Staple

American General
Life Companies

Application for Group Voluntary Programs

AIG Life Insurance Company*
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, MA 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.

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Please print or type all information requested.

Please complete all sections of the application to avoid delays.

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 _____
FIRST *MIDDLE* *LAST*

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

4. **Select coverages with specific amounts for Life, AD&D, LTD, and STD. 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	LTD Amount	STD Amount
Employee	$_____ ☐ refused	$_____ ☐ refused	$_____ (Must be in multiples of $100 Units – not to exceed max benefit) Salary must be completed above ☐ refused	$_____ (Must be in multiples of $10 Units – not to exceed max benefit) Salary must be completed above ☐ refused
Spouse/Civil Union Partner	$_____ ☐ refused	$_____ ☐ refused		
Child(ren)	$_____ ☐ refused			

5. Complete the following for employee/member, spouse/civil union partner and dependents requesting coverage. A civil union partner is a same sex partner who has been granted substantially the same benefits, protections and responsibilities under the law as granted to a spouse in a marriage. Partners in same-sex relationships from other jurisdictions that provide substantially all of the rights and benefits of marriage will be considered civil union partners under New Jersey Law.

	Name	Age	Date of Birth MM/DD/YY	Sex	Place of Birth	Height	Weight	Social Security # Employee ID #
EE						ft. in.	lbs.	
SP/ CP						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

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

	EMPLOYEE/ MEMBER	SPOUSE/CIVIL UNION PARTNER	CHILD
6. Have you ever been diagnosed with or treated for any disease or disorder 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 medications?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7c. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?	☐ Yes ☐ No		

SIGNATURE IS REQUIRED ON THE NEXT PAGE.

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If "yes" to any part of questions 6 and 7, give details below (not required for child(ren) if employee spouse/civil union partner is also applying. Use a separate sheet of paper if more space is needed for answers:

Question No.	Does Question Apply to Employee, Spouse/Civil Union Partner or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

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 includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

_____ ➧ _____

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

_____ ➧ _____

(DATE SIGNED) *(SIGNATURE OF SPOUSE/CIVIL UNION PARTNER, IF APPLYING FOR INSURANCE)*

➧ Witness to above Signature(s): _____

BENEFICIARY DESIGNATION (Complete only if applying for Life/AD&D benefits)
Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse/civil union partner and/or children's insurance applied for, and the spouse/civil union partner named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse/civil union partner 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