No

Sign on reverse

Replacement Question:

Do you have any existing or pending[1] annuity or life insurance contracts?..... ☑Yes ❑No

If yes, do you intend to replace[2] the existing insurance with the insurance being applied for?..... ❑Yes ☑No
-If you do intend to replace[2] the existing insurance, please provide the following information:

Policy Number _____Insurance Company _____

Policy Number _____Insurance Company _____

[1] Policy pending under a binding or conditional receipt; [2]Replace means that the insurance being applied for may replace, change or use monetary value from an existing or pending annuity or life insurance policy.

Authorization and Signatures
I agree that all statements and answers made in all parts of this application are true and complete to the best of my knowledge and belief. I understand this application shall be the basis for and become part of any policy issued; and that the Company will rely on the statements and answers when making its decision to issue a policy. I understand that any false or incomplete statements or answers may void coverage. I understand that any policy issued will not take effect until it has been approved and the initial full premium(s) due have been received by the Company while I am alive. I further understand that all statements and answers in all parts of this application must continue to be true and complete; and that I must notify the Company of any changes to the statements and answers given in any part of the application which occur before the policy is issued. I have also read and understand the disclosures provided.

I give my consent to any consumer reporting agency or insurance support organization and the MIB to give the Company information related to: my medical consultations; treatments; hospital confinements; drug or alcohol use; prescriptions; motor vehicle records from the Department of Motor Vehicles; or any other information about me. I understand that the information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued.

I also authorize the Company to start electronic debits for the payment of premiums and to continue such debits against the bank account at the financial institution [previously given to the Company for the payment of premiums on the referenced policy]. I certify that I am a signatory on the account. I understand that: 1) a payment is not deemed made until the Company receives the actual payment; and 2) I am liable to the Company for the dishonor of any debit and the related costs. This payment authorization may be terminated by me or the Company at any time for any reason. Written notice of such termination must be given to the non-terminating party. Such notice to the Company is not effective until the Company has a fair amount of time to act on it.

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date

Health Insurance Portability and Accountability Act ("HIPAA")
The purpose of this authorization is to seek your permission to access information that will be used in the underwriting of your policy. American General Life Insurance Company and its representatives (referred to as the "Company", "we", "us" or "our") are subject to federal privacy laws and any information released to us will be used and disclosed as described in our Privacy Policy. However, upon our disclosure the information may no longer be protected by federal privacy rules.

This authorization is voluntary; however, if you do not provide it, we may not be able to obtain the medical information necessary to consider your application. This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. You are entitled to receive a copy. Please read and sign below.

I authorize health care providers and facilities, pharmacies or pharmacy benefit managers, any insurance or reinsurance company, any consumer reporting agency or insurance support organization, and the Medical Information Bureau (MIB) to give the Company any information relating to my health (except psychotherapy notes) and my insurance policies and claims. This information may include: information relating to any medical consultation or treatments, hospital confinements, drug or alcohol use, prescriptions, diseases including HIV or AIDS, and other information about me such as my name and address.

The information obtained will be used to determine insurance eligibility, as well as eligibility for benefits and contestability of the policy issued. Any information gathered during the evaluation of my application may be disclosed to: reinsurers, MIB, or other persons or organizations performing services; including me; my physician; anyone required by law to receive such information; or to detect health care fraud.

I understand that I can revoke this authorization at any time by sending a written request to the Company. This revocation will not apply to uses and disclosures of my information by the Company for underwriting, claims administration and other uses associated with the application or policy administration. This revocation will not apply to the extent the Company relied on the authorization, or, the law allows the Company to contest a claim or the policy itself.

John Doe
Proposed Insured and Owner Signature

[Anytown, US]
City, State

7/ 20/2012
Date