APPLICATION TO AMERICAN GENERAL LIFE INSURANCE COMPANY **PART 1M**
(To Be Completed By The Medical Examiner)

Name of Proposed Insured _____ Birth Date _____ Age _____
Month Day Year

1. Name, address and telephone number of the proposed insured's primary physician. (If no primary physician, provide the name, address and telephone number of physician last seen.)

_____

Date, reason, findings and treatment at last visit _____

Name and address of physician(s) and other licensed health care provider(s) treating conditions in questions 6-9.

	Yes	No
2. Is the proposed insured currently taking any medication or under medical observation, treatment, or therapy? If "Yes," give details including reasons for medication, treatment or therapy and name, address and telephone number of physician.	☐	☐
3. Has the proposed insured had a change in weight of 10 or more pounds in the past year?	☐	☐
4. Within the past 5 years, has the proposed insured consulted a physician or other licensed health care provider or been a patient in a hospital, clinic or treatment facility or gone to a hospital emergency room, walk in clinic, or similar clinic for medical care or consultation?	☐	☐

5.

Family History:	Age If Living	Age at Death	Cause of Death	Details/Date of Any Heart Disease Diagnosis	Details/Date of Any Cancer Diagnosis
Father					
Mother					
Brothers					
Sisters					

6. Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice regarding high blood pressure by a physician or other licensed health care provider?	☐	☐
If "Yes," Date of diagnosis _____ Describe Treatment _____		
Last blood pressure reading and date _____ Highest blood pressure reading in past 12 months _____		
Average blood pressure reading _____		
7. Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice regarding diabetes by a physician or other licensed health care provider?	☐	☐
If "Yes," Date of diagnosis _____ Describe treatment _____		
List any disability related to diabetes _____ Last blood sugar or HA1C reading and date _____		
Has the proposed insured experienced diabetic coma or vascular, kidney, heart, eye or other problems related to diabetes?	☐	☐
8. Has the proposed insured ever been diagnosed with or been treated for severe headaches, stress, nervous disorder, or mental disorder, including anxiety, depression or bipolar disorder, by a physician or other licensed health care provider?	☐	☐
If "Yes," Diagnosis _____ Date of diagnosis _____		
Describe treatment _____		
What factors lead to the diagnosis? _____ List any disability related to the diagnosis _____		
Has the proposed insured been hospitalized related to the diagnosis?	☐	☐
If "Yes," provide date and details _____		
How many attacks or occurrences in the past 12 months? _____ How often do symptoms occur? _____		
9. Has the proposed insured ever been diagnosed with, been treated for, tested positive for, or been given medical advice concerning sleep apnea, asthma, chronic bronchitis, or chronic obstructive pulmonary disease (COPD) by a physician or other licensed health care provider?	☐	☐
If "Yes," Diagnosis _____ Date of diagnosis _____		
Describe treatment _____ Date of last treatment _____		
Describe symptoms (when & how often do they occur?) _____		
List any disability related to the diagnosis _____		
10. Within the past 5 years, has the proposed insured used tobacco (cigarettes, cigars, pipe, snuff, chewing tobacco) or nicotine patches, nicotine gum,or any other form of nicotine?	☐	☐
If "Yes," Type _____ Date of Last Use _____ Frequency/Amount _____		
11. Within the past 5 years, has the proposed insured used alcoholic beverages?	☐	☐
If "Yes," Average No. of drinks per week _____ Maximum No. of drinks per day _____		
Type (Beer, Wine, Liquor) _____ Date of last use _____		

	Yes	No
12. Has the proposed insured ever received medical treatment or counseling from a physician or other licensed health care provider for, or been advised by a physician or other licensed health care provider to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has the proposed insured used such a non-prescribed drug or controlled substance or used any prescription medication other than as prescribed by a physician or other licensed health care provider?	☐	☐
If "Yes," Type of drug(s)/alcohol product(s) _____ Date last used _____		
Name(s) of doctor/facility_____ Phone (_____)_____		
Address _____ City _____ Zip_____		
Treatment Dates _____ Support Groups _____ Last Date attended_____		
Details of any drug or alcohol related arrests _____		
13. Within the past 10 years, has the proposed insured been diagnosed by a physician or other licensed health care provider as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for the Human Immunodeficiency Virus (HIV)?	☐	☐
14. Within the past 12 months, has the proposed insured experienced any of the following: paralysis for which the cause is not known and for which a physician or other licensed health care provider has not been consulted, one or more sores that have not healed, changes in the appearance of a mole, bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, or numbness?	☐	☐
15. In the past 24 months, has the proposed insured been advised by a physician or other licensed health care provider concerning any abnormal diagnostic test result(s) or been advised to have any diagnostic test(s) (including self-administered) or treatment or surgery which was not completed, or does the proposed insured have one or more test results pending (except those tests related to the Human Immunodeficiency Virus (AIDS virus))?	☐	☐
16. Does the proposed insured have a pending appointment with any physician or other licensed health care provider or have the intent to make such an appointment within the next 60 days?	☐	☐
17. Has the proposed insured been advised to enter a hospital, nursing home, hospice or assisted living facility?	☐	☐
18. Has the proposed insured made claim for or received disability benefits (other than for routine pregnancy) or Worker's Compensation benefits in the past 5 years?	☐	☐
If "Yes," Type of Disability _____ Details _____		
19. Within the past 24 months, has the proposed insured:		
(a) been diagnosed with, been treated for, tested positive for, or been given medical advice concerning fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing or shortness of breath by a physician or other licensed health care provider?	☐	☐
(b) received home health care services, physical therapy or rehabilitation therapy?	☐	☐
(c) resided in senior citizen's housing or a retirement or assisted living community?	☐	☐
(d) required assistance or supervision with or had any limitations in performing, any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)?	☐	☐
(e) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside the home or preparing meals?	☐	☐
20. Has the proposed insured ever been diagnosed with, been treated for, or consulted a physician or other licensed health care provider for any of the following: (If "Yes," check applicable boxes below.)		
(a) heart disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, high cholesterol or other disorder of the heart?	☐	☐
(b) a blood clot, aneurysm, stroke, transient ischemic attack, or other disease or disorder of the arteries or veins?	☐	☐
(c) cancer, malignant tumor or growth, leukemia, melanoma, Hodgkin's disease, non-Hodgkin's lymphoma, masses, cysts, polyps or other similar abnormalities?	☐	☐
(d) a disease or disorder of the thyroid or other glands or a disease or disorder of the immune or lymphatic system?	☐	☐
(e) a disease or disorder of the digestive system, throat, esophagus, stomach, intestine, liver, pancreas, or gall bladder?	☐	☐
(f) a disease or disorder of the urinary tract, kidneys, bladder, or prostate, or polycystic kidneys, or ever been diagnosed with protein in the urine?	☐	☐
(g) a disease or disorder of the respiratory system, or emphysema, or other lung disorder?	☐	☐
(h) a disease or disorder of the nervous system, brain, or spinal cord, or cerebral palsy, multiple sclerosis, paralysis or seizures?	☐	☐
(i) Alzheimer's disease or dementia?	☐	☐
(j) glaucoma, macular degeneration, or optic neuritis?	☐	☐
(k) a disease or disorder of the blood, or anemia, hemophilia, or sickle cell anemia?	☐	☐
(l) a disease or disorder of the muscles or bones, including but not limited to the back or joints?	☐	☐
(m) a disease or disorder of the reproductive system?	☐	☐
(n) memory loss, unconsciousness, attention deficit disorder, or loss of concentration?	☐	☐
(o) carpal tunnel syndrome or rheumatoid arthritis?	☐	☐
(p) a disease or disorder of the breast, disorder of menstruation, miscarriage, or complications of pregnancy?	☐	☐
(q) a disease or disorder of the skin, eyes, ears, sinuses, or lymph glands?	☐	☐
(r) chronic fatigue syndrome, Epstein-Barr Virus, fibromyalgia, or Lyme Disease?	☐	☐
21. Has the proposed insured been advised to modify or restrict eating, drinking or living habits because of any health condition?	☐	☐

If answered "Yes" to questions 4, 13-21, provide appropriate details such as: diagnosis; date of diagnosis; name, address and telephone number of physician; tests performed; test results; medications or recommended treatment.

_____

_____

_____

_____

Continuation of PART 1M

I agree that all statements and answers in this application are complete and true to the best of my knowledge and belief. I agree that this application will become a part of the policy applied for and any policy will be issued on the basis of my answers and statements. I agree that no agent of the Company or the Medical Examiner has authority to waive any answer or otherwise modify this application or bind the Company in any way by making any promise or representation which is not set out in writing in this application. **Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.**

Dated at _____ _____
Signature of Proposed Insured

this _____ day of _____ , _____

Witnessed by _____ _____
(Medical Examiner) Signature of Parent or Guardian required if Proposed Insured has not reached his sixteenth birthday.

American General Life Insurance Company

American General Center • Nashville, Tennessee 37250-0001
Home Office - Houston, TX

PART 2M

MEDICAL EXAMINER'S REPORT

22. a. Height (in shoes) ft. in.	Weight (Clothed) lbs.	Males Only: Chest (Full Inspiration) in.	Chest (Forced Expiration) in.	Abdomen, at Umbilicus in

b. Did you weigh? ☐ Yes ☐ No Did you measure? ☐ Yes ☐ No

23. Blood Pressure (If pressure over 140/90 give additional readings)

Systolic			
Diastolic 5th phase			

24. Pulse:	At Rest	After Exercise	3 Minutes Later
Rate			
Irregularities per min.			

25. Heart: Is there any:
Enlargement ☐ Yes ☐ No Dyspnea ☐ Yes ☐ No
Murmur(s) ☐ Yes ☐ No Edema ☐ Yes ☐ No
(describe below–if more than one, describe separately)

	Murmur #1	Murmur #2
Location		
Constant	☐	☐
Inconstant	☐	☐
Transmitted	☐	☐
Localized	☐	☐
Systolic	☐	☐
Presystolic	☐	☐
Diastolic	☐	☐
Soft (Gr. 1-2)	☐	☐
Mod. (Gr. 3-4)	☐	☐
Loud (Gr. 5-6)	☐	☐
After exercise:		
Increased	☐	☐
Absent	☐	☐
Unchanged	☐	☐
Decreased	☐	☐

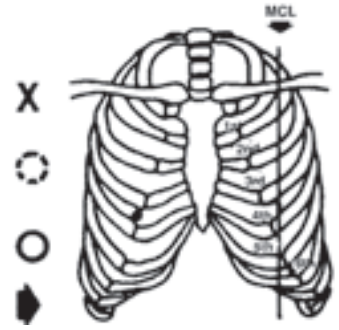
Indicate:

Apex by X

Murmur area by ◌

Point of greatest intensity by ○

Transmission by



For comments and your impression.

Examiner's Observation and Remarks

	Yes	No
a. Does the applicant appear to be stated age?	☐	☐
If "No," explain _____		
b. Are there any obvious physical abnormalities?	☐	☐
If "Yes," explain _____		
c. Does applicant use any devices to aid in locomotion (i.e., cane, walker, wheelchair)?	☐	☐
If "Yes," explain _____		
d. Does applicant seem alert, oriented to time and place?	☐	☐
If "No," explain _____		
e. Does applicant have any speech difficulties?	☐	☐
If "Yes," explain _____		

Details of "Yes" answers. (Identify item.)

URINALYSIS ➤	Are you satisfied it is authentic? ☐ Yes ☐ No	Specific Gravity	Albumin (even a trace)	Sugar (even a trace)	Occult blood?	Are you mailing specimen to office? (See Instructions below.) ☐ Yes ☐ No

NOTICE–FORWARD Specimen to Lab, if

a. Albumin or sugar is found, or there is any history or presence of hypertension (blood pressure exceeds 150/90), heart or genito-urinary disorder.
b. Amount of insurance (listed above) is **$100,000** or more through age 55; **$50,000** or more ages 56 and over.
c. Agent requests it when examination arranged.

I certify that the proposed insured was examined by me in private at ☐ my office ☐ applicant's home ☐ applicant's place of work

this_____ day of_____, _____ at _____ o'clock A.M. P.M.

Signature of Examiner_____ Address_____

This report should be returned to our Company address shown above.