

- American General Life Insurance Company, Houston, TX
- The United States Life Insurance Company in the City of New York, New York, NY
- AIG Life Insurance Company, Wilmington, DE

Subsidiaries of American International Group, Inc.

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Personal Information

1. Proposed Insured (Complete separate Part B for each Proposed Insured)

Name _____ Date of Birth _____ Social Security # _____

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

2. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone number of doctor last seen.)*

Name _____ Phone (____) _____

Address _____ City, State _____ ZIP _____

Date, reason, findings and treatment at last visit _____

3. Build

A. Admitted Height and Weight _____ ft. _____ in. _____ lbs

(Examiners: Also record measured height and weight on Exam page 1.)

B. Has the Proposed Insured had any weight change in excess of 10 lbs. in the past year? yes no If yes, complete the following:

Loss _____ lbs. Gain _____ lbs. Reason _____

4. Family History

Age if Living	Age at Death	Cause of Death	History of Heart Disease?	History of Cancer?
Father _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____
Mother _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____
Brother _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____
Brother _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____
Sister _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____
Sister _____			<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Age of Onset _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____ Type _____ Age of Onset _____

5. Personal Health History

A. Has the Proposed Insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

- 1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? yes no
- 2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? yes no
- 3) cancer, tumors, masses, cysts or other such abnormalities? yes no
- 4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? yes no
- 5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? yes no
- 6) a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? yes no
- 7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? yes no
- 8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder? yes no
- 9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? yes no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

B. Is the Proposed Insured currently taking any medication, treatment or therapy or under medical observation? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

C. Has the Proposed Insured in the past three years had but NOT sought treatment for:

- 1) fainting spells, nervous disorder, headaches, convulsions or paralysis? yes no
- 2) any pain or discomfort in the chest or shortness of breath? yes no
- 3) disorders of the stomach, intestines or rectum, or blood in the urine? yes no

(If yes, list condition such as: date of first occurrence; symptoms; and how treated.)

Details _____

D. Has the Proposed Insured ever:

- 1) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? yes no
- 2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? yes no

(If yes answered to D1 or D2, please provide details below.)

Type of drug(s)/alcohol product(s) _____ Date last used _____
Name(s) of doctor/facility _____ Phone () _____
Address _____ City, State _____ ZIP _____
Treatment Dates _____
Support group(s) _____ Last date attended _____
Details of any drug or alcohol related arrests _____

5. Personal Health History (continued)

E. Has the Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details

F. Other than previously stated, in the past 10 years, has the Proposed Insured:

1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details

2) been advised to have any diagnostic test, hospitalization or treatment that was NOT completed? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; recommended tests, medications or treatment.)

Details

3) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? yes no

(If yes, list condition and provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details

G. Does the Proposed Insured have any symptoms or knowledge of any other condition that is NOT disclosed above? yes no

(If yes, provide details such as: date of first diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details

Agreement and Signatures

I, the Proposed Insured signing below, agree that I have read the statements contained in this application and any attachments or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related attachments including supplement(s) and addendum(s); and (2) shall be the basis for any policy and any rider(s) issued. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement, I understand and agree that even if I paid a premium no insurance will be in effect under this application, or under any new policy or any rider(s) issued by the Company, unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; and (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of the Proposed Insured(s) that would change the answers to any questions in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that if all three conditions above are not met: (1) no insurance will begin in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

I understand and agree that no agent is authorized to: accept risks or pass upon insurability; make or modify contracts; or waive any of the Company's rights or requirements.

I have received a copy or have been read the Notices to the Proposed Insured(s).

Fraud

Any person who, with intent to defraud or facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

SIGNATURE OF PROPOSED INSURED

Signed at (city, state) _____ On (date) _____

Proposed Insured (If under age 15, signature of parent or guardian)

SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

If Agent recorded information

_____ Writing Agent Name (Please print)	_____ Writing Agent #	_____ Date
<input checked="" type="checkbox"/> _____ Writing Agent Signature	<input checked="" type="checkbox"/> _____ Countersigned (Licensed resident agent if state required)	

If Tele-interviewer recorded information

_____ Name (Please print)	_____ Company	_____ Date
------------------------------	------------------	---------------

If Paramedical Examiner/Medical Doctor recorded information

Examiner's Address _____ **Paramed: Use company stamp below.**

Examiner's Phone # () _____

Examiner's Name _____

Examiner's Signature _____

_____ Date _____

Physical Measurements

1. Proposed Insured

- A. Name _____
- B. Build: Measured Height (*in shoes*) _____ ft. _____ in. Weight (*clothed*) _____ lbs (*Please weigh insured.*)
- C. Are you currently taking Blood Pressure Medication(s)? yes no
 Medication(s) _____

Blood Pressure (*Record all readings.*) If blood pressure exceeds 140/90, repeat reading at end of examination.*

	1st Reading	2nd Reading	3rd Reading	*Repeat Reading
Systolic BP				
Diastolic 5th Phase BP				
Pulse Rate				
Irregularities Per Min.				

- D. Did you weigh Proposed Insured? yes no
- E. Have any of the following been completed in conjunction with this exam?
 Blood Urine EKG Stress Test Chest x-ray
- F. Is appearance unhealthy or older than stated age? yes no
- G. Do you have any pertinent information not disclosed previously? yes no
 (*Details of yes answers to questions F and G*)

- H. Are you related to the Proposed Insured by blood or marriage or do you have any business or professional relationship with the Proposed Insured? (*If yes, explain.*) yes no

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. Examination of heart and lungs must be with stethoscope against bare skin.

1) Heart

- a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? yes no
- b. Is heart enlarged? (*If yes, describe.*) _____ yes no
- c. Is murmur present? (*If yes, complete 1d.*) _____ yes no
- d. Before exercise, murmur is:
 Constant Transmitted to where? _____
 Inconstant Localized at: Apex Base Elsewhere
 Systolic (*Give details.*) _____
 Diastolic Murmur grade: (*Please circle*) 1/6 2/6 3/6 4/6 5/6 6/6
 After valsalva, murmur is:
 Unchanged Decreased Increased Absent

Your impression _____

Report by Examining Medical Doctor (continued)

2) Has this examination revealed any abnormality of the following: *(Provide details to yes answers below.)*

a) Eyes, ears, nose, mouth and throat? *(If vision or hearing is markedly impaired, indicate degree and correction.)* yes no

Details _____

b) Endocrine system *(including thyroid)?* yes no

Details _____

c) Nervous system *(including reflexes, gait, paralysis)?* yes no

Details _____

d) Respiratory system? yes no

Details _____

e) Abdomen *(including scars)?* yes no

Details _____

f) Genito-urinary system? yes no

Details _____

g) Skin *(including scars)*, lymph nodes, blood vessels *(including varicose veins)?* yes no

Details _____

h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* yes no

Details _____

Signature

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____ day of _____, 20_____, at _____ am pm

Location of Exam _____ **Paramed: Use company stamp below.**

Examiner's Address _____

Examiner's Phone # () _____

Examiner's Name _____

Examiner's Signature **X** _____

(Agent should inform Paramedical Examiner/Medical Doctor of proper location to send form upon completion.)

- American General Life Insurance Company, Houston, TX**
 The United States Life Insurance Company in the City of New York, New York, NY

Subsidiaries of American International Group, Inc.

In this form, the "Company" refers to the insurance company whose name is checked above.

The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other company shown is responsible for such obligations or payments.

Notice and Consent for AIDS Virus (HIV) Antibody Testing

To determine your insurability, the Company has requested that you provide a sample or samples of your bodily fluids (blood, urine, and/or oral fluid) as may be allowed under state or jurisdictional law for testing and analysis. One of the tests to be performed will determine the presence or absence of antibodies to the Human Immunodeficiency Virus (HIV). The testing will be performed by a licensed laboratory in accordance with guidelines approved by the Centers for Disease Control. By signing and dating this form, you agree that this testing may be done and that underwriting decisions may be based upon the test results.

Information on HIV

HIV, the virus that causes AIDS, is transmitted from one person to another through blood, semen, and vaginal fluids. The disease is spread primarily during anal, vaginal, or oral intercourse, the sharing of needles and syringes used for shooting drugs, or from a mother to her unborn child. HIV is not spread through casual contact, such as eating with or touching a person infected with the virus. There is no medical evidence that HIV is spread by kissing. Persons most at risk of contracting HIV are men who have sex with other men; intravenous ("IV") drug users; prostitutes (male or female); persons who have had many sexual partners since 1977; persons who received transfusions of blood or blood products prior to March, 1985; the sexual partners of persons in any of these groups; and infants born to infected mothers.

Pre-Testing Considerations

Many public health organizations have recommended that before taking an HIV antibody test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, before being tested.

Meaning of Test Results

A positive result, which is a series of three positive tests, does not mean you have Acquired Immune Deficiency Syndrome (AIDS). A positive test indicates that you have been infected with HIV, the causative agent for AIDS, and that you are at significantly increased risk of developing alterations of your immune system, including AIDS and AIDS-Related Complex (ARC). The test for HIV antibodies is extremely accurate and reliable. However, in rare instances, the test may be positive in individuals who are not infected with the virus (false positive) and occasionally it may be negative in persons infected with HIV (false negative), especially when infection occurred within the 3-6 months prior to testing. Your private physician, a public health clinic or an AIDS information organization in your city can provide you with further information on the medical implications of a positive test.

Disclosure of Test Results

All test results will be treated confidentially. The laboratory will report them only to the Company. The test results may be disclosed as required by law or may be disclosed to employees of the Company who have responsibility for making underwriting decisions on behalf of the Company or to outside legal counsel who needs such information to effectively represent the Company in regard to your application. The results may be disclosed to a reinsurer if the reinsurer is involved in the underwriting process. Please also be advised that the jurisdiction in which you reside may require reporting of positive HIV test results or other test results by the Company and/or the laboratory that conducts the test to a regulatory agency. Such reporting may include disclosure of personal information such as your name, address and date of birth.

If your HIV antibody test is normal (negative), no routine notification will be sent. You will be notified of an abnormal (positive or indeterminate) test result if you indicate that you desire this result be made known to you. You may also identify another person to whom you want the abnormal results released. If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

If your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB) as described in the notice given you at the time of application. The MIB is an organization of life and health insurance companies, which operates as an information exchange on behalf of its members. There will be no records with the MIB that you had a positive HIV antibody test; however, there will be a record that you have some laboratory abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request and with your authorization, will supply the information on you in its file to that member.

Notification of Abnormal Test Result

In the event of an abnormal result:

Send the result to me at:

Address: _____

I authorize the Company to send the result to another person:

Name: _____

Address: _____

I authorize the Company to send the result to the following physician or health care provider:

Name: _____

Address: _____

Consent

I have read and I understand this HIV Testing Notice and Consent form. I voluntarily consent to the withdrawal of blood and/or collection of other bodily fluids from me, the testing of bodily fluids and the disclosure of the test results as described above. I have read the information on this form about what a test result means and understand that I should contact my physician, a public health clinic or an AIDS information organization for further information and counseling if the test result is abnormal.

I understand I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

This consent will be valid for six (6) months from the date of my signature below.

Authorization

Name of Proposed Insured

Date of birth

X _____
Signature of Proposed Insured or Parent/Guardian (if under age 15)

Date signed

X _____
Signature of Person Obtaining Consent

Date signed

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

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

I hereby authorize all of the people and organizations listed below to give AIG Life Insurance Company, American General Life Insurance Company, American International Life Assurance Company of New York, Delaware American Life Insurance Company, Pacific Union Assurance Company, The United States Life Insurance Company in the City of New York, and the American General Life Companies LLC, (an affiliated service 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.

Signature of Proposed Insured or
Proposed Insured's Personal Representative

Date

Description of Authority of Personal Representative
(if applicable)