Accident Expense Plus[SM]
Producer Application Instructions - Georgia

Follow the checklist and instructions below to ensure that all application forms are properly completed and transmitted. All state required disclosure information must be presented to your client at the time of application.

GEORGIA FORMS CHECKLIST

	REQUIRED FORMS		
✓	**Form Name**	**Form Number**	**Action**
✓	Application	AGLC102438-GA	Complete the application information. Obtain applicant signatures on page 3. Sign the application verifying the information is correct.
✓	Bank Draft Authorization	AGLC102113	The Bank Draft Authorization must be completed, signed by the applicant and submitted with the application.
✓	Notice to Proposed Insured	AGLC102339-2006	Leave with applicant.
✓	Outline of Coverage	07120-OLC-11	Complete Benefits Schedule information on page 1. Check Critical Illness Rider on page 4 if applying for the CI Rider. Complete the Premiums section on page 5. Present to applicant at time of application.
✓	HIPAA Privacy Notice	AGLC100605	Leave with applicant.
	SUPPLEMENTAL FORMS		
	Credit Card Authorization	AGLC100949	If applicant would prefer to make initial premium payment with a credit card, complete the form and submit with application. Please note that we cannot accept recurring credit card payments for this product, only for the first premium payment.
	Shopper' s Guide to Cancer Insurance	AGLC101866	If applying for the Critical Illness Rider, present this guide to the applicant at time of application.
	Acknowledgement of Receipt of Cancer Insurance Shopper's Guide	AGLC101775	If Shopper's Guide to Cancer Insurance is presented to applicant, have them sign this acknowledgement and submit with application.
	Policy Delivery Receipt	AGLC101336	This form is only required by LA, PA, SD, and WV. However, it is a good business practice to have the policyholder sign that they have received their policy when you deliver it to them.

American General
Life Companies

Application for Accident and Health Insurance
Georgia Version

American General Life Insurance Company
A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

"Proposed Insured" refers to primary, spouse, and children proposed for coverage in this application.

1. Primary Proposed Insured

Last First Middle

2. Address

Street

City State Zip Code

3. Social Security No.

4. Birth Date and Place
Month | Day | Year | State | Country

5. Age

6. Sex ❑ M ❑ F

7. U.S. Citizen ❑ Yes ❑ No
If no, date of entry _____ visa type _____

8. Spouse (if coverage applied for) Sex ❑ M ❑ F

Name _____
Last First Middle

Month | Day | Year | State | Country

Birth Date and Place Social Security No. Age

9. Primary Proposed Insured Height _____ Weight _____

10. Spouse Height _____ Weight _____

11. Beneficiary

Name _____
Last First Middle

Social Security No. Date of Birth Relationship

12. Primary Proposed Insured Driver's License
#_____ State of Issue _____

13. List Dependent(s) Information:

Full Name	Age	Relationship	Birth Date Mo. Day Yr.	Sex M	Sex F
a.				❑	❑
b.				❑	❑
c.				❑	❑
d.				❑	❑
e.				❑	❑

Insurance Plan

❑ **Accident**

Coverage Level
- ❑ Primary Proposed Insured
- ❑ Primary Proposed Insured/Spouse
- ❑ Family
- ❑ Primary Proposed Insured/Children

Deductible Amount: $ _____

Benefit Payable per Calender Year, per Insured: $ _____

❑ **Critical Illness Benefit Rider**

Coverage Level
- ❑ Primary Proposed Insured
- ❑ Primary Proposed Insured/Spouse
- ❑ Family
- ❑ Primary Proposed Insured/Children

Benefit Payable per Lifetime, per Insured:

Primary Proposed Insured $ _____

Spouse $ _____

Children $ _____

Questions 14-17 are only applicable if applying for the Critical Illness Benefit Rider.

14. Additional Information – In the past 1 year, had any Proposed Insured used tobacco (cigarette, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum or any other form of nicotine? ❑Yes ❑No

For a "Yes" answer, please indicate Primary Proposed Insured and/or Spouse. ❑Primary Proposed Insured ❑Spouse

Health Questions	Yes	No
15. Within the past 10 years has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), for AIDS Related Complex (ARC), or for any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑	❑
16. In the last 5 years, has any Proposed Insured been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's disease or non-Hodgkin's lymphoma?	❑	❑
17. In the last 5 years, has any Proposed Insured been diagnosed as having or been treated for or consulted a licensed health care provider for:		
a. Stroke or transient ischemic attack (TIA)?	❑	❑
b. Diabetes?	❑	❑
c. Disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	❑	❑
d. Kidney failure or abnormal kidney function?	❑	❑
e. An organ transplant or been advised of the need of an organ transplant?	❑	❑

Health History—Details For Any "Yes" Answers

Question #	Name of Proposed Insured	Relationship			Description
		Primary Proposed Insured	Spouse	Child	

All Coverage—Existing or Pending Insurance Question

Does any Proposed Insured have any existing or pending accident or sickness insurance?
(If yes, complete section following)

Name of Proposed Insured	Company Name	Type*	Face Amount	Replace** Yes	Replace** No
				❑	❑
				❑	❑
				❑	❑

* Type A = accident, CI = critical illness, or O = other

** Replace means that the insurance policy being applied for replaces any accident and sickness policy pending or presently in force including health, accident, critical illness, disability or cancer insurance. If replacement may be involved, complete and submit any state-required replacement forms.

Modal Premiums

Frequency of modal premium: ❑Annual ❑Semi-annual ❑Quarterly ❑Monthly (Bank Draft only)

Method: ❑Direct Billing ❑Bank Draft (Complete Bank Draft Authorization.) ❑List Bill: Number _____

❑Credit Card – Initial Premium Only (Complete Credit Card Authorization.)

Accident	Critical Illness Benefit Rider	Total Modal Premium
$_____	$_____	$_____

AGREEMENT – AUTHORIZATION – ACKNOWLEDGEMENT – UNDERSTANDING

between Proposed Insured ("You or Your") and the Company and its affiliates ("We" or "Us")

Agreement.

Your insurance will not begin until: (a) We have issued Your policy and (b) received Your first premium in full. You must pay your first premium in full within 45 days of the date Your policy is issued. Even if You pay Your premium in advance, there will be no coverage until the day Your policy is issued. If Your policy is not issued for any reason, We will (a) refund Your premium, and (b) have no liability regarding this application.

The policy You are applying for is NOT major medical insurance. It is a limited benefit policy. This means that it pays benefits only as defined in the policy. Benefits payable are subject to the conditions, limits, reductions and exclusions in the policy.

All statements and answers are complete and true to the best of Your knowledge and belief. No agent can: (a) waive any answer, (b) modify this application, (c) bind Us or (d) make any promise or representation not contained in this application.

Authorization.

By signing the application, You authorize Us to release the information obtained in the application in these circumstances only: (a) to reinsurers or other persons or entities performing business or legal services in connection with this application or claims, (b) as may be lawfully required, or (c) as You may further authorize.

A photocopy is as valid as an original. This Authorization will be valid for 24 months of the date signed below.

You or Your representative may request a copy. You also may revoke this Authorization at any time by written notification to Us at our Home Office.

Acknowledgement.

By signing this application, you acknowledge receipt of the Outline of Coverage, Notice to the Primary Proposed Insured and the HIPAA Privacy Notice. If you are completing this application using voice signature, you acknowledge that you already have a copy of the Outline of Coverage and the HIPAA Privacy Notice, and that Notices to the Primary Proposed Insured have either been read to you or provided to you.

Understanding.

If You are receiving Medicaid payments, benefits under the policy may reduce those payments or any Medicaid benefits otherwise payable.

Anyone 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.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Signed at _____ _____ _____

City State Date

X _____ X _____

Signature of Primary Proposed Insured Signature of Owner (if other than Primary Proposed Insured)

Information Sharing (Optional)

By signing below, You further authorize Us to use and/or share the demographic information in this application to provide You with information about other products and/or service offered by Us.

X _____

Signature of Primary Proposed Insured

Agent Section.

I certify that I have asked each question and that the answers have been truly and accurately recorded as given to me. I have recorded any unfavorable information of which I have knowledge concerning any Proposed Insured. I also have provided the required Outlines of Coverage and the HIPAA Privacy Notice.

X _____ _____

Signature of Licensed Agent Printed Name of Agent

_____

Agent Number

American General
Life Companies

Effective Date: April 14, 2003

NOTICE OF HEALTH INFORMATION PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

THIS NOTICE IS PROVIDED TO YOU FOR INFORMATIONAL PURPOSES ONLY. YOU ARE NOT REQUIRED TO CALL OR TAKE ANY ACTION IN RESPONSE TO THIS NOTICE.

This Notice applies to the individual health and long term care insurance business of American General Life Insurance Company of Delaware, American General Life and Accident Insurance Company, American General Life Insurance Company, and The United States Life Insurance Company in the City of New York (collectively the "Company").

As used in this Notice, "Personal Health Information" means individually identifiable information about you including demographic information (like your name, address and gender) which is collected from you or from members of the health care industry (like doctors or employee benefit plans) and relates to your health, health care provided to you, or payment for health care provided to you.

This Notice will tell you about the ways we use and disclose your Personal Health Information for underwriting, claims administration, plan of care, other payment and health care operations matters, and other circumstances as either required or permitted by law. For purposes of this Notice, "health care operations" means our business operations relating to health and long term care insurance coverage. Please note that not all of the companies listed above necessarily issue both health and long term care insurance policies. To the extent that applicable state law further limits or restricts the uses and disclosures discussed below, we will comply with the more stringent state law. Except as outlined below, we cannot use or disclose your Personal Health Information without your written authorization.

We are required by law to: maintain the privacy of your Personal Health Information, give you this Notice of our legal duties and privacy practices, and abide by the terms of this Notice as long as it remains in effect.

We reserve the right to change any of our privacy practices and the terms of this Notice and to apply our updated privacy practices to all Personal Health Information maintained by us or by those who work on our behalf. In the event of a material change to our Notice, a revised Notice will be sent to all affected policyholders.

USES AND DISCLOSURES OF YOUR PERSONAL HEALTH INFORMATION

For Plan of Care: We may disclose information to doctors, dentists, pharmacies, hospitals and other health care providers who take care of you. For example, doctors may request medical information from us to supplement their own records. We may also send certain information to doctors for patient safety or other treatment-related issues.

For Claim Payments and Processing: We may use and disclose your Personal Health Information as necessary for benefit verification and claim payment purposes. For instance, we may use information regarding services you receive from health care providers (such as physicians) to process and pay claims.

For Business Operations: We may use and disclose your Personal Health Information as necessary, and as permitted by law, for our health care operations which include but are not limited to underwriting, premium rating, premium collection, customer service, payment of commissions, reinsurance, compliance, auditing, and other functions related to the administration of your health and/or long term care insurance coverage.

For example:

- **Collection of Information**: To properly underwrite and administer your insurance coverage, we collect medical and non-medical personal information such as your age, occupation, physical condition, and health history, including drug and alcohol usage. You are our most important source of information; however, we may also collect or verify information by contacting the following sources: consumer reporting agencies, the Medical Information Bureau Inc., insurance companies to which you have applied for coverage (including the Company), and medical professionals and facilities which have provided services to you.
- **Business Associates:** Certain services are performed through contracts with outside persons or organizations, such as underwriting support services, actuarial services, legal services, care coordination services, etc. At times it may be necessary for us to disclose your Personal Health Information to one or more of these outside persons or organizations who assist us with our health care operations. In all cases, we require these business associates to appropriately maintain the privacy of your information.
- **Agents:** In order to allow your agent to serve you, we may provide the agent with copies of certain correspondence we send to you, including our declination of your application, our offer of coverage to you at a higher than standard rate, our offer to

accept your application with modifications to the benefits you requested, your replacement of your policy, or your cancellation of your policy. We may also provide certain information to the agent necessary for determining payments to the agent or notify the agent when you submit a claim.

- **Family, Friends and Others Involved in Your Care:** We may from time to time disclose your Personal Health Information to family, friends, and others (such as your designees) who are involved in your care or in payment for your care in order to facilitate that person's involvement in caring for you or paying for your care. If you are unavailable, incapacitated, or facing an emergency medical situation, and we determine that a limited disclosure may be in your best interest, we may share limited Personal Health Information with such individuals. We may also disclose limited Personal Health Information to a public or private entity that is authorized to assist in disaster relief efforts in order for that entity to locate a family member or other persons that may be involved in some aspect of caring for you. You have the right to stop or limit these disclosures.
- **Service-Related Uses and Marketing:** We may contact you to provide information on payment of your claims, or information about health-related benefits and services that may be of interest to you. We will not use your Personal Health Information for marketing non-health products without your authorization.

Other Uses and Disclosures: In some circumstances, such as those described below, we may disclose your Personal Health Information to third parties without your authorization:

- We may release your Personal Health Information for any purpose allowed by law;
- We may release your Personal Health Information to law enforcement officials as allowed by law to report wounds, injuries, and crimes;
- We may release your Personal Health Information for public health activities, such as permitted reporting of disease, injury, death, and for required public health investigations;
- We may release your Personal Health Information as required by law if we believe you to be a victim of abuse, neglect, or domestic violence;
- If you are covered under a group plan, we may release your Personal Health Information to your plan sponsor as permitted by the group health plan and as provided for in the group health plan's notice of privacy practices if required. However, prior to any such disclosure the plan sponsor must certify that the information provided will be maintained in a confidential manner and not used for employment related decisions or in connection with any other benefit or benefit plan of the plan sponsor, or in any other manner not permitted by law;
- We may release your Personal Health Information if allowed by law to a government oversight agency conducting audits, investigations (such as investigations into consumer complaints), or civil or criminal proceedings;
- We may release your Personal Health Information if required to do so by a court or administratively ordered subpoena or discovery request;
- We may release your Personal Health Information for certain research purposes when such research is approved by an institutional review board with established rules to ensure privacy;
- We may release your Personal Health Information if you are a member of the military as required by armed forces services. We may also release your Personal Health Information if necessary for national security, intelligence activities, disaster relief purposes, to avert a serious threat to health or safety, or for the protection of the President and others;
- We may release your Personal Health Information to workers' compensation agencies if necessary for your workers' compensation benefit determination;
- We may release your Personal Health Information to coroners, medical examiners, and funeral directors if needed, for example, to identify a deceased person. We may also release your Personal Health Information to organ or tissue procurement organizations, consistent with applicable law;
- We may release your Personal Health Information to a correctional institution if you are or become an inmate of a correctional institution;
- We may release your Personal Health Information to non-affiliated organizations or persons such as other insurance institutions, agents, insurance support organizations, or law enforcement and governmental authority as necessary to prevent criminal activity, fraud, material misrepresentation, or material nondisclosure in connection with your coverage or application for coverage; and
- We may release your Personal Health Information to any affiliated company. Such company's use will be limited to use in connection with a compliance audit, market conduct audit, or other compliance or regulatory activity.

YOUR RIGHTS REGARDING YOUR PERSONAL HEALTH INFORMATION

You have the following rights:

- To copy and/or inspect much of the Personal Health Information that we retain on your behalf. All requests must be made in writing and signed by you or your representative. We may charge a reasonable fee for copies and postage and, in certain cases, may deny your request.
- To request that we send communications of Personal Health Information about you by alternative means or to alternative locations, if all or part of that

information could endanger you. For example. you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

- To request in writing that Personal Health Information that we maintain about you be amended or corrected. We are not obligated to make all requested amendments but will give each request careful consideration. All amendment requests, in order to be considered by us, must be in writing, signed by you or your representative, and must state the reasons for the amendment/correction request. If an amendment or correction you request is made by us, we may also notify others who work with us and have copies of the uncorrected record if we believe that such notification is necessary.
- To receive a list of certain disclosures made by us of your Personal Health Information. The list will not include our disclosures related to payment or health care operations, disclosures made to you or with your authorization, or certain other disclosures, such as for national security purposes. Your request for a listing of disclosures must be in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. The first accounting in any 12-month period is free. You will be charged a reasonable fee for each subsequent accounting you request within the same 12-month period.
- To request restrictions on certain of our uses and disclosures of your Personal Health Information for plan of care, payment, or health care operations by notifying us of your request for a restriction in writing. Your request must describe in detail the restriction you are requesting. We are not required to agree to your restriction request but will attempt to accommodate reasonable requests when appropriate. We retain the right to terminate an agreed-to restriction if we believe such termination is appropriate. In the event of a termination by us, we will notify you of such termination. You also have the right to terminate, in writing or orally, any agreed-to restriction.
- To receive a paper copy of this Notice. You may ask us to give you a copy of this Notice at any time. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy.
- If you have signed an authorization for uses and disclosures not related to payment or health care operations, you have the right to revoke that authorization in writing at any time, except to the extent that we have taken action in reliance of such authorization, or if other law provides us with the right to contest a claim under the policy itself.

If you would like to exercise a right discussed in this Notice, please send your written request to the appropriate address below:

For policies issued or serviced by *American General Life and Accident Insurance Company*	Director, Compliance American General Life and Accident Insurance Company 268N American General Center Nashville, TN 37250
For policies issued or serviced by *all other companies covered by this Notice*	Chief Compliance Officer American General Life Companies 2929 Allen Parkway Houston, TX 77019

COMPLAINTS

If you believe your privacy rights have been violated, please send your written complaint to the appropriate address below:

For policies issued or serviced by *American General Life and Accident Insurance Company*	Director, Compliance American General Life and Accident Insurance Company 268N American General Center Nashville, TN 37250
For policies issued or serviced by *all other companies covered by this Notice*	Chief Compliance Officer American General Life Companies 2929 Allen Parkway Houston, TX 77019

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services in Washington. D.C., in writing within 180 days of a violation of your rights. We will not retaliate against you for filing a complaint.

FOR FURTHER INFORMATION

If you have questions or need further assistance regarding this Notice, you may contact us at the appropriate address below:

For policies issued or serviced by *American General Life and Accident Insurance Company*	Customer Service American General Life and Accident Insurance Company 338N American General Center Nashville, TN 37250 Telephone: 1-800/888-2452
For policies issued or serviced by *all other companies covered by this Notice*	American General Life Companies Service Center P. O. Box 4373 Houston, TX 77210-4373 Telephone: 1-800/231-3655

ACCIDENT COVERAGE OUTLINE OF COVERAGE
Policy Form 07120-11

Read Your Policy Carefully

This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract, and only the actual policy provisions will control. The policy itself sets forth, in detail, the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

ACCIDENT ONLY COVERAGE

Accident only coverage is designed to provide Insured Persons with coverage for certain losses resulting from a covered accident ONLY, subject to any exclusions contained in the policy. Coverage is not provided for any loss due to sickness. Coverage is not provided for basic hospital, basic medical surgical or major medical expenses.

BENEFITS SCHEDULE

Maximum Amount per Insured, per Calendar Year $_____

Deductible Amount $_____

BENEFITS

When We receive due written proof that expenses incurred due to an Accident satisfy the Deductible Amount, as shown in the Benefit Schedule, We will pay for the following listed benefits, less any adjustment or discounts, up to the Maximum Amount, per Insured, per Calendar Year as shown in the Benefit Schedule.

ACCIDENTAL EMERGENCY CARE BENEFIT
(Within 72 hours following Accidental Injury)

ACCIDENT FOLLOW UP CARE BENEFIT
Follow up treatments must occur within 30 Days of the Accidental Injury or discharge from the hospital, and must be furnished by a Physician in a Physician's Office or in a Hospital on an outpatient basis. Benefit will not be payable for the same visit that the Physical Therapy Benefit is payable or on the same day for which the Accidental Emergency Care Benefit is payable.

AMBULANCE BENEFIT
(Benefit only payable if Accidental Emergency Treatment Benefit is payable.)

DRUG BENEFIT
(Benefits for drugs administered in a Hospital or Urgent Care Center)

FRACTURE BENEFIT
Diagnosis of the Fracture must be within 14 Days of the Accidental Injury.

MAJOR DIAGNOSTIC EXAMINATIONS
Benefit is limited to one Major Diagnostic Exam per Year for each Insured Person.

Major Diagnostic Exams are limited to the following: CT (computerized tomography) scan, MRI (magnetic resonance imaging) and EEG (electroencephalogram).

PHYSICAL THERAPY BENEFIT
Physical Therapy must begin within 30 days of the Accidental Injury or discharge from the Hospital and must be completed within six months after the Accidental Injury. Benefit is limited to one Physical Therapy treatment per day, up to a maximum of ten treatments for each Accidental Injury.

PROSTHESIS BENEFIT
Benefit limited to a maximum of one Prosthetic Device received within one year of the Accidental Injury.

X-RAY BENEFIT
The x-ray or set of x-rays must be performed within 14 days of the Accidental Injury.

BENEFIT PAYMENT CONDITIONS

The payment of benefits for an Accident is subject to the following conditions:

(a) The Accidental Injury and Care occurs while the coverage on an Insured Person is effective under the policy;
(b) The initial Care must begin within 72 hours of the Accidental Injury;
(c) The benefit payment is not precluded by any general or specific exclusion, description, or any failure to meet any condition precedent stated in the policy; and
(d) Care for the Accidental Injury is received within the United States.

We reserve the right to request that a Physician of our choice review any Diagnosis in the event of a dispute or disagreement regarding the appropriateness or correctness of a Diagnosis. We also reserve the right to require that an Insured Person submit to an examination to confirm a disputed Accidental Injury. We reserve the right to request that an independent and acknowledged expert in the applicable field of medicine review the evidence used in making any disputed Diagnosis. We will pay for any such requested examination or review.

EXCLUSIONS

For any Insured Person:

(a) We will pay NO benefits under the policy if covered services provided are not related to a covered Accident.
(b) We will pay NO benefits for any Accident or any loss caused in whole or in part by, or resulting in whole or in part from the following:
  i) the Insured Person's suicide or attempt at suicide, or intentional self-inflicted injury or sickness, or any attempt at intentional self-inflicted injury or sickness while sane or insane;
  ii) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic; or any other drug or intoxicant including those prescribed by a Physician that are misused by the Insured Person;
  iii) the Insured Person's commission of or attempt to commit an assault or felony;
  iv) the Insured Person engaging in an illegal activity or occupation;
  v) the Insured Person's voluntary participation in any riot or civil insurrection;
  vi) declared or undeclared war, or any act of declared or undeclared war;
  vii) the Insured Person's operating, learning to operate, serving as a crew member of, or jumping, parachuting, or falling from an aircraft or hot air balloon, including those which are not motor driven;
  viii) the Insured Person's engaging in hang gliding, bungee jumping, parachuting, sailgliding, parasailing or parakiting or any similar activity;
  ix) the Insured Person's riding in or driving any motor driven vehicle in a race, stunt show or speed test;
  x) the Insured Person practicing for or participating in any semi-professional or professional competitive athletic contest for which such Insured Person receives any compensation or remuneration;
  xi) the Insured Person's operating any type of land, water, or air vehicle while having a blood alcohol content at or above the level made illegal for operation of such vehicle by the jurisdiction where the Accidental Injury occurred; and
  xii) any illness, loss, or condition specifically excluded from the definition of any Accident.

DEFINITIONS

ACCIDENT means the unforeseen occurrence of an event, which results in Accidental Injury to an Insured Person wholly independent of disease, bodily infirmity, illness, infection or any other physical condition.

ACCIDENTAL INJURY means bodily injury to an Insured Person as the result of an Accident, after coverage under the Policy takes effect and while the Policy is in force, which results in Care within 72 hours after the injury is sustained.

AMBULANCE means a specially equipped vehicle, licensed and used to transport the sick or injured.

CALENDAR YEAR means the period from January 1st to December 31st.

CARE means medical treatment or attention received in an Emergency Room, Hospital, Urgent Care Center, or Physician's office. Such Care must be within 72 hours of the Accidental Injury. Care does not include any psychiatric treatment.

DEDUCTIBLE AMOUNT means the dollar amount shown in the Benefit Schedule above which must be incurred under the policy by an Insured Person each Calendar Year before benefits are payable under the policy. If the Insured elects to cover a spouse and/or child(ren), the Deductible Amount will be satisfied when the total of all dollar amounts incurred by the family unit are equal to two (2) times the Deductible Amount.

DIAGNOSIS/DIAGNOSED means a definitive Diagnosis made by a Physician, licensed and practicing in the United States and its territories and, where applicable, specializing in a particular field of medicine, which:

(a) is based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations and where the results are documented in and supported by the Insured Person's medical records; and
(b) meets all diagnostic requirements stated in the policy for the particular Accident being Diagnosed.

EMERGENCY ROOM means a specified area within a Hospital that is designated for the emergency Care of accidental injuries. This area must:

(a) be staffed and equipped to handle trauma;
(b) be supervised and provide Care by a Physician; and
(c) provide Care seven days per week, 24 hours per day.

HOSPITAL means an institution that:

(a) is operated pursuant to law and is licensed as a Hospital by the responsible state agency;
(b) is primarily and continuously engaged in providing or operating, either on its premises or in facilities available to the Hospital on a prearranged basis and under the supervision of a staff of duly licensed Physicians, medical, diagnostic and major surgical facilities for the Care of sick or injured persons on an inpatient basis for which a charge is made; and
(c) provides 24-hour nursing service by or under the supervision of registered graduate professional nurses (RNs).

It does NOT mean or include:

(a) convalescent, assisted living, extended care, hospice, rest or nursing facilities; or
(b) facilities primarily affording custodial, educational or rehabilitative care; or facilities primarily for the aged or for substance abusers; or
(c) a private monitored room.

INSURED means the person named as "Insured" in the Policy Data (or the Insured Spouse, if one is indicated as an "Insured Person" in the Policy Data and such Insured Spouse becomes the Insured upon the death of the person named as "Insured" in the Policy Data).

INSURED PERSON means all persons who are indicated as an "Insured Person" in the Policy Data as being covered by the policy.

PHYSICIAN means a person who:

(a) is a legally qualified-practitioner of the healing arts and is licensed in the United States or its territories;
(b) practices within the scope of his or her license;
(c) is not the Insured Person;
(d) is not related to the Insured Person as a spouse, parent, child or sibling; and
(e) does not customarily reside in the same household as the Insured Person.

PHYSICAL THERAPY means a branch of rehabilitative health care that uses specially designed exercises and equipment to help patients regain or improve their physical abilities.

PROSTHETIC DEVICE means a removable artificial substitute or replacement of a part of the body.

It does NOT mean or include:

(a) dental aids, including false teeth;
(b) eye glasses;
(c) cosmetic prosthesis such as hair wigs;
(d) other types of prosthetic devices that are permanently implanted, such as an artificial hip or tooth;
(e) any experimental prostheses; or
(f) an auditory prosthesis (a device that substitutes for or enhances the ability to hear).

SURGERY means a surgical operation or procedure, especially one involving the repair or removal of an organ or tissue due to an Accidental Injury.

UNITED STATES means the 50 states, plus the District of Columbia, and includes Guam, the U.S. Virgin Islands and Puerto Rico.

URGENT CARE CENTER means a facility operated pursuant to law and licensed by the responsible state agency. Such center is dedicated to the delivery of unscheduled, walk-in care outside of a Hospital Emergency Room. The center must be under the supervision of a duly licensed Physician.

GUARANTEED RENEWABLE TO AGE 65

Your policy may be continued by paying the appropriate premiums when they are due. A Grace Period of 31 days will be granted for each premium payment after the first. The Company retains no right to restrict your benefits after the policy has been issued. The premiums can be changed on a class basis only. Any such change will be based on the Insured's age at the Date of Issue. Such change will not become effective until you have been notified in writing.

TERMINATION DATE

Coverage under the policy for each Insured Person will terminate on the policy anniversary on or next following the date that Insured Person reaches the maximum coverage age. The maximum coverage age for the Insured and Insured Spouse is age 65. The maximum coverage age for an Insured Child is explained in the policy. The policy can be continued for the remaining Insured Person after coverage has been terminated for an Insured Person due to reaching the maximum coverage age.

The policy will terminate:

(a) on the policy anniversary on or next following the date that the last Insured Person reaches their maximum coverage age;
(b) on any premium due date requested by you in writing;
(c) at the end of the Grace Period, if any renewal premium is not paid prior to that time; or
(d) at the end of the month In which the Insured dies.

OPTIONAL RIDER

☐ **CRITICAL ILLNESS BENEFIT RIDER (OPTIONAL)**

If the Critical Illness Benefit Rider is selected, the plan pays for the following Critical Illnesses – Invasive Cancer, Heart Attack and Stroke, subject to the Waiting Period and the Benefit Payable Per Lifetime, Per Insured.

PREMIUMS

Plan: ☐ **Individual** ☐ **Individual & Spouse** ☐ **Parent & Children** ☐ **Family**

Premium Summary

Premiums: Payable _____ until age 65:
(mode)

Primary $ _____

Spouse $ _____

Child $ _____

Total Premium $ _____

THIS OUTLINE OF COVERAGE IS ONLY A SUMMARY OF THE COVERAGE PROVIDED; THE POLICY ITSELF SHOULD BE CONSULTED TO DETERMINE GOVERNING CONTRACTUAL PROVISIONS.

American General
Life Companies

American General Life Insurance Company
A subsidiary of American International Group, Inc.
2727-A Allen Parkway • Houston, TX 77019

The underwriting risks, financial obligations and support functions associated with the products issued by American General Life Insurance Company are solely its responsibility. American General Life Insurance Company is responsible for its own financial condition and contractual obligations.

BANK DRAFT AUTHORIZATION

☐ **American General Life Insurance Company, Houston, TX**

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

☐ **American General Life Insurance Company of Delaware, Wilmington, DE**

The company checked above ("Company") will withdraw the premiums from the specified account. "You", "your", "I", and "me" refer to the bank account Owner whose name appears below.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Automatic Bank Draft Agreement

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason.

This must be dated and signed by the bank account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Routing Number ⑆ | | | | | | | | | ⑆

Account Number | | | | | | | | | | | | | | | ⑈

Type of Account: ☐ Checking ☐ Savings Credit Union: ☐ yes ☐ no

Name of Primary Proposed Insured _____ Premium Amount $ _____

Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

Preferred Withdrawal Date (1st-28th) _____ ☐ **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name _____

Signature(s) of Bank Account Owner(s) **X** _____

Please attach voided check or deposit slip.

Detach this page and leave it with the proposed insured

NOTICES TO THE PROPOSED INSURED

American General Life Insurance Company, Houston, TX

This notice is provided on behalf of American General Life Insurance Company ("The Company") and American General Life Companies LLC, an affiliated service company.

FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

MEDICAL INFORMATION BUREAU

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 in 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.

INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: American General Life Companies LLC, P.O. Box 1931, Houston, TX 77251-1931

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

American General
Life Companies

American General Life Insurance Company

ACKNOWLEDGEMENT OF DELIVERY OF A BUYER'S GUIDE TO CANCER INSURANCE

Proposed Insured Name: _____

For the Proposed Insured (Please fill out if you are present with the agent)

By signing below, I acknowledge that I have received a copy of the Buyer's Guide from the agent.

Proposed Policyowner Name: _____

Proposed Policyowner Signature: _____

Date: _____

For the Agent

Check one of the following to acknowledge your delivery of the Buyer's Guide:

_____ I have met with the client in person and have given the client a copy of the Buyer's Guide, and have asked him or her to sign this acknowledgment form.

_____ I have mailed the Buyer's Guide to the client; therefore, no signature was obtained.

If mailed, date mailed to client: _____

Agent Name: _____

Agent Signature: _____ Date: _____

Client Copy Agent Copy – retain this copy for your records

Many policies promise to increase benefits after a patient has been in the hospital for 90 consecutive days. However, since the average stay in a hospital for a cancer patient is 13 days, large dollar amounts for extended benefits have very little value for most patients.

Many cancer insurance policies have fixed dollar limits. For example, a policy might pay only up to $1,500 for surgery costs or $1,000 for radiation therapy, or it may have fixed payments such as $50 or $100 for each day in the hospital. Others limit total benefits to a fixed amount such as $5,000 or $10,000.

No policy will cover cancer diagnosed before you applied for the policy. Some policies will deny coverage if you are later found to have had cancer at the time of purchase, even if you did not know it.

Most cancer insurance does not cover cancer-related illnesses. Cancer or its treatment may lead to other physical problems, such as infection, diabetes or pneumonia.

Many policies contain time limits. Some policies require waiting periods of 30 days or even several months before you are covered. Others stop paying benefits after a fixed period of two or three years.

Prepared by the National Association of Insurance Commissioners

AGLC101866

A Shopper's Guide To CANCER INSURANCE

Should You Buy Cancer Insurance?

Cancer Insurance Is Not a Substitute For Comprehensive Coverage

Caution: Limitations On Cancer Insurance

Cancer Insurance ...

Cancer insurance provides benefits only if you get cancer. No policy will cover you for cancer diagnosed before you applied for the policy. Examples of other specified disease policies are heart attack or stroke policies. The information in this booklet applies to cancer insurance, but could very well apply to other specified disease policies.

Cancer Insurance Is Not A Substitute For Comprehensive Coverage ...

Cancer treatment accounts for about 10% of U.S. health expenses. In fact, no single disease accounts for more than a small proportion of the American public's health care bill. This is why it is essential to have insurance coverage for all conditions, not just cancer.

If you and your family are not protected against catastrophic medical costs, you should consider a major medical policy. These policies pay a large percentage of your covered costs after a deductible is paid either by you or your basic insurance. They often have very high maximums, such as $100,000 to $1,000,000. Major medical policies will cover you for any accident or sickness, including cancer. They cost more than cancer policies because they cover more, but they are generally considered a better buy.

Should You Buy Cancer Insurance? ... Many People Don't Need It

If you are considering cancer insurance, ask yourself three questions: Is my current coverage adequate for these costs? How much will the treatment cost if I do get cancer? How likely am I to contract the disease?

If you have Medicare and want more insurance, a comprehensive Medicare supplement policy is what you need.

Low-income people who are Medicaid recipients do not need any more insurance. If you think you might qualify, contact your local social service agency.

Duplicate Coverage is Expensive and Unnecessary. Buy basic coverage first, such as a major medical policy. Make sure any cancer policy will meet needs not met by your basic insurance. You cannot assume that double coverage will result in double benefits. Many cancer policies advertise that they will pay benefits no matter what your other insurance pays. However, your basic policy may contain a coordination of benefits clause. That means it will not pay duplicate benefits. To find out if you can get benefits from both policies, check your major medical insurance as well as the cancer policy.

Some Cancer Expenses May Not be Covered Even by a Cancer Policy. Medical costs of cancer treatment vary. On the average, hospitalization accounts for 78% of such costs and physician services make up 13%. The remainder goes for other professional services, drugs and nursing home care. Cancer patients often face large, non-medical expenses that are not usually covered by cancer insurance. Examples are home care, transportation and rehabilitation costs.

Don't be Mislead by Emotions. While 3 in 10 Americans will get cancer over a lifetime, 7 in 10 will not. In any one year, only one American in 250 will get cancer. The odds are against you receiving any benefits from a cancer policy. Be sure you know what conditions must be met before the policy will start to pay your bills.

Caution: Limitations Of Cancer Insurance ...

Cancer policies sold today vary widely in cost and coverage. If you decide to purchase a cancer policy, contact different companies and agents, and compare the policies before you buy. The following are some common limitations.

Some policies pay only for hospital care. Today cancer treatment, including radiation, chemotherapy and some surgery, is often given on an outpatient basis. Because the average stay in the hospital for a cancer patient is only 13 days, a policy that pays only when you are hospitalized has limited value.