American General Life Insurance Company of Delaware*

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

*This company does not solicit business in New York.

These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

American General
Life Companies

Application for Group Voluntary Programs

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Please print or type all information requested.

All applications missing information, will be returned.

Group Policy Number _____ **Billing Location** _____

Employee's Annual Salary _____ **Hire Date** _____

Job Title _____

1. Name of Employer/Association _____

2. Employee's/Member's full name _____ Soc. Sec. No. _____
   FIRST MIDDLE LAST

3. Home Address _____
   NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Life Insurance
   Select specific Life amounts. Also select specific AD&D amounts if available under your group policy.
   If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter.

	Life Amount	AD&D Amount
Employee:	$	$
Spouse:	$	$
Child(ren):	$	/ / / / / / / /

5. Complete the following for employee/member, spouse and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security #
EE						ft. in.	lbs.	
SP						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

If you are eligible for Guarantee Issue, do not complete question 6 and 7 unless you are applying for an amount in excess of the Guarantee Issue.

	EMPLOYEE/MEMBER	SPOUSE	CHILD
6. Have you ever been diagnosed with or treated for any disease of the heart, kidneys, liver or lungs, cancer or tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7a. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7b. Are you presently taking any medication?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7c. Have you, in the past 12 months, missed more than 5 consecutive days of work due to illness or injury?	☐ Yes ☐ No		

If "yes" to any part of questions 6 and 7, give details on following page (not required for child(ren) if employee or spouse is also applying). Use a separate sheet of paper if more space is needed for answers.

SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE

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Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names, Address and Phone # of Physicians Hospitals/Clinics Consulted

8. Complete this item only if the plan description material offers smoker/non-smoker rates for life insurance. If not completed, you will be billed using smoker rates.

	EMPLOYEE	SPOUSE
Have you used tobacco in any form during the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No

AUTHORIZATION

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advise, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. 2. I understand that this information will be used by the Company solely to determine eligibility for insurance. 3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which the Company has taken in reliance upon this authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier. 4. I know that I should retain a copy of this authorization for my records. 5. I agree that a photocopy of this authorization is as valid as the original. 6. To the best of my knowledge and belief, all the statements made above are true and complete. 7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application. 8. I authorize deductions from earnings for the costs of this insurance. 9. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.

   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.

_____ ➡ _____
(DATE SIGNED) *(SIGNATURE OF EMPLOYEE/MEMBER)*

_____ ➡ _____
(DATE SIGNED) *(SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)*

➡ Witness to above Signature(s): _____

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and/or children's insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Ex. Mary A Jones, Wife Not Mrs. John Jones	First Name	Initial	Last Name	Relationship