

# Accident Choice Plus<sup>SM</sup>

## Producer Application Instructions – TENNESSEE

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.

### **TENNESSEE FORMS CHECKLIST**

	REQUIRED FORMS		
✓	Form Name	Form Number	Action
✓	Application	AGLC105596-TN	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-43	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.
	<b>SUPPLEMENTAL FORMS</b>		
	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 Tennessee Version

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

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

### Primary Proposed Insured Information

First Name: Maralo MI      Last Name Allen

Date of Birth (MM/DD/YYYY): 07/10/1964 Age\*: 51 Sex: ☒ Male (M) ☐ Female (F)

Address\*: 3829 Annette Ln

City\*: Memphis State\*: TN Zip\*: 38127

E-Mail Address: maraloallen38127@24hourmail.net

Social Security Number: 587-33-3245 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)
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**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	<input type="checkbox"/> \$500					
\$1,700 - \$2,499	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	(Check One)			
\$2,500 - \$3,349	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	(Check One)		
\$3,350 - \$4,199	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	(Check One)	
\$4,200 or Greater	<input type="checkbox"/> \$500	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$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 ☐ No2) Does the Primary Proposed Insured's employment or work duties involve any of the following activities?..... ☐ Yes ☐ No

- |  |  |
|--|--|
| <ul style="list-style-type: none"> <li>• Actor Musician, Performers, Entertainers, or Athletes</li> <li>• Pilot</li> <li>• Bartending</li> <li>• Movers</li> <li>• Police, Security Guard, Firefighter, Military</li> <li>• Logging Industry</li> <li>• Railroad worker</li> <li>• Route and Door-to-Door Sales</li> </ul> | <ul style="list-style-type: none"> <li>• Agricultural work or farm labor</li> <li>• Commercial driver (truck, taxi, bus, etc.)</li> <li>• Excavating</li> <li>• Fishing and Marine industry</li> <li>• Custodians, Janitors, Window Washers</li> <li>• Mining or Mineral exploration and Excavation</li> <li>• Postal Services including mail carrier</li> <li>• Domestic Worker<br/>(Butler, Housekeeper, Lawn Care, Private Child Care, etc.)</li> </ul> |
|--|--|

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)

_____	_____	_____	_____	<input type="checkbox"/> Yes** <input type="checkbox"/> No
<b>Proposed Insured Name</b>	<b>Company Name</b>	<b>Type*</b>	<b>Benefit Amount</b>	<b>Replace***</b>
_____	_____	_____	_____	<input type="checkbox"/> Yes** <input type="checkbox"/> No
<b>Proposed Insured Name</b>	<b>Company Name</b>	<b>Type*</b>	<b>Benefit Amount</b>	<b>Replace***</b>
_____	_____	_____	_____	<input type="checkbox"/> Yes** <input type="checkbox"/> No
<b>Proposed Insured Name</b>	<b>Company Name</b>	<b>Type*</b>	<b>Benefit Amount</b>	<b>Replace***</b>
_____	_____	_____	_____	<input type="checkbox"/> Yes** <input type="checkbox"/> No
<b>Proposed Insured Name</b>	<b>Company Name</b>	<b>Type*</b>	<b>Benefit Amount</b>	<b>Replace***</b>

\*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:** \$ 38.33  
**Accidental Death & Dismemberment Rider:** \$ \_\_\_\_\_  
**Critical Illness Rider:** \$ 18.65  
**Accident Only Disability Income Rider:** \$ \_\_\_\_\_  
**Total Periodic Premium:** \$ 38.33

**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.

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

<b>Signed at</b>	<u>Memphis</u>	<u>TN</u>	<u>3/14/2016</u>
	<b>City</b>	<b>State</b>	<b>Date</b>
<b>X</b>		<u>Maralo Allen</u>	
	<b>Signature of Primary Proposed Insured</b> (If minor, Signature of Parent or Guardian)	<b>Printed Name of Primary Proposed Insured</b> (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.

<b>X</b>		<u>Sean McCloskey</u>	
	<b>Signature of Licensed Agent</b>	<b>Printed Name of Agent</b>	
	<u>4U46A</u>	<u>3/14/2016</u>	
	<b>Agent Number</b>	<b>Date</b>	



**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 administered by a Physician and taken according to the Physician's instructions) or illegal drugs or while intoxicated ("intoxicated" means that condition as defined by the law of the jurisdiction in which the Accident occurred); or
  - (3) the Insured Person's 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.

### **PRE-EXISTING CONDITION LIMITATION**

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

### **DEFINITIONS**

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

- 1. It is the direct cause of a loss, and is wholly independent of Sickness, bodily infirmity or any other cause, including any physical condition.
- 2. It is definite as to time and place.
- 3. It happens involuntarily, or entails unforeseen consequences if it is the result of an intentional act.
- 4. It is sustained on or after the Insured Person's Effective Date of coverage under the Policy and while the Policy is in force.
- 5. It directly produces at the time objective findings of an injury which is more than simply a gradual deterioration or progressive degeneration.

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

**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 ILLNESS BENEFIT RIDER (OPTIONAL)**

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



**PREMIUMS****Premium Summary**

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

<b>Insured</b>	<b>\$</b> 19.67
<b>Spouse Rider</b>	<b>\$</b>
<b>Child Rider</b>	<b>\$</b>
<b>Accidental Death and Dismemberment Rider</b>	<b>\$</b>
<b>Accident Disability Income Rider</b>	<b>\$</b>
<b>Critical Illness Benefit Rider</b>	<b>\$</b> 18.65
<b>Total Premium</b>	<b>\$</b> 38.33

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

**American General**

Life Companies

American General Life Insurance Company 2727-A Allen Parkway Houston, Texas 77019 1-800-811-2696	<i>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.</i>
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**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 \_\_\_\_\_

Financial Institution Address \_\_\_\_\_ City, State \_\_\_\_\_ ZIP \_\_\_\_\_

Routing Number 

--	--	--	--	--	--	--	--	--	--



Account Number 

--	--	--	--	--	--	--	--	--	--	--	--	--	--	--



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

Name of Primary Proposed Insured \_\_\_\_\_ Premium Amount \$ \_\_\_\_\_

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 \_\_\_\_\_

Signature(s) of Bank Account Owner(s) **X** signbank \_\_\_\_\_

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

Additional Payment Information

**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: YMCE225427Name of Proposed Insured: Maralo AllenProposed Policy Owner: Maralo AllenE-mail Address: maraloallen38127@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): Maralo AllenCardholder Billing Address: po box 492Memphis, TN, 38101Credit Card Number: 4736-9052-0145-5675Expiration Date: 03/2019Card Type: ☐ American Express® ☐ MasterCard® ☒ Visa®Premium Amount: 38.33

Payment frequency of ongoing premium payments:

Additional Payment Information


☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Monthly

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

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

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

Signature of Authorized Person on Account:

X Date: 3/14/2016

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**RZD eZign Audit Trail**

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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: Maralo Allen

Signature: *Maralo Allen*

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

\*\* 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

electronically save this page for your future reference and access or that you were able to e-mail this disclosure and consent to an address where you will be able to print on paper or save it for your future reference and access. Further, if you consent to receiving notices and disclosures exclusively in electronic format on the terms and conditions described above, please let us know by clicking the 'I agree' button below.

By checking the 'I agree' box, I confirm that:

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- I can print on paper the disclosure or save or send the disclosure to a place where I can print it, for future reference and access; and
- Until or unless I notify E Broker Center Inc. as described above, I consent to receive from exclusively through electronic means all notices, disclosures, authorizations, acknowledgements, and other documents that are required to be provided or made available to me by E Broker Center Inc. during the course of my relationship with you.