AIChE The Global Home of Chemical Engineers

American General Life Insurance Company

Application For Group Term Life Insurance

(Herein called the Company)

Are you a: ☐ **Member** ☐ **Spouse of a Member**

▼ Member/Applicant information *Please print or type*

Name (First, Middle, Last)

Address

City | State | ZIP

Age | Date of Birth | Place of Birth (State) | Height ft. in. | Weight lbs. | Sex (M/F)

Home Phone No. | Work Phone No. | Email Address

Social Security # | Beneficiary | Relationship

Name and Address of Applicant's Physician

(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise, your beneficiary will be your children, parents, siblings, or estate, in that order.)

▼ Spouse information *(if applying)*

Name (First, Middle, Last)

Age | Date of Birth | Place of Birth (State) | Height ft. in. | Weight lbs. | Sex (M/F)

Home Phone No. | Work Phone No. | Email Address

Social Security # | Beneficiary | Relationship

Name and Address of Spouse's Physician

(Unless otherwise requested, the applicant will be the beneficiary of any spouse insurance applied for.)

▼ Check Life Insurance plan(s) desired

Life Insurance for Applicant: ☐ $100,000 ☐ Other $ _____ *(up to $100,000, in $10,000 increments)*

Life Insurance for Spouse: ☐ $100,000 ☐ Other $ _____ *(up to $100,000, in $10,000 increments)*

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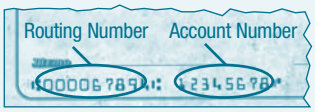
▼ Select your preferred payment preferences

Payment Method:

☐ **Bill Me by Mail**

See your checks for:



Bill Me via EFT:

☐ Checking Account Number: _____ Bank Routing Number: _____

☐ Savings Account Number: _____ Bank Routing Number: _____

Payment Frequency: *(Monthly payment frequency not available with Bill Me by Mail option.)*

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

▼ Please answer these brief questions

	Applicant	Spouse
1. Has the applicant or spouse, if applying, ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) or tested positive for an immune disorder?	☐ YES ☐ NO	☐ YES ☐ NO
2. Has the applicant or spouse, if applying, during the past 5 years, been diagnosed with, or been treated for drug or alcohol abuse?	☐ YES ☐ NO	☐ YES ☐ NO
3. Has the applicant or spouse, if applying, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	☐ YES ☐ NO	☐ YES ☐ NO
4. Is the applicant or spouse, if applying, now taking prescription medication or receiving medical attention?	☐ YES ☐ NO	☐ YES ☐ NO
5. Has the applicant or spouse, if applying, ever had life or health insurance declined, modified, or rated?	☐ YES ☐ NO	☐ YES ☐ NO

For "Yes" answers to questions 1-5 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right. . . . . ☐ YES ☐ NO

Question #	Applicant	Spouse	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

▼ Existing and pending insurance section

Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (*If none, check "None."*) . . . . . ☐ NONE

Applicant	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage? Yes	No

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▼ Please read the following, then sign and date below to apply

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY: I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., formerly known as the Medical Information Bureau, 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 coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes 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 MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

IMPORTANT NOTICE — Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime.

Applicant's Signature	Date	Spouse's Signature *(if applying)*	Date
X	/ /	X	/ /

Please reply today!

It takes just minutes to apply to give you and your family this solid life insurance protection.
Send No Money Now! We'll send you a premium notice upon approval.

▼ Simply complete the application and return it to: ▼

AIChE Insurance Program Administrator
159 East County Line Road • Hatboro, PA 19040-9635
Questions? Call 1-800-98-AIChE (982-4243)

(These Notices must be retained by the applicant)
MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. American General Life Insurance 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. 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.

American General Life Insurance 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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

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 a 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.