In-Force Change Application

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, New York 10005-1400

Mailing Instructions: Send form(s) to P.O. Box 818005 • Cleveland, OH 44181
Faxing Instructions: For conversions: 1-800-382-4662 • For all other requests: 1-855-601-1834

Some transactions may not be available for all policies for each company listed above. Contact your service center or agent for further details. The insurance company checked above ("Company") is 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.

Use permanent ink when completing this form. Be sure to answer all questions that pertain to your request. Provide details for any questions answered "Yes". Personally sign and date. Carefully read the Notices to the Proposed Insured(s) and keep with your policy.

Current Policy Number ______________________________ **Insured's Name**____________________________________

Owner's Name ____ **Owner's SSN/ITIN** ___________________________

Requested Change:

Instructions: For these changes, please complete the entire application, sign and date page 7.

- ☐ Application for Reduction of Premium Rate/Reversion
- ☐ Increase Specified Amount: Base Coverage:______________________
- ☐ Addition or Increase of Rider and/or Benefit
  - ☐ Accidental Death Benefit: Amount ______________________
  - ☐ Child Rider: Amount____
    (Complete all info for the primary insured & each child)
  - ☐ Disability Income Rider ☐ DI Rider 2 ☐ DI Rider 5 *(Choose one)*
    Monthly Benefit $__________________________ Occupational Class: __________________
    Number of years: _____ Number of months: _____ ☐ On-the-Job ☐ Off-the-Job
  - ☐ Guaranteed Insurability Option Rider
  - ☐ Spouse Rider: Amount ______________________ Plan:______________________________
    (Complete all info for the primary insured & spouse)
  - ☐ Term Rider: Amount________________________ Plan:______________________________
    Insured____
  - ☐ Waiver of Monthly Deduction
  - ☐ Waiver of Monthly Guarantee Premium
  - ☐ Waiver of Premium
  - ☐ Other Insured Rider: Amount __________________________
  - ☐ Other Rider: Amount ________________________ Explain type: _______________________
- ☐ Smoker/Tobacco/Nicotine Change: ____
- ☐ If Universal Life Plan, Planned Periodic Premium $ ____________________________________

Instructions: For the changes listed below, complete Section I, and sign and date page 7. If a face increase or benefit/rider addition is requested, complete the entire application, sign and date page 7.

Exercise Guaranteed Insurability Option (GIO)

GIO Amount: ____________________________________

Option Date: ____________________________________

Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.

Is insured totally disabled? .... ☐ yes ☐ no

Check all applied for:

☐ Waiver of Premium/Monthly Deduction

☐ Accidental Death Benefit

☐ Other ____

Automatic Premium Loan desired (if available)

☐ yes ☐ no

Term Conversion

CONVERSION AMOUNT

Base Coverage: ____________________________________

Effective Date: ____________________________________

New Plan:____

Benefits: If the insured is totally disabled, the insured is not eligible for Waiver of Premium.

Is insured totally disabled? .... ☐ yes ☐ no

Check all applied for:

☐ Waiver of Premium/Monthly Deduction
☐ Accidental Death Benefit
☐ Other ____

Automatic Premium Loan (if available).................. ☐ yes ☐ no
Death Benefit Option (UL Only): ☐ Level ☐ Increasing
For Index UL, complete the Index UL Supplemental Application.
After the conversion, will there be any remaining coverage on the existing policy? .... ☐ yes ☐ no
Amount remaining after conversion: ______________________

New Policy # ______________________________ ***(Office use only)***

SECTION I – GENERAL INFORMATION:

A. PRIMARY INSURED

First Name____________________________ MI_____ Last Name ______________________ SSN ___________________________

Gender ☐ M ☐ F Birthplace (*US State, or country*) ____ Date of Birth ______________

Tobacco Use: Have you ever used any form of tobacco or nicotine products? .... ☐ yes ☐ no

Type and *Quantity* used __________________ If yes, a current user? ☐ yes ☐ no If no, date of last use ______________________

U.S. Citizen or Permanent Resident (Green Card holder) ☐ yes ☐ no

If no, Country of Citizenship ________________________ Date of Entry___________ Visa Type__________ (Copy of Visa Required)

Address ____ City ____________________ State ______ ZIP_____________

☐ **CHECK HERE IF NEW ADDRESS**

Primary Phone ______________________ Alternate Phone________________________ Email ______________________________

Employer ____ Occupation ____

Job Duties ____ Length of time in occupation __________________________

Average number of hours worked ________________________________ Able to perform ____________________________________

Personal Earned Income (Annual): $ ______________ Household Income (Annual): $ _____________ Net Worth $ ________________
Personal Earned Income means monies received for work performed.

B. OTHER INSURED

First Name____________________________ MI_____ Last Name ______________________ SSN ___________________________

Relationship to Primary Insured ____

Gender ☐ M ☐ F Birthplace (*US State, or country*) ____ Date of Birth ______________

Tobacco Use: Have you ever used any form of tobacco or nicotine products? .... ☐ yes ☐ no

Type and *Quantity* used __________________ If yes, a current user? ☐ yes ☐ no If no, date of last use ______________________

U.S. Citizen or Permanent Resident (Green Card holder) ☐ yes ☐ no

If no, Country of Citizenship ________________________ Date of Entry___________ Visa Type__________ (Copy of Visa Required)

Address ____ City ____________________ State ______ ZIP_____________

Primary Phone ______________________ Alternate Phone________________________ Email ______________________________

Employer ____ Occupation ____

Job Duties ____ Length of time in occupation __________________________

Personal Earned Income (Annual): $ ______________ Household Income (Annual): $ _____________ Net Worth $ ________________
Personal Earned Income means monies received for work performed.

C. CHILD INFORMATION *Complete information for all children covered by child rider*

	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							

Child Information: (If more Dependent Information needs to be entered, please use the Remarks section.)

D. SPOUSE INFORMATION *Complete information for spouse covered by rider*

Spouse's Name _________________________ MI _______ Last Name___________________________________ Gender ☐ M ☐ F

Address ____ City ____________________ State ______ ZIP_____________

Date of Birth ____ SSN ____

E. DESIGNATION OF OWNER FOR NEW POLICY *Complete if the Primary Insured is not the Owner*

Change of ownership: ☐ **Yes** ☐ **No** *(If yes, new and old owner(s) will also need to complete page 6.)*

First Name ____________________ MI ____________________ Last Name ____________________

SSN/ITIN ____________________ Date of Birth ____________________

☐ **CHECK HERE IF NEW ADDRESS**

Address ____________________ City ____________ State ______ ZIP ____________

Primary Phone ____________________ Email ____________________

If the owner is a trust, please designate information for the Trust name, Trust Tax ID, Current Trustee and Date of Trust in the Special Remarks section on Page 6 and complete the Certification of Trust. If the owner is a Business, complete the Business Certification.

F. PREMIUM PAYOR *Complete if other than Owner*

First Name ____________________ MI_____ Last Name ____________________ SSN ____________________

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.

G. BILLING INFORMATION

Frequency: ☐ Annual ☐ Semi Annual ☐ Quarterly ☐ Monthly ☐ Other

Method: ☐ Direct ☐ List Bill ☐ Government Allotment ☐ Bank Draft

☐ Use existing bank draft information from policy____________ Draft Date ____________ (if different from existing draft)

☐ Use new bank draft information (A new EFT authorization form will need to be completed.)

H. PREMIUM PAYMENT ENCLOSED

☐ yes ☐ no Amount $ ____________________ Check # ____________________

I. BENEFICIARY DESIGNATIONS *Beneficiary Designations must equal 100%*

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.

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:			

SECTION II:

A. BACKGROUND INFORMATION *For all covered persons*

Complete questions 1 through 12 for all persons proposed to be insured under the applied-for coverage. If an answer of yes applies to ANY insured provide details. You may be asked to complete and submit an additional form.

1. Have you ever used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? .... ☐ yes ☐ no
2. Have you ever sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances?........ ☐ yes ☐ no
3. In the past five years, have you been charged with or convicted of any driving violations to include driving under the influence of alcohol or drugs? .... ☐ yes ☐ no
4. In the past five years, have you flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? .... ☐ yes ☐ no
5. In the past five years, have you engaged in motor sports events or racing (auto, truck, motorcycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years?........ ☐ yes ☐ no

A. BACKGROUND INFORMATION *For all covered persons (continued)*

6. Do you intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no

7. Have you ever requested or received a pension, benefits, or payments because of an injury, sickness, or disability in the past 5 years? ☐ yes ☐ no

8. Have you ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? ☐ yes ☐ no

9. Have you ever been convicted of, or currently charged with, a felony or misdemeanor, or currently incarcerated or on parole or probation? ☐ yes ☐ no

10. Is there an intention that any party, other than the Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of any Proposed Insured as a result of this application? ☐ yes ☐ no

11. Does the Owner or any Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ☐ yes ☐ no

12. Is the Owner, any Proposed Insured, or any person or entity, being paid (cash, services, etc) as an incentive to enter into this transaction? ☐ yes ☐ no

Details:

____

____

____

B. MEDICAL INFORMATION

1. **Primary Insured:** Height ___ ft ___ in Weight ____lbs Change of weight in last year? ☐ None Gain:____ lbs Loss:____ lbs

Other Insured: Height ___ ft ___ in Weight ____lbs Change of weight in last year? ☐ None Gain: ____ lbs Loss:____ lbs

Child 1: Height ___ ft ___ in Weight ____lbs Birth Weight (if less than 1 year old) ____________

Child 2: Height ___ ft ___ in Weight ____lbs Birth Weight (if less than 1 year old) ____________

Child 3: Height ___ ft ___ in Weight ____lbs Birth Weight (if less than 1 year old) ____________

2. Name and address of personal physician

Primary Insured:______________________________________

Other Insured:______________________________________

Child 1: ______________________________________

Child 2: ______________________________________

Child 3: ______________________________________

3. Date, reason, findings and treatment at last visit

Primary Insured:______________________________________

Other Insured:______________________________________

Child 1: ______________________________________

Child 2: ______________________________________

Child 3: ______________________________________

Complete questions 4 through 9 for all proposed insureds who are covered by this policy. If an answer of yes applies to ANY insured provide details such as date of first diagnosis, name and address of doctor, tests performed, test results, medication(s) or recommended treatment.

4. Have you ever been diagnosed as having, been treated for, or consulted a member of the medical profession for:

a. coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? ☐ yes ☐ no

b. blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no

c. cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? ☐ yes ☐ no

d. pituitary, thyroid, adrenal, or disease or disorder of any other glands? ☐ yes ☐ no

e. anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? ☐ yes ☐ no

f. colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? ☐ yes ☐ no

g. disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? ☐ yes ☐ no

h. asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no

B. MEDICAL INFORMATION *(continued)*

i. seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? ☐ yes ☐ no

j. attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? ☐ yes ☐ no

k. anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? ☐ yes ☐ no

l. arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? ☐ yes ☐ no

m. glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? ☐ yes ☐ no

Details:____

____

____

5. Other than previously stated, have you taken any medications, had treatment or therapy or been under medical observation within the past 12 months? ☐ yes ☐ no

Details:____

____

6. Have you ever tested positive for the Human Immunodeficiency Virus (HIV) or been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☐ no

Details:____

____

7. Other than previously stated, in the past 5 years, have you been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was **NOT** completed (except for those tests related to the Human Immunodeficiency Virus), or do you have any test results pending? ☐ yes ☐ no

Details:____

____

8. Have you been treated for or been diagnosed with, or do you have, any other medical, physical, or psychological condition **NOT** disclosed above? ☐ yes ☐ no

Details:____

____

9. Have you made a claim for or received disability or Worker's Compensation benefits (other than for routine pregnancy) in the past 5 years? ☐ yes ☐ no

If "Yes," provide Name, Type, Details, Date/Duration: ____

C. EXISTING COVERAGE

1. Does any Proposed Insured have any existing life insurance policies? ☐ **yes** ☐ **no**

2. If question 1 is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced?	1035 Exchange?
1						☐ Y ☐ N	☐ Y ☐ N
	Company Name: ____________ Amount of Coverage $ ________						
	Proposed Insured Name: ____________						
2						☐ Y ☐ N	☐ Y ☐ N
	Company Name: ____________ Amount of Coverage $ ________						
	Proposed Insured Name: ____________						
3						☐ Y ☐ N	☐ Y ☐ N
	Company Name: ____________ Amount of Coverage $ ________						
	Proposed Insured Name: ____________						
4						☐ Y ☐ N	☐ Y ☐ N
	Company Name: ____________ Amount of Coverage $ ________						
	Proposed Insured Name: ____________						

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending

D. SPECIAL REMARKS: Use this space to provide any additional comments or remarks not given in detail above

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Insured (and any Owner or Other Insured and any Assignee or Irrevocable Beneficiary signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. 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 its contestable period.

I understand and agree that no agent is authorized to accept risks or pass upon insurability, make or modify contracts, or waive any of the Company's rights or requirements.

I have received a copy of or have been read the Notices to the Proposed Insured(s).

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; MIB, LLC (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; reinsurers; MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application or for such other period permitted by applicable state law where the policy is issued. I agree that a copy of this consent will be as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

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 New 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.

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.

Fraud: Any person 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 (Owner): 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: _____).

IRS Certification (New Owner): 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 ______________________________

(If Corporate Officer or Trustee)

Owner signed at (city, state) ______________________________

Owner signed on (date) ______________________________

Primary Insured Signature (if other than Owner)

X

(If under age 16, signature of parent or guardian)

Primary Insured signed at (city, state) ______________________________

Primary Insured signed on (date) ______________________________

Other Required Signature (Assignee or Irrevocable Beneficiary)

X

Signed at (city, state) ______________________________

Signed on (date) ______________________________

Owner Signature for New Policy

X

Owner Title ______________________________

(If Corporate Officer or Trustee)

Owner signed at (city, state) ______________________________

Owner signed on (date) ______________________________

Other Insured Signature

X

(If under age 16, signature of parent or guardian)

Other Insured signed at (city, state) ______________________________

Other Insured signed on (date) ______________________________

AGENT ONLY

Agent Signature

X______________________________

Agent signed on (date) ______________________________

Agent name (please print) ______________________________

State License # ______________________________

Agent # ______________________________

Percentage of Split ______________________________

Agent Telephone # ______________________________

Agency # ______________________________

Local Office ______________________________

HIPAA Authorization

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
- MIB, LLC (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 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.

MIB ACKNOWLEDGEMENT

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

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______________________

____