



**This is only a sample application. It is not a promise to issue coverage.**

To apply, call Choice Mutual  
(licensed to sell AIG products)  
**at 1-800-644-2926.**



# Application for Individual Guaranteed Issue Whole Life Insurance Graded Death Benefit

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX, 77019  
A member of American International Group, Inc. (AIG)

## PART 1: TELL US ABOUT YOURSELF

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Place of Birth (State/Country) \_\_\_\_\_

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

Gender:  Male  Female Social Security Number \_\_\_\_\_

E-mail Address \_\_\_\_\_

Are you a United States citizen or do you have Permanent Legal Resident (Green Card) status?  Yes  No

## PART 2: TELL US ABOUT THE COVERAGE YOU ARE REQUESTING

What amount of insurance are you applying for?

Amount of Life Insurance: \$ \_\_\_\_\_ (from \$5,000-\$25,000)

Do you have any existing annuity or life insurance or have any application pending for such coverage with this Company or any other company?  Yes  No

Will the life insurance policy being applied for replace or change any annuity or life insurance coverage in force or pending?  Yes  No

If "Yes", please complete: Company Name \_\_\_\_\_

Face Amount \_\_\_\_\_ Month/Year Issued \_\_\_\_\_

Beneficiary Designation: Who do you want the insurance proceeds to go to? (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary #	Beneficiary Name (please print)	Relationship to You	%Share
Beneficiary #1	_____	_____	_____
Beneficiary #2	_____	_____	_____

## PART 3: HOW WILL YOU PAY FOR COVERAGE?

How often do you want to pay?

Annually  Semi-annually  Quarterly  Monthly

Your premium amount for the payment frequency selected above is: \$ \_\_\_\_\_

How will you pay? [Check one]

Bank Draft (Complete Bank Draft Authorization)

Credit Card (Complete Credit Card Authorization)

N/A Bill me Directly (Monthly premium frequency not available with this payment method)

Other (please explain) \_\_\_\_\_

Who will pay for your coverage?

(Complete only if the person paying for this policy is someone other than you)

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

Home Street Address \_\_\_\_\_ Gender:  Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to You \_\_\_\_\_

Is the Premium Payor a United States citizen or does the Premium Payor have Permanent Legal Resident (Green Card) status?  
 Yes  No

(If "Bank Draft" or "Credit Card" is not the chosen form of payment, then also complete the Payor authorization form)

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**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.**

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**I agree that:**

- To the best of my knowledge and belief, all statements in this application for life insurance are true and complete.
  - My statements in this application and any amendment(s) are the basis of any policy issued.
  - I understand that no insurance will take effect until a policy is delivered to me and the full first premium due is paid.
  - I have not previously applied for this product in the last 12 months.
  - I understand that the total combined amount of all American General Life Insurance Company guaranteed issue whole life insurance benefits on my life cannot exceed \$25,000.
- 

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_



- American General Life Insurance Company**, 2727-A Allen Parkway, Houston, TX 77019
- The United States Life Insurance Company in the City of New York**, One World Financial Center, 200 Liberty St., New York, NY 10281  
*A member of American International Group, Inc. (AIG)*

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.

**LEAVE THIS FORM WITH THE PROPOSED INSURED(S)**

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**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.

**SAMPLE**  
**FROM CHOICE MUTUAL**

# SUMMARY AND DISCLOSURE NOTICE FOR TERMINAL ILLNESS AND CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDERS

American General Life Insurance Company

## SUMMARY AND DISCLOSURE NOTICE FOR ACCELERATED DEATH BENEFITS

### Required at Time of Application

**Receipt of a benefit under an accelerated death 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 death 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 death benefit rider that is included in the policy. It is also important to carefully read any accelerated death benefit rider included in the policy.

### TAX CONSEQUENCES

The accelerated death benefit riders are intended to qualify for favorable tax treatment. However, accelerated death benefits payable under an accelerated death benefit rider MAY BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from an accelerated death benefit rider.

### BENEFIT DESCRIPTIONS

Accelerated benefit means the payment, during the Insured's lifetime, of a portion of the Insured's death benefit under the policy as described in an accelerated death benefit rider. Each accelerated death benefit rider described in this summary provides that the Owner may elect an accelerated benefit in an amount determined by the Company if the Insured 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 DEATH BENEFIT

The Rider provides that the Owner may elect an accelerated death benefit if the Insured is diagnosed as having a Terminal Illness, subject to the provisions of the rider. Terminal Illness means an illness that is expected to result in the death of the Insured in 24 months or less (12 months or less in Florida) from the date of the request for the accelerated death benefit.

### BENEFIT AMOUNT FOR TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

The accelerated death benefit that is eligible to be paid under the Terminal Illness Accelerated Death Benefit Rider is equal to:

1. The Terminal Illness Accelerated Death Benefit Amount shown in the rider; less
2. The sum of any outstanding loans and accrued loan interest; less
3. An administrative fee, not to exceed the Maximum Administrative Fee shown in the rider.

You may elect to receive the entire terminal illness accelerated death benefit or any portion of this benefit amount. This amount is paid to You in a lump sum.

### EFFECT OF BENEFIT PAYMENT ON POLICY – TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

The accelerated death benefit plus accrued interest on the accelerated death benefit will be treated as a lien against the policy's death benefit proceeds. There will be no reduction or lien against any term or accidental death benefit riders attached to the policy. Once a lien has been established it cannot be repaid. The death benefit proceeds will be reduced by the amount of the accelerated death benefit plus accrued interest on the accelerated death benefit and the sum of any other outstanding loans plus accrued loan interest made after the accelerated death benefit is paid.

## **CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER**

The Chronic Illness Accelerated Death Benefit Rider provides that Owner may elect an accelerated benefit if the Insured is certified as being Chronically Ill, subject to the provisions of the rider. Chronically Ill means that the Insured has been certified by a licensed health care practitioner within the preceding 12-month period as:

1. Being unable to perform, without 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. Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

The Activities of Daily Living are Bathing, Contenance, Dressing, Eating, Toileting and Transferring.

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

1. Short-term or long-term memory; and
2. Orientation as to people, places or time; and
3. Deductive or abstract reasoning.

## **BENEFIT AMOUNT FOR CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER**

The accelerated death benefit that is eligible to be paid under the Chronic Illness Accelerated Death Benefit Rider is equal to:

1. The Chronic Illness Accelerated Death Benefit Amount shown in the rider; less
2. A pro-rata amount of any policy loans.

You may elect to receive the entire chronic illness accelerated death benefit or any portion of this benefit amount. This amount will be paid to You in a lump sum.

## **EFFECT OF BENEFIT PAYMENT ON POLICY – CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER**

The accelerated death benefit payment will reduce certain policy components by a proportional amount. This proportion will equal the Chronic Illness Accelerated Death Benefit Amount, before reduction for repayment of policy loans, divided by the death benefit amount immediately before the payment. The components that will be reduced are:

1. Death benefit proceeds; and
2. Face amount; and
3. Cash value; and
4. Premiums; and
5. Policy loan amount, if any.

## **LIMITATIONS**

Any accelerated death benefit will be subject to the following limitations:

1. The benefit is not intended to allow third parties to cause You to involuntarily access the policy proceeds payable to the named beneficiary. Therefore, the accelerated death benefit will not be available if You are required to request it for any third party, including any creditor, governmental agency, trustee in bankruptcy or any other person or as the result of a court order.
2. If the Insured dies after a request for an accelerated death benefit has been submitted and before You receive the accelerated death benefit payment, such request will be voided and the policy's death benefit proceeds will be payable, subject to all other policy provisions.

## **MEDICAID/GOVERNMENT BENEFITS**

Receipt of accelerated death benefits from a life insurance policy MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID AND SUPPLEMENTAL SECURITY INCOME ("SSI"), OR OTHER GOVERNMENT PROGRAMS. In addition, exercising the option to accelerate the death benefit and receiving that benefit before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

## **IMPORTANT NOTICES**

**There is no premium or charge to include a Terminal Illness Accelerated Death Benefit Rider or a Chronic Illness Accelerated Death Benefit Rider on a policy.**

**Accelerated benefits do not and are not intended to qualify as long-term care insurance.**



**Recurring Credit Card Authorization Form**  
**Form to be used for the collection of**  
**Recurring Credit Card information on authorized plans.**

Please read this authorization carefully and complete all requested items.

Policy Number: \_\_\_\_\_

Name of Proposed Insured: \_\_\_\_\_

Proposed Policy Owner: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

(Note: A valid e-mail address is necessary in order for us to notify you of your recurring credit card set up, charges, and declines. Without a valid e-mail address, we will not be able to set up your recurring credit card request at this time. Should you not have an e-mail address we will need to ask that you select a different method of payment.)

Cardholder Name (exactly as it appears on the card): \_\_\_\_\_

Social Security Number: \_\_\_\_\_

Cardholder Billing Address: \_\_\_\_\_

Credit Card Number: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Card Type:     American Express®     MasterCard®     Visa®

Premium Amount: \_\_\_\_\_

Payment frequency of ongoing premium payments:

Annual     Semi-annual     Quarterly     Monthly

By signing below, I, \_\_\_\_\_, authorize American General Life Insurance Company or The United States Life Insurance Company in the City of New York (the "Company") or its representative to charge my debit/credit card for the amount indicated above on a recurring basis as premiums become due.

I understand and agree that this transaction is subject to the acceptance by, and the terms and conditions of, the credit card company/bank indicated. I also understand this Authorization is not a part of the policy/contract of insurance, and that if premiums are not paid within the applicable grace period, the coverage will lapse. I further understand and agree that the Company shall incur no liability if the bank/credit card company dishonors any amount charged under this Authorization. I also agree that this Authorization may be terminated at any time and for any reason by either myself or the Company upon notice to the other party. Upon termination of this Authorization, the Company will bill me directly for any premium amount due.

I understand that I will be provided with confirmation of the recurring charge amount ; however, the initial charge to my account will include all currently due and past due premiums.

Signature of Authorized Person on Account: \_\_\_\_\_

X \_\_\_\_\_ 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)
  - Draft will occur on the date of issue or the date of submit unless a preferred withdrawal date is chosen below.
  - Subsequent Premiums, if different: \$ \_\_\_\_\_
- Draft Only Subsequent Premiums
  - Check/Complete one of the following:
    - Collected check with application in the amount of \$ \_\_\_\_\_.
    - Will collect check 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 the first premium 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 (Please Print) \_\_\_\_\_ Email Address 1 \_\_\_\_\_

Date of Birth 1 (MM-DD-YYYY) \_\_\_\_\_ SSN1 / TIN 1 \_\_\_\_\_

Name 2 (Please Print) \_\_\_\_\_ Email Address 2 \_\_\_\_\_

Date of Birth 2 (MM-DD-YYYY) \_\_\_\_\_ SSN2 / 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). 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.**

**SAMPLE FROM CHOICE MUTUAL**

