Supplemental Application for Chronic Illness Accelerated Death Benefit Rider

American General Life Insurance Company, Houston, TX

This is a supplement to the application for the Life Insurance for the Primary Proposed Insured. Please complete if the Chronic Illness Accelerated Death Benefit Rider is being elected.

(Check the box that applies)

☐ New Application ☐ Reinstatement ☐ Base Policy Specified Amount Increase

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1. Primary Proposed Insured

First Name _____ MI ____ Last Name _____ Date of Birth _____

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2. Benefits (Complete for New Application Only)

A. Maximum Monthly Benefit Percentage: ☐ **2%** ☐ **4%**

B. Lifetime Maximum Benefit Percentage: _____**%**

Note: If the Chronic Illness Accelerated Death Benefit Rider is approved and added to your policy, the policy will also include, at no additional charge, a Terminal Illness Accelerated Death Benefit Rider. The Disclosure of Accelerated Death Benefits form must be completed for the Chronic Illness Accelerated Death Benefit Rider, if required by the state of issue.

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3. Health Questions – In this section, "you" refers to the Primary Proposed Insured.

A. During the last 12 months, have you:

1. Required assistance or supervision of any kind to perform an activity of daily living (ADLs) which consist of: Mobility (including the use of a pronged cane), taking medications, dressing, eating, walking, bathing or toileting? ☐ Yes ☐ No
2. Used any of the following:
   ☐ Yes ☐ No - catheter; ☐ Yes ☐ No - chair lift; ☐ Yes ☐ No - dialysis;
   ☐ Yes ☐ No - motorized scooter; ☐ Yes ☐ No - oxygen equipment; ☐ Yes ☐ No - respirator;
   ☐ Yes ☐ No - walker; ☐ Yes ☐ No - or wheelchair; ☐ Yes ☐ No - quad or three-pronged cane
3. Been advised to enter, reside in or require any of the following:
   ☐ Yes ☐ No - nursing home ☐ Yes ☐ No - assisted living facility
   ☐ Yes ☐ No - long term care facility ☐ Yes ☐ No - residential care facility
   ☐ Yes ☐ No - adult day care ☐ Yes ☐ No - skilled nursing facility (SNF)
   ☐ Yes ☐ No - required home health care ☐ Yes ☐ No - Continuing Care Retirement Community (CCRC)

B. During the last 3 years, have you:

1. Used insulin to treat Diabetes? ☐ Yes ☐ No
2. Been diagnosed or treated by a licensed health care provider for Diabetes WITH COMPLICATIONS* (*such as eye, kidney, or nerve damage)? ☐ Yes ☐ No
3. Been diagnosed or treated by a licensed health care provider for Diabetes AND:
   ☐ Yes ☐ No - Heart Disease ☐ Yes ☐ No - Stroke ☐ Yes ☐ No - Peripheral Vascular Disease

C. Have you EVER been diagnosed with, been treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Alzheimer's disease ☐ Yes ☐ No
2. Dementia ☐ Yes ☐ No
3. Mild Cognitive Impairment (MCI) ☐ Yes ☐ No
4. Organic Brain Syndrome (OBS) ☐ Yes ☐ No
5. Amputation due to disease ☐ Yes ☐ No
6. ALS (Lou Gehrig's disease) ☐ Yes ☐ No
7. Stroke ☐ Yes ☐ No

8. Cerebral Vascular Accident (CVA) ☐ Yes ☐ No
9. Transient Ischemic Attack (TIA) ☐ Yes ☐ No
10. Organ Transplant (other than corneal) ☐ Yes ☐ No
11. Multiple Sclerosis ☐ Yes ☐ No
12. Huntington's Chorea ☐ Yes ☐ No
13. Muscular Dystrophy ☐ Yes ☐ No
14. Myasthenia Gravis ☐ Yes ☐ No
15. Macular Degeneration ☐ Yes ☐ No
16. Blindness ☐ Yes ☐ No
17. Optic Neuritis ☐ Yes ☐ No
18. Osteoporosis with fractures ☐ Yes ☐ No
19. Parkinson's disease ☐ Yes ☐ No
20. Post-Polio Paralytic Syndrome ☐ Yes ☐ No
21. Polymyositis ☐ Yes ☐ No
22. Scleroderma ☐ Yes ☐ No
23. Memory loss ☐ Yes ☐ No
24. Unplanned weight loss greater than 15 pounds within the last 2 years ☐ Yes ☐ No
25. Arthritis with narcotic pain medication within the past 12 months ☐ Yes ☐ No

D. Do you have a parent or sibling diagnosed or treated by a licensed health care provider for Huntington's chorea or Polycystic Kidney Disease? ☐ Yes ☐ No

If any question in 3. A-D was answered yes, the rider is not available for the Primary Proposed Insured and this supplemental application should not be completed or submitted.

E. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Disorientation ☐ Yes ☐ No
2. Multiple falls ☐ Yes ☐ No
3. Injury due to a fall ☐ Yes ☐ No
4. Chest Pain ☐ Yes ☐ No
5. Loss of balance ☐ Yes ☐ No
6. Loss of strength ☐ Yes ☐ No
7. Tremors ☐ Yes ☐ No
8. Dizziness ☐ Yes ☐ No

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4. Lifestyle / Supplemental Information – In this section, "you" refers to the Primary Proposed Insured.

A. Do you have a handicap sticker, handicap placard, or handicap license plate? (Give reason below) ☐ Yes ☐ No

B. In the last 24 months, have you had to limit or been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below) ☐ Yes ☐ No

C. In the past 24 months, have you required assistance with any Instrumental Activities of Daily Living (IADL's) which consist of: shopping, arranging transportation, housekeeping, cooking, laundry, meal preparation, managing finances, managing medications, using the telephone or used a straight cane? (If yes, give reason below) ☐ Yes ☐ No

D. Within the past 5 years, have you received any:
☐ Yes ☐ No - long term care benefits ☐ Yes ☐ No - disability income benefits
☐ Yes ☐ No - Social Security Disability Income Benefits
(If yes, please provide details in **Section 5, Remarks**.)

E. Within the past 5 years, have you been declined for: Long term care insurance; Long term care insurance rider or Accelerated Death Benefit Rider attached to a life insurance policy or an annuity contract? (If yes, please provide the name of the company, date and the reason, if known, in **Section 5, Remarks**.) ☐ Yes ☐ No

5. Remarks

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6. Replacement Question

You are applying for a life insurance policy with an accelerated death benefit rider. By applying for this policy, do you intend to replace any Long term care (LTC) insurance policy; Long term care insurance rider or Accelerated Death Benefit Insurance Rider attached to a life insurance policy or an annuity contract that is currently in force? ..... ☐ Yes ☐ No

I, the Primary Proposed Insured signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within the contestable period.

I understand that benefits under the Chronic Illness and Terminal Illness riders are provided through an accelerated death benefit option, and that if I exercise the accelerated benefit option, any beneficiary I designate will receive a reduced death benefit.

I acknowledge, that I have read the Important Notice and have received a copy of the notice.

IMPORTANT NOTICE TO APPLICANT/BUYER REGARDING ACCELERATED DEATH BENEFITS

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, 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.

The accelerated death benefit rider for which you are applying contains a Waiver of Monthly Deduction provision that provides for waiver of the monthly deductions and the continuation guarantee account's monthly deductions, if any, under the applied-for policy under certain conditions described in the rider.

Caution: If your answers on this application are misstated or untrue, the insurer may have the right to deny benefits or rescind your accelerated death benefit coverage.

X _____ _____

Signature of Primary Proposed Insured — Date

Writing Agent Name: _____

Last — First

Writing Agent Number: _____ Agency Number: _____

X _____ _____

Signature of Licensed Writing Agent — Date