AMERICAN GENERAL FINANCIAL GROUP

Part B Life Insurance Application

☐ **American General Life Insurance Company, Houston, TX**
☐ **All American Life Insurance Company, Springfield, IL**
☐ **The Old Line Life Insurance Company of America, Milwaukee, WI**
☐ **The American Franklin Life Insurance Company, Springfield, IL**
☐ **The Franklin Life Insurance Company, Springfield, IL**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**

Members American General Financial Group. American General Financial Group is the marketing name for American General Corporation and its subsidiaries.

In this application, "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.

Personal Information

1. Primary Proposed Insured

Name ______________________ Date of Birth __________ Social Security # __________

2. Other Proposed Insured

Name ______________________ Date of Birth __________ Social Security # __________

3. Children *(Provide name and date of birth for all children.)*

____

____

Medical History

4. Physician Information

Name and address of each proposed insured's personal physician(s). *(Write None if proposed insured(s) do not have one.)*

Primary Proposed Insured ______________________________

Other Proposed Insured ______________________________

Child(ren) ______________________________

Name of insured, date, reason, findings and treatment at last visit ______________________________

____

____

____

____

5. Height and Weight

Primary Proposed Insured _____ ft. _____ in. _____ lbs. **Other Proposed Insured** _____ ft. _____ in. _____ lbs.

Child Name ______________ _____ ft. _____ in. _____ lbs. If less than 1 yr. old, weight at birth _____

Child Name ______________ _____ ft. _____ in. _____ lbs. If less than 1 yr. old, weight at birth _____

Child Name ______________ _____ ft. _____ in. _____ lbs. If less than 1 yr. old, weight at birth _____

Has any proposed insured had any weight change in excess of 10 lbs. in the past year? ☐ yes ☐ no *(If yes, explain.)*

____

6. Family History

	Age if Living	Age at Death	Cause of Death
Primary Proposed Insured			
Father			
Mother			
Other Proposed Insured			
Father			
Mother			

7. Personal Health History

Complete questions A through G for all proposed insureds who are applying. If yes answer applies to any proposed insured, provide details, such as: ***proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)*** *or* ***recommended treatment*** *in the area provided.*

A. Has any 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 any question above is answered yes, explain.)

Name of Proposed Insured	Details

B. Is any proposed insured currently taking any medication, treatment or therapy or under medical observation? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

C. Has any 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 any question above is answered yes, explain.)

Name of Proposed Insured	Details

Personal Health History (cont.)

If yes answer applies to any proposed insured, provide details, such as: ***proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)*** *or* ***recommended treatment*** *in the area provided.*

D. Has any 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, complete Drug/Alcohol Questionnaire.)

E. Has any proposed insured ever been diagnosed or treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

F. In the past 10 years, has any proposed insured:

1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? ☐ yes ☐ no
2) had any laboratory tests, treatments or diagnostic procedures, including x-rays, scans or EKGs? ☐ yes ☐ no
3) been advised to have any diagnostic test, hospitalization or treatment that was not completed? ☐ yes ☐ no
4) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? ☐ yes ☐ no

(If any question above is answered yes, explain.)

Name of Proposed Insured	Details

G. Does any proposed insured have any symptoms or knowledge of any other condition that is not disclosed above? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

Statements and Signatures

Statement by the Proposed Insured(s)

I have read the above statements or they have been read to me. The above statements 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 related forms; and (2) shall be the basis for any policy issued on this application. 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 it is within its contestable period and if such misrepresentation materially affects the acceptance of the risk. Except as may be provided in a Limited Temporary Life Insurance Agreement (LTLIA) for which all eligibility requirements are met, I understand and agree that no insurance will be in effect pursuant to this application, or under any policy issued by the Company, unless or until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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.

Insurance 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.

Proposed Insured(s) Signature(s)

Signed at *(city, state)*____________________ On *(date)*____________________

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

X____________________
Other 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(s) has been truthfully and accurately recorded on the Part B application.

____
Writing Agent Name *(please print)*

____
Writing Agent #

X____________________
Writing Agent Signature

X____________________
Countersigned *(Licensed resident agent if state required)*

I certify that the information supplied by the proposed insured(s) has been truthfully and accurately recorded on the Part B application.

____
Other Company Representative Name *(please print)*

____
Company

X____________________
Other Company Representative Signature

Paramedical Examiner/Medical Doctor Signature

Agent should inform paramed or medical doctor of proper location to send form upon completion.

I certify that this exam was conducted the ________day of ____________, 20_______, at_________ ☐ am ☐ pm

Examiner's Address ____________________

Examiner's Phone # (   ) ____________________

Examiner's Name ____________________

Examiner's Signature X____________________

Paramed: Use company stamp below.

Physical Measurements

1. Primary Proposed Insured

A. Name ______________________________

B. Build: Height *(in shoes)* __________ ft. __________ in. Weight *(clothed)* __________ lbs. *(Please weigh insured.)*

C. *Blood Pressure (Record all readings.)*

If blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided.

Treated ☐ yes ☐ no Rx ______________________________

	Initial Measurement	Repeat Measurement
Systolic BP		
Diastolic 5th Phase BP		
Pulse Rate		
Irregularities Per Min.		

D. Other *(Males only)*: Chest *(Full Inspiration)* ________ Chest *(Forced Expiration)* ________ Abdomen *(at Umbilicus)* ________

2. Other Proposed Insured

A. Name ______________________________

B. Build: Height *(in shoes)* __________ ft. __________ in. Weight *(clothed)* __________ lbs. *(Please weigh insured.)*

C. Blood Pressure *(Record all readings.)*

If blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided.

Treated ☐ yes ☐ no Rx ______________________________

	Initial Measurement	Repeat Measurement
Systolic BP		
Diastolic 5th Phase BP		
Pulse Rate		
Irregularities Per Min.		

D. Other *(Males only)*: Chest *(Full Inspiration)* ________ Chest *(Forced Expiration)* ________ Abdomen *(at Umbilicus)* ________

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. This report is confidential between the Company and the doctor. Examination of heart and lungs must be with stethoscope against bare skin.

1. Name of person examined ______________________________
2. Did you weigh proposed insured? ☐ yes ☐ no
3. Is appearance unhealthy or older than stated age? ☐ yes ☐ no
4. 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 4d.)* ______________________________ ☐ yes ☐ no
   d. Before exercise, murmur is:

      ☐ Constant Transmitted to where? ______________________________

      ☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere

      ☐ Systolic *(Give details.)* ______________________________

      ☐ Diastolic Murmur grade: 1/6 2/6 3/6 4/6 5/6 6/6 *(please circle)*

      After valsalva, murmur is:

      ☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent

      Your impression ______________________________

      ____

      ____

Report by Examining Medical Doctor (continued)

5. Has this examination revealed any abnormality of the following: (***Circle** applicable items if listed.)*
   a) Eyes, ears, nose, mouth and throat? *(If vision or hearing markedly impaired, indicate degree and correction.)* ☐ yes ☐ no
   b) Endocrine system *(including thyroid)?* ☐ yes ☐ no
   c) Nervous system *(including reflexes, gait, paralysis)?* ☐ yes ☐ no
   d) Respiratory system? ☐ yes ☐ no
   e) Abdomen *(including scars)?* ☐ yes ☐ no
   f) Genito-urinary system? ☐ yes ☐ no
   g) Skin *(including scars)*, lymph nodes, blood vessels *(including varicose veins)?* ☐ yes ☐ no
   h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* ☐ yes ☐ no
6. Do you have any pertinent information not disclosed above? *(If yes, describe in question 9.)* ☐ yes ☐ no
7. Have any of the following been completed in conjunction with this exam? ☐ yes ☐ no
   ☐ Blood ☐ Urine ☐ EKG ☐ Stress Test ☐ Chest x-ray
8. Specimen kit
   Please indicate where and when specimen kit was sent ☐ CRL ☐ Other__________ Date mailed __________
9. Details of yes answers to Questions 1–6

   ____

10. 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

    ____

Signatures

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the ______day of __________, 20_____, at_______ ☐ am ☐ pm

Location of Exam ____________________

Authorized By ____________________

Examiner's Address ____________________

Examiner's Phone # ____________________

Examiner's Name ____________________

Examiner's Signature **X**____________________

Paramed: Use company stamp below.

AMERICAN
GENERAL
FINANCIAL GROUP

HIV Testing Notice and Consent

California Version

- ☐ American General Life Insurance Company (AGLC), P.O. Box 2764, Houston, TX 77252-2764
- ☐ The American Franklin Life Insurance Company (AMFLIC), P.O. Box 19518, Springfield, IL 62794-9518
- ☐ All American Life Insurance Company (AAL), P.O. Box 401, Milwaukee, WI 53201-0401
- ☐ The Franklin Life Insurance Company (FLIC), P.O. Box 19518, Springfield, IL 62794-9518
- ☐ The Old Line Life Insurance Company (OLL), P.O. Box 401, Milwaukee, WI 53201-0401
- ☐ The United States Life Insurance Company in the City of New York(USL), P.O. Box 4728, Houston, TX 77210-4728

Members American General Financial Group. American General Financial Group is the marketing name for American General Corporation and its subsidiaries.

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*