AIG

Term Conversion Request
No Underwriting Required

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of New York**
A member of American International Group, Inc. (AIG)
P.O. Box 305355 • Nashville, TN 37230-5355

Please fax forms to: 1-800-382-4662

In this request, "Company" refers to the insurance company whose name is checked above. The insurance company checked above is solely responsible for the obligation and payment of benefits under any policy it may issue.

Instructions:

This form is used to request full or partial term conversions for a Primary Insured on an inforce single life policy and/or rider where evidence of insurability is NOT required. If additional insurance over the conversion amount is required or riders or benefits that require evidence of insurability are required, please complete the inforce change application for the applicable state.

Required Forms are listed below.

- Term Conversion Request Form
- Full copy of signed and dated Illustration (UL Plans only)
- First modal premium payment and/or completed Bank Draft Authorization form
- Business Certification or Certification of Trust, if applicable
- TIR Disclosure Form if required
- Index UL Supplemental Application

A. CURRENT POLICY INFORMATION

Existing Policy #:_____ **Company Code:** _____

Insured Name: _____

Owner name (if other than Insured)**:**_____

B. CONVERSION REQUEST

Conversion Privilege: Conversion periods vary by policy. You may wish to contact the Producer Call Center for information. If the insured meets the "total disability" definition of any premium waiver benefit under the policy to be converted, the insured may not be eligible to convert to a new policy or to include a premium waiver rider on the new policy.

Base Coverage Amount: _____ Conversion Effective Date: _____

New Plan Name: _____ Amount $_____

Is Automatic Premium Loan Provision to be in effect? (Whole Life plans only) ☐ Yes ☐ No

Death Benefit Option (UL plans only): ☐ Level ☐ Increasing

For Index UL, complete the Index UL Supplemental Application.

TERM POLICY CONVERSION	TERM RIDER CONVERSION
☐ Full conversion of Term Policy. ☐ Partial conversion of Term Policy. Balance of term insurance to: ☐ BE TERMINATED. ☐ Policy to remain inforce at reduced amount of $_____	☐ Full conversion of Term rider: ☐ Base plan to remain inforce. ☐ Base plan to be terminated. ☐ Partial conversion of Term rider: ☐ Balance of Term to be terminated. $_____

Benefits and Riders:

If any of the following benefits and riders are currently a part of the policy being converted, and the Owner requests available and comparable coverage, or if the Owner wishes to add the Terminal Illness Rider to the new policy, check the appropriate box(es) below. Depending on the new policy selected for the conversion, not every listed benefit and rider will be available.

☐ Child Term Rider ☐ Disability Income Rider ☐ Premium Waiver ☐ Terminal Illness Rider

C. PRIMARY INSURED INFORMATION FOR NEW POLICY

Insured Name: _____

SSN _____ Date of Birth _____Gender ☐ M ☐ F

Address _____ City_____ State _____ Zip_____

Primary Phone _____ Alternate Phone _____ Email _____

D. DESIGNATION OF OWNER FOR NEW POLICY

Complete owner information for new policy below.
Change of ownership: ☐ **Yes** ☐ **No** *(If yes, new and old owner(s) will also need to complete Section I on page 3.)*

D1: Owner Information for New Policy

Name: _____ SSN/ITIN _____ Date of Birth _____

Address _____ City_____ State _____ Zip_____

Primary Phone _____ Alternate Phone _____ Email _____

D2: Trust Information for New Policy *If the owner is a trust, complete the Certification of Trust. If the owner is a business, complete the Business Certification.*

Exact Name of Trust: _____ Trust Tax ID # _____

Current Trustee(s)_____ Date of Trust _____

E. PAYOR INFORMATION - *Complete if Payor is different from Owner.*

Payor Name: _____ SSN/ITIN_____

Address _____ City_____ State _____ Zip_____

If Payor is different from the Insured or the Owner and Bank Draft is not the chosen form of payment, also complete the Payor Authorization Form.

F. BENEFICIARY INFORMATION

The undersigned contract owner hereby revokes any previous beneficiary designation on the coverage being converted as well as optional mode of settlement with respect to any death benefit proceeds payable at the death of the insured under the new policy. If this conversion transaction results in coverage remaining under the current policy number, beneficiary designations of record for that policy will be retained. If beneficiary is a trust, provide name and date of trust agreement.

Primary Insured:

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							☐ Primary ☐ Contingent
	Address:		Email:				
2							☐ Primary ☐ Contingent
	Address:		Email:				
3							☐ Primary ☐ Contingent
	Address:		Email:				

G. CHILD RIDER INSURED(S)

List all children 24 and under.

	Name: First, Middle Initial, Last	Age	Date of Birth	Gender	Height	Weight	Birth Weight (if less than 1 year old)
Child 1							
Child 2							
Child 3							
Child 4							
Child 5							

H. BILLING

Frequency: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly (Bank Draft Only)

Method: ☐ Direct ☐ List bill ☐ Government Allotment ☐ Bank Draft*

*☐ Use existing bank draft information from policy _____Draft Date _____ (if different from existing draft)

Premium $_____ Draft Initial Premium? ☐ Yes ☐ No

If new Plan Universal Life: Initial Premium $_____ Planned Periodic Premium $_____

*If setting up under a new Bank Draft arrangement, will need to submit a completed Bank Draft Authorization form.

Payment Enclosed: ☐ Yes ☐ No Amount _____ Check # _____

I. AUTHORIZATION AND SIGNATURES

The Owner of the Existing Policy, the Owner of the New Policy, and any Assignee and/or Irrevocable Beneficiary must sign below. (If other than an individual, give the official capacity of the person signing.) I hereby request that the Existing Insurance Policy be converted as indicated above. My request is made in accordance with and subject to all the terms and conditions of the conversion provision of the policy being converted. I understand that the New Policy will be issued at the Primary Insured's current attained age.

If a new Owner for the New Policy has been designated above, the undersigned persons/entities agree that, the exercise of the "free look" right under that New Policy will result in the voiding of the Policy from its beginning. In such case, the converted policy or rider (as applicable) will be deemed not to have been converted, and no conversion credit or other sum shall be deemed to have been transferred by means of the conversion.

Notice: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

IF THIS IS A FULL TERM CONVERSION, PLEASE NOTE:

I hereby absolutely assign and transfer to the company identified in this application all of my rights, title and interest of every kind in and to the current policy including, but not limited to the right to surrender, assign, transfer or change the beneficiary.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct ITIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Owner Signature for Existing Policy

X

Owner Title _____
(include title of owner if a corporation)

Owner signed at (city, state) _____

Owner signed on (date) _____

Owner Signature for New Policy

X

Owner Title _____
(include title of owner if a corporation)

Owner signed at (city, state) _____

Owner signed on (date) _____

Assignee or Irrevocable Beneficiary Signature *(if applicable)*

X

Agent Signature

X _____

Agent signed on (date) _____

J. AGENT INFORMATION

Agent(s) to Receive Commission	Agency Number	Agent Number	Percent of Split

Agent/Agency Telephone # _____ **Fax #** _____

Email Address _____ **State/Local Office Code**_____

HOW TO PROCESS A TERM CONVERSION

Step 1 - Contact the Producer Call Center at 1-800-351-2452 to verify conversion eligibility guidelines. They can provide the conversion expiry date, the underwriting class, and answer questions about form and illustration requirements. Paperwork MUST be received in the Home Office before the conversion period expires.

Step 2 - Determine what product you will be converting to.

Step 3 - Assemble the requirements.

A. Will this conversion require underwriting?
Generally the answer is no and you would therefore use the Term Conversion Request Form.
If the conversion will require underwriting, for an increase in face amount, addition of riders, or change in smoker status, you will need to use the appropriate Inforce Change Application.

B. Is customer converting to a Universal Life product?
If yes, an illustration is required. Illustrations can be prepared using regular new business illustration software or agent can contact the Marketing Support staff for assistance.

C. Will the new policy be paid via bank draft?
If yes, a completed Bank Draft Authorization Form is needed.

D. Is the ownership being changed during the conversion?
If yes, complete sections D and I.

E. Are there any other forms applicable as a result of business rules, product requirements, or state regulations?
Examples of additional forms that could be needed are the TIR Disclosure form, VUL Supplemental Application, Index UL Supplemental Application, Payor Authorization Form, Business Certification, or Certification of Trust.

F. Are there any special signatures required?
If existing policy has assignment, designated assignee or irrevocable beneficary must sign.

Step 4 - Fax the requirements to 1-800-382-4662. Do not mail after faxing unless you are submitting a check.

Step 5 - Mail the original of any checks to:

US Mail: P.O. Box 305355 • Nashville, TN 37230-5355
Overnight Mail: 2 American General Center • Nashville, TN 37250-0002

If agent needs need to follow up on the status of the conversion request, please contact the Producer Call Center at 1-800-351-2452. Please visit the Producer Web Site at eStation.americangeneral.com for additional conversion information and links to important forms and documents.

Index Universal Life Supplemental Application

Policy # (if known):_____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #

This supplement must accompany the appropriate application for life insurance. This supplement and the application will be attached to and made a part of the policy.

Dollar Cost Averaging (DCA)

☐ **Please check this box if you are choosing to use the DCA Option.**

Directions: Please complete the DCA section if you wish to elect the DCA feature. You must also indicate the DCA Allocation percentages in the section below for the product being applied for. The Declared Interest Account is not eligible for DCA.

☐ Please check the box to deposit all proceeds from 1035 exchange into the DCA Account.

☐ Please check the box to deposit all lump sum premium into the DCA Account.

Please designate the number of monthly DCA transfers: _____

Note: The minimum DCA Installment Amount for each transfer is $100. The number of monthly DCA transfers is typically 12, however you may choose any number provided the minimum DCA Installment Amount is met.

Directions: Please complete the section below for the product being applied for. Indicate how each premium received should be allocated in the "Premium Allocation (%)" column. If you elected DCA please indicate how each DCA Installment Amount should be allocated in the "DCA Allocation (%)" column. The percentages in the "Premium Allocation (%)" column may differ from those in the "DCA Allocation (%)" column.

Total allocations in each column must equal 100%. Use whole percentages only.

Max Accumulator+ / QoL Max Accumulator+

	Premium Allocation (%)	**DCA Allocation (%)**
Blend Participation Rate Account (*1-Year, utilizing ML Strategic Balanced Index™)*	_____	_____
Global Blend Participation Rate Account (*1-Year, utilizing PIMCO Global Optima Index™)*	_____	_____
High Cap Rate Account (*1-Year, No. II, utilizing S&P 500® Index)*	_____	_____
High Bonus Rate Account (*1-Year, No. I, utilizing S&P 500® Index)*	_____	_____
Declared Interest Account	_____	N/A
	100%	**100%**

Value+ Protector / QoL Value+ Protector

	Premium Allocation (%)	DCA Allocation (%)
Blend Participation Rate Account (*1-Year, utilizing ML Strategic Balanced Index™)*	_____	_____
Global Blend Participation Rate Account (*1-Year, utilizing PIMCO Global Optima Index™)*	_____	_____
Cap Rate Account (*1-Year, utilizing S&P 500® Index)*	_____	_____
Participation Rate Account (*1-Year, utilizing S&P 500® Index)*	_____	_____
Declared Interest Account	_____	N/A
	100%	**100%**

Other

(Use for products not listed above unless otherwise instructed.)

Product Name: _____

Write in account name and indicate how each premium received should be allocated in the "Premium Allocation" column. If you elected DCA please indicate how each DCA Installment Amount should be allocated in the "DCA Allocation" column.

	Premium Allocation	DCA Allocation
_____	_____ %	_____%
_____	_____ %	_____%
_____	_____ %	_____%

Agreement: I acknowledge that I have read this supplemental application or that it has been read to me. The completed supplemental application is true and complete to the best of my knowledge and belief. I agree that this supplemental application shall form a part of my application for insurance.

Owner Signature

X _____

Owner signed on (date)_____

AGENT INSTRUCTIONS: Submit this form with the policy application packet.

Summary And Disclosure Notice For Accelerated Benefits

American General Life Insurance Company, American General Center, Nashville, Tennessee 37250-0001
A member of American International Group, Inc. (AIG)

Receipt of a benefit under an accelerated benefit rider will reduce any death benefit that may become payable under the policy to which the rider is attached.

PURPOSE OF THIS SUMMARY AND DISCLOSURE

THIS SUMMARY PROVIDES A BRIEF DESCRIPTION OF THE BASIC FEATURES OF THE ACCELERATED BENEFIT RIDERS LISTED BELOW. THIS IS NOT AN INSURANCE CONTRACT, BUT ONLY A SUMMARY OF THE COVERAGE PROVIDED BY EACH RIDER.

If a policy is issued, it is important to check the policy for details on any accelerated benefit rider that is included in the policy and to check the Insured Person(s) covered under each rider. It is also important to carefully read any accelerated benefit rider included in the policy. A policy may not include every accelerated benefit rider described in this summary.

TAX CONSEQUENCES

Benefits paid under an accelerated benefit rider may cause the Owner to incur a tax obligation. Neither the Company nor its agents are authorized to offer you tax advice. You should consult your accountant, attorney or other qualified tax professional to assess the impact of a benefit.

BENEFIT DESCRIPTIONS

Accelerated Benefit means the payment, during the Insured Person's lifetime, of a portion of the Insured Person's death benefit under the policy. An accelerated benefit rider provides that the Owner may receive an Accelerated Benefit if the Insured Person experiences a covered qualifying event, subject to the provisions of the rider. The covered qualifying event varies by rider, as described below.

TERMINAL ILLNESS ACCELERATED BENEFIT RIDER

The Terminal Illness Accelerated Benefit Rider provides that the Owner may elect an Accelerated Benefit if the Insured Person is diagnosed as having a Terminal Illness, subject to the provisions of the rider. Terminal Illness means an illness or physical condition that is certified by a Physician to be reasonably expected to result in the Insured Person's death within 24 months from the date of certification.

CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER

The Chronic Illness Accelerated Death Benefit Rider provides that the Owner may elect an Accelerated Benefit if the Insured Person is certified as having a Chronic Illness, subject to the provisions of the rider.

Chronic Illness means an illness or physical condition that was certified by a Licensed Health Care Practitioner as affecting the Insured Person so that:

(a) he or she:

(1) is unable to perform, with Substantial Assistance from another person, at least two Activities Of Daily Living for a period of at least 90 days due to a loss of functional capacity; or

(2) requires Substantial Supervision by another person to protect him or her from threats to health and safety due to Severe Cognitive Impairment; and

(b) is deemed a "chronically ill person" as defined under the federal Health Insurance Portability and Accountability Act (Public Law 104-191), as amended.

The required certification must be renewed by a Licensed Health Care Practitioner every 12 months.

The Activities Of Daily Living are Bathing, Continence, Dressing, Eating, Toileting and Transferring.

Severe Cognitive Impairment means the Insured Person's deterioration or loss of intellectual capacity that is (a) comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia; and (b) is measured by clinical evidence and standardized tests that reliably measure impairment in Insured Person's:

(1) short-term or long-term memory; and

(2) orientation to people, places or time; and

(3) deductive or abstract reasoning.

AGLC111095-CA Rev0618

CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER (CON'T)

The accelerated benefits payable under this rider are generally intended for favorable tax treatment under Section 101(g) of the Internal Revenue Code. There may be tax consequences in some situations in accepting an accelerated benefit payment amount, such as where payments exceed the per diem limitation under the Internal Revenue Code. You should consult your personal tax advisor to assess the impact of this Benefit prior to accepting the Benefit.

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If you are interested in long-term care or nursing home or home care insurance, you should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If you choose to accelerate a portion of your death benefit as an unrestricted cash benefit, doing so will reduce the amount that your beneficiary will receive upon your death. Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, you should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility. See the rider for specific terms regarding the payment of benefits.

Specific Limitations regarding Chronic Illness Accelerated Death Benefit Rider

Benefits are payable only if the Insured Person is certified by a Licensed Health Care Practitioner as having a Chronic Illness after the first 30 days that an Insured Person's coverage under the rider is in force.

This rider contains an elimination period of 90 consecutive days, beginning at any time after the 30-day waiting period, during which the Insured Person must be continuously Chronically Ill prior to eligibility for benefits under the rider. No benefits are payable during the elimination period.

This is a life insurance benefit that also gives you the option to accelerate some or all of the death benefit in the event that you meet the criteria for a qualifying event described in the policy. This policy does not provide long-term care insurance subject to California long-term care insurance law. This policy is not a California Partnership for Long-Term Care program policy. This policy is not a Medicare supplement policy.

CRITICAL ILLNESS ACCELERATED BENEFIT RIDER

The Critical Illness Accelerated Benefit Rider provides that the Owner may elect an Accelerated Benefit for an Insured Person, subject to the provisions of the rider, if we receive proof acceptable to us of the occurrence and Diagnosis of a Critical Illness.

Critical Illness means any of the following illnesses or conditions of the Insured Person:

(a) Heart Attack. Heart Attack means the death of a portion of the heart muscle resulting from inadequate blood supply to the relevant area. Heart Attack does NOT include angina or the chance finding of electrocardiographic (EKG) changes indicative of a previous heart attack.

(b) Stroke. Stroke means a cerebrovascular incident caused by infarction of brain tissue, cerebral hemorrhage, thrombosis or embolization from an extra-cranial source lasting more than 24 hours and producing measurable neurological deficit that persists for at least 30 consecutive days following the occurrence of the Stroke. Stroke does NOT include Transient Ischemic Attacks (TIAs), Vertebro-basilar insufficiency or incidental findings on imaging studies.

(c) Invasive Cancer. Invasive Cancer means the presence of one or more malignant tumors characterized by the uncontrolled growth and spread of malignant cells and the invasion of normal tissue. Invasive Cancer does NOT include the following:

(1) Leukoplakia;
(2) Hyperplasia;
(3) Carcinoid;
(4) Polycythemia;
(5) Stage 1 Hodgkin's disease;
(6) Stage A prostate cancer;
(7) Duke's stage A colon cancer;
(8) Intraductal non-invasive breast cancer;
(9) Stage 0 or 1 transitional cell carcinoma of urinary bladder;
(10) In Situ Cancer;
(11) Any skin cancer other than malignant melanoma with a depth of 1 mm or deeper or greater than Clark level 2;
(12) T1N0M0 (TNM Classification System) papillary carcinoma of the thyroid less than 1 cm in diameter;
(13) Chronic Lymphocytic Leukemia RAI stage 0; or
(14) Any other pre-malignant lesions, benign tumors or polyps.

CRITICAL ILLNESS ACCELERATED BENEFIT RIDER (CON'T)

(d) End Stage Renal Failure. End Stage Renal Failure means the irreversible and total failure of both kidneys, which requires the undergoing of renal transplantation or regular renal dialysis.

(e) Major Organ Transplant. Major Organ Transplant means the receipt by transplant of any of the following organs or tissues: heart, lung, liver, kidney, pancreas or bone marrow.

(f) Amyotrophic Lateral Sclerosis (ALS). Amyotrophic Lateral Sclerosis (ALS) means a nervous system disease in which degeneration of motor neurons in the brain stem and spinal cord leads to atrophy and paralysis of the voluntary muscles.

(g) Blindness. Blindness means the total and permanent loss of sight in both eyes as a result of disease or injury. Total loss of sight in an eye is defined as corrected vision of 20/200 or worse.

(h) Paralysis. Paralysis means Quadriplegia, Paraplegia or Hemiplegia that is expected to last for a continuous 12-month period or longer from the date of the Diagnosis. Quadriplegia means the complete and irreversible Paralysis of both upper and lower Limbs. Paraplegia means the complete and irreversible Paralysis of both lower Limbs. Hemiplegia means the complete and irreversible Paralysis of the upper and lower Limbs of the same side of the body. Limb means entire arm or entire leg.

BENEFIT AMOUNT

The benefit paid upon election of an Accelerated Benefit is equal to the portion of the death benefit that the Owner elects to accelerate less the following deductions:

(a) the actuarial discount applicable to the elected death benefit;

(b) an administrative charge;

(c) payment of any unpaid but due policy premiums; and

(d) if applicable, payment of a pro rata amount of any policy loans.

As a result of these deductions, any benefit paid will, in all cases, be less than the portion of the death benefit that the Owner elects to accelerate, and may be substantially less.

The benefit paid will never be less than the cash surrender value, if any, which corresponds to the portion of the death benefit that the Owner elects to accelerate.

You have the option to receive any Accelerated Benefit payable under the Chronic Illness Accelerated Death Benefit Rider in one lump-sum payment or in periodic payments for a fixed period of time.

EFFECT OF BENEFIT PAYMENT ON POLICY

The following adjustments are made upon payment of an Accelerated Benefit for any Insured Person:

(a) the Insured Person's death benefit under the policy is reduced by the same amount of the Insured Person's death benefit that the Owner elects to accelerate;

(b) the face amount for the Insured Person's life insurance coverage under the policy is reduced in the same proportion as the reduction in the Insured Person's death benefit;

(c) if applicable, the accumulation value, cash surrender value, cash value and any policy loan are reduced in the same proportion as the reduction in the Insured Person's death benefit; and

(d) the future premium and charges for the Insured Person's life insurance coverage under the policy are set as if such coverage had been originally issued at the reduced coverage amount.

The Insured Person's life insurance coverage under the policy will terminate on a benefit payment date if the face amount for such Insured Person's life insurance coverage under the policy is reduced to zero on such date due to a benefit payment made under the rider.
If a benefit under an accelerated benefit rider is payable and the Owner elects to receive such benefit, the Owner must complete an election form and return it to the Company within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect an Accelerated Benefit under a policy as to the same Critical Illness.

LIMITATIONS

The Owner is not eligible to elect an Accelerated Benefit under an Accelerated Benefit Rider if:

(a) the Owner is required by law to use the rider to meet the claims of creditors, whether in bankruptcy or otherwise (not applicable to Chronic Illness Accelerated Death Benefit Rider);

(b) the Owner is required by a government agency to use the rider to apply for, obtain or keep a government benefit or entitlement (not applicable to Chronic Illness Accelerated Death Benefit Rider);

(c) the Owner is required by a court order to maintain the Insured Person's life insurance coverage under the policy and/or any covered riders for another person's benefit;

(d) the Insured Person's Terminal Illness or Critical Illness results directly from the Insured Person's self-inflicted injury or attempted suicide, while sane or insane; or

(e) the Insured Person's Chronic Illness is due to a condition caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane;

(f) the consent of any irrevocable beneficiary, assignee or other required party to the Owner's election of an Accelerated Benefit has not been obtained.

Specific Limitation regarding Critical Illness Accelerated Benefit Rider

Benefits are payable only for any Critical Illness that First Manifests after the first 30 days that an Insured Person's coverage under the rider is in force.

MEDICAID/GOVERNMENT BENEFITS

Receipt of Accelerated Benefit payments may adversely affect the recipient's eligibility for Medicaid or other government benefits or entitlements.

IMPORTANT NOTICE

There is no premium or charge to include an accelerated benefit rider on a policy.

Any portion of the death benefit that is elected as an Accelerated Benefit is subject to an actuarial discount. The actual benefit payable under an accelerated benefit rider for any given occurrence of a covered qualifying event will not be known until the time of claim. The benefit payable may vary depending on the Company's assessment of the Insured Person's future expected mortality at the time of claim as well as the other factors used in calculating the benefit and may, under certain circumstance, be zero.

To assist you in making a decision about electing a benefit under an accelerated benefit rider, a statement showing the amount of the benefit payable and the effect that the election of Accelerated Benefits will have on your policy will be sent to you once the Company has determined that benefits are payable under the rider.

IMPORTANT CONSUMER DISCLOSURES REGARDING ACCELERATED BENEFIT RIDER

(1) When filing a claim for Critical Illness under a Critical Illness Accelerated Benefit Rider, Terminal Illness under a Terminal Illness Accelerated Benefit Rider, or Chronic Illness under a Chronic Illness an Accelerated Death Benefit Rider, the claimant, except as otherwise provided in the applicable rider, must provide to the Company a completed claim form which must be received at its Administrative Center within the time frame specified in the rider, if any.

(2) For a claimant to be able to elect an Accelerated Benefit under the Chronic Illness Accelerated Death Benefit Rider, such claimant must have been certified as Chronically Ill within the past twelve (12) months by a Licensed Health Care Practitioner. Where an Accelerated Benefit under such a rider is paid periodically, such written certification must be renewed by a Licensed Health Care Practitioner every 12 months.

(3) If a benefit under a Critical Illness Accelerated Benefit Rider or a Terminal Illness Accelerated Benefit Rider is payable and the Owner elects to receive such benefit, the Owner must complete an election form and return it to the Company within 60 days of receipt of the election form. The Company will not provide a later opportunity to elect an Accelerated Benefit under a Policy as to the same Critical Illness.

(4) Under certain circumstances where an insured's mortality (i.e., our expectation of the insured's life expectancy) is not significantly changed by a Critical Illness or Chronic Illness, the accelerated benefit may be zero.

(5) The failure to provide a required claim form and a required election form (with the requested attachments) within the periods set forth for each in a Policy, if any, may preclude payment of a benefit.

(6) Benefits payable under an accelerated benefit rider may be taxable. Neither American General Life Insurance Company nor any agent representing it is authorized to give legal or tax advice. Please consult a qualified legal or tax advisor regarding questions concerning the information and concepts contained in this material.

IMPORTANT CONSUMER DISCLOSURES REGARDING ACCELERATED BENEFIT RIDER (CON'T)

(7) Generally, we will send you an IRS Form 1099-LTC if you receive an accelerated death benefit on account of a Chronic Illness or a Terminal Illness. We will send you an IRS Form 1099-R if you receive an accelerated death benefit on account of a Critical Illness.

The sum that will be included in Box 2 (Accelerated death benefits paid) of IRS Form 1099-LTC or in Box 1 (Gross distribution) of IRS Form 1099-R will be the actual sum you received by check or otherwise minus any refund of premium and/or loan interest included with our benefit payment plus any unpaid but due policy premium, if applicable, and/or pro rata amount of any loan balance.

(8) The maximum amount of life insurance death benefits that may be accelerated as to an Insured Person under all accelerated benefit riders is the lesser of the existing amount of such death benefits or a lifetime maximum of $2,000,000.

(9) See your policy for details.

ACKNOWLEDGMENT

I acknowledge that I have reviewed this Summary and Disclosure Notice and that I will be provided a copy with my policy.

Owner's Signature

X _____

Owner signed on (date) _____

The applicant was shown a copy of this Summary and Disclosure prior to executing an application.

Agent's Signature

X _____

Agent signed on (date) _____

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water Street, New York, NY 10038

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

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.

Policy Number, if available	Name of Insured Applicant	Policy Number, if available	Name of Insured Applicant

PAYMENT OPTIONS: Please select ONLY one payment option:

☐ Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $_____.___ ☐ At Issue ☐ At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $_____.___

☐ Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

☐ Check submitted with application in the amount of $_____.___.
☐ Check submitted on delivery.

DRAFT DETAILS: Please provide the requested details.

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

If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.

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

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: ☐ Checking ☐ Savings

Routing Number _____ (For checking account draft use routing # listed on check)

Account Number _____ (DO NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) _____ Last Name _____

Email Address 1 _____

Date of Birth 1 (MM-DD-YYYY) __/__/____ SSN1 / TIN 1 _____

Name 2 First Name (Please Print) _____ Last Name _____

Email Address 2 _____

Date of Birth 2 (MM-DD-YYYY) __/__/____ SSN1 / TIN 2 _____

Bank Account Owner's Address: (For business accounts, list Business Address)

Street _____ City _____ State _____ ZIP _____

AGREEMENT:

I (we) hereby authorize and request the Company or its representative 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 contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) 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 non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and 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 in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request 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.

Signature of Bank Account Owner

X _____

Date _____

Signature of Bank Account Owner, if joint account

X _____

Date _____

Please attach voided check for checking account draft or deposit slip for savings account draft.

AIG

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

_____ ___/___/___

Name of Insured/Proposed Insured (Please Print) **Date of Birth**

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give American General Life Insurance Company ("AGL"), The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (AGL, US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth.

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- the Medical Information Bureau (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I understand that the Recipients requesting access to my (electronic or paper) medical records are acting as a patient authorized representative and will attempt to access my medical records in an efficient manner, including electronic interchange through a Health Information Exchange or directly through my Providers' electronic health record system.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application.

I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) _____

Signor name (printed) _____

Relationship _____

Description of Authority of Personal Representative (if applicable) _____

_____

Control Number/Policy Number _____

_____

Supplemental Application for Life Insurance Policy to Contain Chronic Illness Accelerated Death Benefit Rider

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

Supplemental Application for Life Application Dated _____

Name of Primary Proposed Insured _____ DOB _____

Name of Additional Proposed Insured (if any) _____ DOB _____

Policy Number (if known) _____

Is the Chronic Illness Accelerated Death Benefit Rider which is anticipated to be issued with the policy being applied for intended to replace any existing long-term care insurance coverage? If "Yes", provide details below. ..... ☐ Yes ☐ No

Name _____ Co. Name _____

Amt. of Coverage _____ Pol. No. _____

I agree that this Supplemental Application shall form a part of my Application For Life Insurance.

Signed at (City and State) _____ Date _____

CAUTION: IF YOUR ANSWERS ON THIS APPLICATION ARE MISSTATED OR UNTRUE, OUR COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR ACCELERATED DEATH BENEFIT COVERAGE.

Primary Proposed Insured's Signature

X

Licensed Agent's Signature

X _____

Additional Proposed Insured's Signature (if any)

X

Proposed Owner's Signature

X

Notice Regarding Premium Default Options

American General Life Insurance Company
A member of American International Group, Inc. (AIG)

If you are applying for a term life insurance policy, that policy does not automatically contain a benefit that can operate to prevent the lapsing of the policy for failure to pay necessary premiums. You may apply for a rider to provide a waiver of premium benefit in the event of your total disability; however, there is an additional charge for such coverage, and the issuance of such coverage is not guaranteed.

If you are applying for a universal life insurance policy containing an accelerated death benefit rider for which there is no separately stated charge, cost of insurance charges, rider premiums, and other fees and charges will be deducted from the policy's Accumulation Value pursuant to the terms of the applicable policy. The policy does not automatically contain a benefit that can operate to prevent the lapsing of the policy for failure to pay necessary premiums. You may apply for a rider to provide a waiver of monthly deduction benefit or a total disability monthly benefit in the event of your total disability; however, there is an additional charge for such coverage, and the issuance of such coverage is not guaranteed.

If you are applying for a universal life insurance policy containing an accelerated death benefit rider for which there is a separately stated charge, the policy will provide a Waiver of Monthly Deduction Benefit. If Accelerated Benefits are received under the Periodic Benefit Payment Option provision of the Rider, then, during each Benefit Period, all or a portion of the Policy's monthly deduction and the continuation guarantee account's monthly deduction, if any, will be waived. The amount of the monthly deduction to be waived will be the Policy's monthly deduction, and the continuation guarantee account's monthly deduction, if any, multiplied by the Waiver of Monthly Deduction Benefit Percentage shown on the applicable Rider Schedule. Such waiver will begin on the date Monthly Benefits begin under this Rider and will continue while the Policy remains in force and Monthly Benefits are paid. Such payment of the Waiver of Monthly Deduction Benefit will not guarantee that the policy will remain in force during or after a Benefit Period. Continuation of the policy while the Waiver of Monthly Deduction Benefit is being paid under the rider will depend upon the amount of such waiver benefit and the payment of any premiums and will be subject to the Grace Period and Termination provisions of the policy. You may be required to pay premiums during and/or after a Benefit Period to keep the policy in force.

I acknowledge that I have read or have had read to me this Notice Regarding Premium Default Options and have received a copy of it.

Owner's Signature

X _____

Owner signed on (date)_____

Owner's name (printed)_____

Important Notice to Applicant/Buyer Regarding Accelerated Death Benefits

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019
The United States Life Insurance Company in the City of New York, 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

Name of Proposed Insured (Please Print):_____

Date of Birth: _____

The benefits provided by this accelerated death benefit are not intended to provide, and will never provide, long-term care insurance, nursing home insurance, or home care insurance. If You are interested in long-time care or nursing home or home care insurance, You should consult with an insurance agent licensed to sell that insurance, inquire with the insurance company offering the accelerated death benefits, or visit the California Department of Insurance Internet Web site (www.insurance.ca.gov) section regarding long-term care insurance.

If You choose to accelerate a portion of Your death benefit, doing so will reduce the amount that Your beneficiary will receive upon Your death.

Receipt of accelerated death benefits may be taxable. Prior to electing to buy the accelerated death benefit, You should seek assistance from a qualified tax adviser.

Receipt of accelerated death benefits may affect eligibility for public assistance programs, such as Medi-Cal or Medicaid. Prior to electing to buy the accelerated death benefit, You should consult with the appropriate social services agency concerning how receipt of accelerated death benefits may affect that eligibility.

Acknowledgment

I acknowledge that I have reviewed and have received a copy of this Important Notice To Applicant/Buyer Regarding Accelerated Death Benefits prior to or concurrently with the completion of an application.

Owner's Signature

X

Owner signed on (date) _____

Owner's name (printed) _____

A copy of this Important Notice To Applicant/Buyer Regarding Accelerated Death Benefits was provided to the Owner prior to or concurrently with the completion of an application.

Agent's Signature

X _____

Agent signed on (date)_____

Agent's name (printed) _____

NOTE: Leave 1 signed original with Owner and submit 1 signed original with application.