AIG AMERICAN GENERAL

Part B Life Insurance Application

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**

Members of American International Group, Inc.

In this application, "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 that it may issue. No other company shown is responsible for such obligations or payments.

Personal Information

1. Primary Proposed Insured

Name _____ Date of Birth _____ Social Security # _____

2. Other Proposed Insured

Name _____ Date of Birth _____ Social Security # _____

3. Children *(Provide name and date of birth for all children.)*

_____

_____

Medical History

4. Physician Information

Name and address of each proposed insured's personal physician(s). *(Write None if proposed insured(s) do not have one.)*

Primary Proposed Insured _____

Other Proposed Insured _____

Child(ren) _____

Name of insured, date, reason, findings and treatment at last visit _____

_____

_____

_____

5. Height and Weight

Primary Proposed Insured _____ ft. _____ in. _____ lbs. **Other Proposed Insured** _____ ft. _____ in. _____ lbs.

Child Name _____ _____ft. _____in. _____lbs. If less than 1 yr. old, weight at birth _____

Child Name _____ _____ft. _____in. _____lbs. If less than 1 yr. old, weight at birth _____

Child Name _____ _____ft. _____in. _____lbs. If less than 1 yr. old, weight at birth _____

Has any proposed insured had any weight change in excess of 10 lbs. in the past year? ☐ yes ☐ no If yes, complete:

Name _____ Loss____ lbs. Gain____lbs. Reason _____

6. Family History

	Age if Living	Age at Death	Heart Disease?	Cancer History?
Primary Proposed Insured				
Father	_____	_____	☐ No ☐ Yes, age of onset ____	☐ No ☐ Yes, age of onset ____ Type _____
Mother	_____	_____	☐ No ☐ Yes, age of onset ____	☐ No ☐ Yes, age of onset ____ Type _____
Other Proposed Insured				
Father	_____	_____	☐ No ☐ Yes, age of onset ____	☐ No ☐ Yes, age of onset ____ Type _____
Mother	_____	_____	☐ No ☐ Yes, age of onset ____	☐ No ☐ Yes, age of onset ____ Type _____

7. Personal Health History

Complete questions A through G for all proposed insureds who are applying. If yes answer applies to any proposed insured, provide details, such as: ***proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)*** *or* ***recommended treatment*** *in the area provided.*

A. Has any proposed insured ever been diagnosed as having, been treated for, or consulted a licensed health care provider for:

1) heart disease, heart attack, chest pain, irregular heartbeat, heart murmur, high cholesterol, high blood pressure or other disorder of the heart? ☐ yes ☐ no
2) a blood clot, aneurysm, stroke, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☐ no
3) cancer, tumors, masses, cysts or other such abnormalities? ☐ yes ☐ no
4) diabetes, a disorder of the thyroid or other glands or a disorder of the immune system, blood or lymphatic system? ☐ yes ☐ no
5) colitis, hepatitis or a disorder of the esophagus, stomach, liver, pancreas, gall bladder or intestine? ☐ yes ☐ no
6) a disorder of the kidneys, bladder, prostate or reproductive organs or sugar or protein in the urine? ☐ yes ☐ no
7) asthma, bronchitis, emphysema, sleep apnea or other breathing or lung disorder? ☐ yes ☐ no
8) seizures, a disorder of the brain or spinal cord or other nervous system abnormality, including a mental or nervous disorder? ☐ yes ☐ no
9) arthritis, muscle disorders, connective tissue disease or other bone or joint disorders? ☐ yes ☐ no

(If any question above is answered yes, explain.)

Name of Proposed Insured	Details

B. Is any proposed insured currently taking any medication, treatment or therapy or under medical observation? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

C. Has any proposed insured in the past three years had but not sought treatment for:

1) fainting spells, nervous disorder, headaches, convulsions or paralysis? ☐ yes ☐ no
2) any pain or discomfort in the chest or shortness of breath? ☐ yes ☐ no
3) disorders of the stomach, intestines or rectum, or blood in the urine? ☐ yes ☐ no

(If any question above is answered yes, explain.)

Name of Proposed Insured	Details

Personal Health History (cont.)

If yes answer applies to any proposed insured, provide details, such as: ***proposed insured's name, date of first diagnosis, name and address of doctor, tests performed, test results, medication(s)*** *or* ***recommended treatment*** *in the area provided.*

D. Has any proposed insured ever:

1) sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs, including prescription drugs? ☐ yes ☐ no
2) used cocaine, marijuana, heroin, controlled substances or any other drug, except as legally prescribed by a physician? ☐ yes ☐ no

(If yes answered to D1 or D2, complete Drug/Alcohol Questionnaire.)

E. Has any proposed insured ever been diagnosed or treated by any member of the medical profession for AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS)? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

F. In the past 10 years, has any proposed insured:

1) been hospitalized, consulted a health care provider or had any illness, injury or surgery? ☐ yes ☐ no
2) had any laboratory tests, treatments or diagnostic procedures, including x-rays, scans or EKGs? ☐ yes ☐ no
3) been advised to have any diagnostic test, hospitalization or treatment that was not completed? ☐ yes ☐ no
4) received or claimed disability or hospital indemnity benefits or a pension for any injury, sickness, disability or impaired condition? ☐ yes ☐ no

(If any question above is answered yes, explain.)

Name of Proposed Insured	Details

G. Does any proposed insured have any symptoms or knowledge of any other condition that is not disclosed above? *(If yes, explain.)* ☐ yes ☐ no

Name of Proposed Insured	Details

Statements and Signatures

Statement by the Proposed Insured(s)

I have read the above statements or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related forms; and (2) shall be the basis for any policy issued. 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) it is within its contestable period; and (2) such misrepresentation materially affects the acceptance of the risk. Except as may be provided in a Limited Temporary Life Insurance Agreement (LTLIA), I understand and agree that no insurance will be in effect pursuant to this application, or under any new policy issued by the Company, unless or until: the policy has been delivered and accepted; the full first modal premium for the issued policy has been paid; and there has been no change in the health of any proposed insured that would change the answers to any questions in the application.

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 insurer's rights or requirements.

Fraud

Any person who, with intent to defraud or facilitate a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

Proposed Insured(s) Signature(s)

Signed at *(city, state)* _____ On *(date)* _____

X _____ **X** _____

Primary Proposed Insured *(If under age 15, signature of parent or guardian)*

Other Proposed Insured *(If under age 15, signature of parent or guardian)*

Signature(s) of Interviewer(s)

To be signed by all interviewers, as applicable

I certify that the information supplied by the proposed insured(s) has been truthfully and accurately recorded on the Part B application.

_____ _____

Writing Agent Name *(please print)*

Writing Agent #

X _____ **X** _____

Writing Agent Signature

Countersigned *(Licensed resident agent if state required)*

I certify that the information supplied by the proposed insured(s) has been truthfully and accurately recorded on the Part B application.

_____ _____

Other Company Representative Name *(please print)*

Company

X _____

Other Company Representative Signature

Paramedical Examiner/Medical Doctor Signature

Agent should inform paramed or medical doctor of proper location to send form upon completion.

I certify that this exam was conducted the _____day of _____, 20_____, at_____ ☐ am ☐ pm

Examiner's Address _____

Examiner's Phone # ( ) _____

Examiner's Name _____

Examiner's Signature **X** _____

Paramed: Use company stamp below.

Physical Measurements

1. Primary Proposed Insured

A. Name _____

B. Build: Height *(in shoes)* _____ ft. _____ in. Weight *(clothed)* _____ lbs. *(Please weigh insured.)*

C. Blood Pressure *(Record all readings.)*

If blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided.

Treated ☐ yes ☐ no Rx _____

	Initial Measurement	Repeat Measurement
Systolic BP		
Diastolic 5th Phase BP		
Pulse Rate		
Irregularities Per Min.		

D. Other *(Males only)*: Chest *(Full Inspiration)* _____ Chest *(Forced Expiration)*_____ Abdomen *(at Umbilicus)* _____

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2. Other Proposed Insured

A. Name _____

B. Build: Height *(in shoes)* _____ ft. _____ in. Weight *(clothed)* _____ lbs. *(Please weigh insured.)*

C. Blood Pressure *(Record all readings.)*

If blood pressure exceeds 140/90, please repeat determination at end of examination and record in space provided.

Treated ☐ yes ☐ no Rx _____

	Initial Measurement	Repeat Measurement
Systolic BP		
Diastolic 5th Phase BP		
Pulse Rate		
Irregularities Per Min.		

D. Other *(Males only)*: Chest *(Full Inspiration)* _____ Chest *(Forced Expiration)*_____ Abdomen *(at Umbilicus)* _____

Report By Examining Medical Doctor

Instructions to doctor:

To be completed in private by doctor only. This report is confidential between the Company and the doctor. Examination of heart and lungs must be with stethoscope against bare skin.

1. Name of person examined _____
2. Did you weigh proposed insured? ☐ yes ☐ no
3. Is appearance unhealthy or older than stated age? ☐ yes ☐ no
4. Heart
   a. Is there any cyanosis, edema, or evidence of peripheral vascular disease, arteriosclerosis or other cardiovascular disorder? ☐ yes ☐ no
   b. Is heart enlarged? *(If yes, describe.)*_____ ☐ yes ☐ no
   c. Is murmur present? *(If yes, complete 4d.)* _____ ☐ yes ☐ no
   d. Before exercise, murmur is:
      ☐ Constant Transmitted to where? _____
      ☐ Inconstant Localized at: ☐ Apex ☐ Base ☐ Elsewhere
      ☐ Systolic *(Give details.)* _____
      ☐ Diastolic Murmur grade: 1/6 2/6 3/6 4/6 5/6 6/6 *(please circle)*
      After valsalva, murmur is:
      ☐ Unchanged ☐ Decreased ☐ Increased ☐ Absent
      Your impression _____

Report by Examining Medical Doctor (continued)

5. Has this examination revealed any abnormality of the following: (***Circle*** *applicable items if listed.)*
   a) Eyes, ears, nose, mouth and throat? *(If vision or hearing markedly impaired, indicate degree and correction.)* ☐ yes ☐ no
   b) Endocrine system *(including thyroid)?* ☐ yes ☐ no
   c) Nervous system *(including reflexes, gait, paralysis)?* ☐ yes ☐ no
   d) Respiratory system? ☐ yes ☐ no
   e) Abdomen *(including scars)?* ☐ yes ☐ no
   f) Genito-urinary system? ☐ yes ☐ no
   g) Skin *(including scars),* lymph nodes, blood vessels *(including varicose veins)?* ☐ yes ☐ no
   h) Musculoskeletal system *(including spine, joints, amputations, deformities)?* ☐ yes ☐ no
6. Do you have any pertinent information not disclosed above? *(If yes, describe in question 9.)* ☐ yes ☐ no
7. Have any of the following been completed in conjunction with this exam? ☐ yes ☐ no
   ☐ Blood ☐ Urine ☐ EKG ☐ Stress Test ☐ Chest x-ray
8. Specimen kit
   Please indicate where and when specimen kit was sent ☐ CRL ☐ Other _____ Date mailed _____
9. Details of yes answers to Questions 1–6

   _____

   _____

   _____

   _____

   _____

   _____
10. Are you related to the proposed insured by blood or marriage or do you have any business or professional relationship with the proposed insured? *(If yes, explain.)* ☐ yes ☐ no

    _____

    _____

Signatures

Paramedical Examiner/Medical Doctor Signature

I certify that this exam was conducted the _____day of _____, 20_____, at_____ ☐ am ☐ pm

Location of Exam _____

Authorized By _____

Examiner's Address _____

Examiner's Phone # _____

Examiner's Name _____

Examiner's Signature **X**_____

Paramed: Use company stamp below.

AIG AMERICAN GENERAL

HIV Testing and Consent
Ohio Version

☐ **American General Life Insurance Company, Houston, TX**
☐ **The United States Life Insurance Company in the City of New York, New York, NY**

Members of American International Group, Inc.

In this form, the "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 that it may issue. No other company shown is responsible for such obligations or payments.

HIV Test Informed Consent Form

In order for us to evaluate your eligibility for insurance coverage, we request that you provide a blood, urine, and/or oral fluid (saliva) sample for HIV testing and analysis. The test that will be performed will determine the presence of antibodies to the HIV virus. By signing and dating this form, you agree that the HIV antibody test may be performed on your blood or other bodily fluid sample and that underwriting decisions may be based on the test results. A positive test result will adversely affect your insurance application. It also may result in uninsurability for life, health, or disability insurance for which you may apply in the future.

The HIV Virus

The HIV virus causes a life-threatening disorder of the immune system called Acquired Immune Deficiency Syndrome (AIDS). Antibodies to the HIV virus are found in the blood and other bodily fluids of most people with AIDS and AIDS-Related Complex (ARC), and can be found in people who do not have AIDS or ARC but have been exposed to the virus. The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion), or from an infected mother to her new-born infant.

The HIV antibody test is actually a series of tests performed upon your blood or other bodily fluid sample by a medically accepted procedure which is extremely reliable. The testing will be performed by a licensed laboratory.

Pre-Testing Consideration

Many public health organizations have recommended that before taking an HIV virus antibody test a person seek counseling to become informed about the implications of such tests. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results

All test results are confidential, except as provided by law. State law requires that the laboratory notify the Ohio Department of Health of positive test results.

The results of the test will be reported to the insurance company named on your application for insurance. The Insurer may not by law, release positive test results except as provided below:

If your HIV antibody test result is normal, you will not be notified. You will be notified of an abnormal (positive) test result if you indicate that you desire a positive result be made known to you. You may also identify another person to whom you want the positive results released.

If you want a physician or other health care provider to be notified of an abnormal HIV antibody test result, you must indicate the name and address of that physician or provider.

Abnormal test results may be disclosed to persons hired by the Insurer who participate in medical underwriting decisions of the Insurer. Abnormal test results may also be disclosed to affiliates of the Insurer who require the results for medical underwriting purposes.

In addition, if your HIV antibody test is abnormal, a generic code signifying a non-specific blood, oral fluid (saliva) or urine abnormality may be made known to the Medical Information Bureau, Inc. (MIB). The MIB is an organization of life and health insurance companies which operates as an information exchange on behalf of its members. There will be no record with the MIB that you had a positive HIV antibody test; however, there will be a record at the MIB that you have some blood, oral fluid (saliva) or urine abnormality. If you apply to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply the information on you in its file to that member.

Test Results

While a positive test result does not necessarily mean that you have AIDS, it does mean that you are at serious risk of developing AIDS or AIDS-related conditions. You may be infected with the HIV virus and infectious to others. You should seek medical follow-up care with your personal health care provider.

HIV test results are highly reliable but not 100% accurate. If the test gives a positive result you should consider retesting in order to confirm the result. If the test gives a negative result, there is still a small possibility you may be infected with HIV. This is most likely to happen in recently infected persons. It takes at least 4 to 12 weeks for a positive test result to develop after a person is infected, and may take as long as 6 to 12 months.

Other Sources of Information

For more information about AIDS you may call the Ohio AIDS Hotline at 1-800-332-2437.

Consent for HIV Testing

I have read and I understand this HIV Test Informed Consent Form. I voluntarily consent to the withdrawal of blood or to the providing of another bodily fluid sample, the testing of my blood or other bodily fluid for HIV antibodies, and the disclosure of the test results as described above. I will be given a copy of this form. This CONSENT is valid for ninety (90) days from the date of my signature below. The Insurer agrees to complete testing and provide the authorized notifications, as appropriate, within this 90 (ninety) day period.

Notification of Positive Test Result

In the event of a positive test result:

☐ Send the result to me at:

_____

Address

☐ I authorize the Insurer to send the result to another person:

_____

Name

_____

Address

☐ I authorize the Insurer to send the result to the following physician or health care provider:

_____

Physician's Name

_____

Address

Authorization

_____

Name of Applicant (Please Print)

_____ _____

Signature of Applicant Date

_____ _____

Signature of Legal Guardian, if any Date

_____ _____

Signature of Person obtaining consent Date

Forward a signed copy to the Insurer and leave a copy with the Proposed Insured.