AIG

Individual Application for Group Accident and Sickness Indemnity Insurance

American General Life Insurance Company*

Houston, Texas

Administrative Office: P.O. Box 30083, Tampa, FL 33630-3083

*This company does not solicit business in New York.

Please print or type all information requested. Group Policy Number _____ Hire Date _____

Group Policyholder: _____

Applicant's Name: _____
(First, Middle, Last)

Applicant's Address: _____
(Number) (Street) (City) (State) (Zip) (Daytime Phone Number)

Social Security # / Employee ID No.: _____ Date of Birth: _____ Gender M/F _____ Height _____ Weight _____
(mm/dd/yy)

Benefits Requested

Accident and Sickness

☐ AG Group HospitalCare ☐ A ☐ B ☐ C ☐ D ☐ E ☐ Other

☐ (Applicant Only) ☐ (Applicant & Spouse)

☐ (Applicant & Child(ren) ☐ (Applicant & Family)

Accident Only*

☐ AG Group EmergencyCare ☐ A ☐ B ☐ C ☐ Other

*Questions 1-3 do not need to be completed.

☐ (Applicant Only) ☐ (Applicant & Spouse)

☐ (Applicant & Child(ren) ☐ (Applicant & Family)

(Write spouse's name below if you are applying for Applicant and Spouse or Applicant and Family coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

NAME		AGE	DATE OF BIRTH MM/DD/YY	SEX	HEIGHT	WEIGHT	SOCIAL SECURITY #
SP							
CH							
CH							
CH							
CH							

1. To the best of your knowledge and belief, has any proposed insured ever been diagnosed with or treated for any of the following: (If YES, please check (✓) the appropriate box)

	Applicant Yes	Applicant No
• disease or disorder of the heart; lung; kidney; liver	☐	☐
• tumors; cancer; diabetes;	☐	☐
• high blood pressure;	☐	☐
• brain or nervous system disease;	☐	☐
• mental or nervous disorders;	☐	☐
• alcohol or drug dependency;	☐	☐
• arthritis or other musculoskeletal disease or disorder;	☐	☐
• any other serious disorder?	☐	☐

2. Within the last 10 years, have you or any proposed insured tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS – related complex (ARC), or other immune disorders? Yes ☐ No ☐

3. Within the last 12 months, have you or any proposed insured missed more than 5 consecutive days of work due to illness or injury? Yes ☐ No ☐

If any question answered "YES", please give proposed insured person's name and explain. Please specify condition, date occurred, duration, degree of recovery and name/address of doctor/hospital/clinic. Use a separate sheet if necessary:

Name of Person	Question Number	Date	Duration	Details	Name of Physician or Hospital

Beneficiary * (Please print full name and relationship):

First Name	Initial	Last Name	Relationship

* **The applicant will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.**

AUTHORIZATION: I authorize the premium for this insurance to be deducted from my salary and forwarded to the Company.

I/We hereby represent that the above is true and correct to the best of my/our knowledge and belief. I understand my/our answers to the above questions determine my/our eligibility for coverage and that coverage will not become effective unless and until this application is approved and accepted. I/We understand that if coverage does become effective, the coverage effective date will be indicated in the Certificate of Insurance I will receive.

Applicant's Signature _____ Date _____

For Administrative Use Only (if Agent is involved)

Agent Name _____ License Number _____ Agent Signature _____

FRAUD NOTICE: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.