



## Tips for Accelerated Application & Compliant Replacement Processing

Complete, detailed, legible information can improve the application to issue timing. Shown below are key data elements and forms that will help to ensure an in good order application and minimize app to issue turnaround time.

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### Coversheet/Transmittal – Please provide:

- Contact name, phone, and e-mail address
- Companion and/or Alternate/Additional policies, if applicable
- Special issue or other instructions

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### Part A – Please provide or complete in legible handwriting or typed -- e.g., capital letters and no cursive handwriting:

- Correct state version of application and all forms required. Should match the state in which the owner has signed.
- Name, address and date of birth
- Social Security number (insured and owner SSN needed, if different parties)
- Birthplace
- All tobacco use questions answered completely
- Driver's license number and state, if applicable; Questions must be answered if applicant is over 16 years of age
- All employer and employment information
- All income specified
- Citizenship information
- Owner information, if different than applicant
- Beneficiary information
- Entity Information / Trust ID for owner
- Plan name and term, if applicable
- Face amount for insured, any riders requested, and Premium Class Quoted
- Premium frequency, mode, and method
- Bank draft and/or void check provided for monthly payment, if applicable
- Initial Premium Received – if yes, Limited Temporary Life Insurance (LTLIA) may be applicable; See Other Forms section below.
- All payor information including SSN, if payor different than applicant/owner
  - If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form
- All replacement information must be received
  - Existing coverage, (insuring) company name and face amount
  - NAIC replacement form for NAIC states if other coverage exists
  - Correct state required replacement form(s) received, must be signed and dated on or before the Part A
  - Refer to the Replacement Section of this form for additional, more detailed information.
- All background information questions answered with complete details or applicable questionnaires provided for any "Yes" answers
- Signatures of Insured & Owner (if owner is different than insured)
- City/State/Date of signing
- Agent's signature
- All pages of application and supplemental forms (see below for more info on commonly needed forms)

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### Other Forms – (varies by product, coverage requested and state) – Please provide or complete:

- State required HIV forms
- HIPAA authorization with applicant signature
- Agent Report
  - Agent questions, agent/agency codes and agent signature are required
  - Answer 'yes' or 'no' to the inforce and/or pending coverage question (must match answer on Part A)
  - Answer 'yes' or 'no' to the coverage being replaced question (must match answer on Part A)
  - License number, agent phone number, email and fax number
- Paramedical Exam with lab slip or Part B, if required
  - Must be on the same state form as Part A; answer 'yes' or 'no' to each question. Details are required for all questions answered 'yes'
- Child Rider Supplement, if applying for Child coverage
- Index Universal Life Supplement, if applying for an indexed universal life product

- Limited Temporary Life Insurance (LTLIA) Agreement,
  - If eligible for LTLIA, collect initial premium and complete agreement; LTLIA is given to applicant and copy or duplicate original is returned to American General.
  - If not eligible for LTLIA, do NOT collect initial premium and do NOT complete LTLIA.
- Illustration or quotation, when applicable
  - Must match application information
- State applicable disclosure forms

**Replacement Section** – Shown below are 3 critical areas of focus -

**Existing Coverage Information**

- Answer 'yes' or 'no' to the inforce or pending policies question. (A); If 'yes',
  - Provide Policy Number or write 'Unknown' in the Policy Number field (B)
  - Provide name of existing insurer in Company Name field (C)
  - Provide face amount of existing coverage in the Amount of Coverage field (D)
  - Provide insured's name if a multi person app is being taken (E)

**Replacement Information**

- Answer 'yes' or 'no' to coverage being replaced question (F)
  - If an application for other coverage is pending, the replacement question should be answered 'no', unless some sort of limited, temporary coverage related to that application exists, even if no policy is to be put inforce.
  - If the replacement question is answered 'yes', then a Replacement Notice is required. However, in states that require notice form AGLC0188, the form MUST be completed if the existing coverage question (A) is answered 'yes', even if not replacing.

**1035 Information**

- Answer 'yes' or 'no' to the 1035 Exchange question. (G)

**Existing Coverage and Replacements**

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

- A. Do any of the Proposed Insureds have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?.....**  yes  no **(A)**
- B. If question 12A 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
	<b>(B)</b>					<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
1	Company Name: <b>(C)</b>		Amount of Coverage \$ <b>(D)</b>				
	Proposed Insured Name: <b>(E)</b>						

**Notice Regarding Replacement**

- Verify use of the correct Replacement Notice for the state in which the application is signed.
- Answer all replacement and financing questions; do not leave any fields blank.
- If the existing policy or contract number is not known, applicant should write 'Unknown' in the space provided.
- Answer the **Reason for Replacement** section, if applicable.
- If the Notice has a Sales Material section, (1) complete it and (2) submit any individualized sales materials, including illustrations. If no sales materials were used, write 'None' in the space provided.
- Be sure the applicant signs and dates the form(s). **Notice Regarding Replacement must be dated on or before the date of the Part A.**
- Agent signature and date are required.

**Reminders:**

- Group coverage being replaced does not require a Notice Regarding Replacement; however, the Existing Coverage Question and Replacement Question are all required to be completed on the Part A.
- If an existing internal cash value policy (WL, UL, VUL or ROP Term) has lapsed or was cancelled within the last 4 months, the application is processed as a replacement and all replacement requirements apply.

**Individual Life Insurance Application  
Single Insured – Part A  
Florida Version**

- 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, 45<sup>th</sup> Floor, New York, NY 10005-1400

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.

**1. Primary Proposed Insured**

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F  
 SSN \_\_\_\_\_ Birthplace\* (US State, or country) \_\_\_\_\_ DOB \_\_\_\_\_ Current Age \_\_\_\_\_  
**Tobacco Use** Has the Primary Proposed Insured 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 \_\_\_\_\_  
 Driver's License  yes  no License State \_\_\_\_\_ Number \_\_\_\_\_  
 If over age of 16 and no license, please explain. \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_ Email \_\_\_\_\_  
 Employer \_\_\_\_\_ Occupation \_\_\_\_\_ Date of Employment (mm/dd/yy) \_\_\_\_\_  
 Job Duties \_\_\_\_\_ Average No. of hours worked per week \_\_\_\_\_  
 Actively at work?  yes  no Able to perform all job duties?  yes  no If either is no, explain \_\_\_\_\_  
 Personal Earned Income (Annual): \$ \_\_\_\_\_ Household Income (Annual): \$ \_\_\_\_\_ Net Worth \$ \_\_\_\_\_  
 Personal Earned Income means monies received for work performed.  
 If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:  
 Owner \$ \_\_\_\_\_ Spouse \$ \_\_\_\_\_ Father \$ \_\_\_\_\_ Mother \$ \_\_\_\_\_ Siblings \$ \_\_\_\_\_ Premium Payor \$ \_\_\_\_\_  
**Citizenship** U.S. Citizen or Permanent Resident Card holder  yes  no If no, answer the following:  
 Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_ Visa Type \_\_\_\_\_ (Copy of Visa Required)  
 Own property or have a mortgage in the U.S.?  yes  no Plan to remain in the U.S.?  yes  no

**2. Owner - Complete if Primary Proposed Insured is not the Owner - (If Owner is a business, charitable entity or trust, answer question 5 below.)**

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F  
 SSN \_\_\_\_\_ DOB \_\_\_\_\_ Relationship to Proposed Insured \_\_\_\_\_  
 Driver's License  yes  no License State \_\_\_\_\_ Number \_\_\_\_\_  
 U.S. Citizen  yes  no If no, Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_  
 Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Primary Phone \_\_\_\_\_ Email \_\_\_\_\_  
 (If contingent Owner is required, use question 12.)

**3. Reason for Insurance - (If Business, complete Financial Questionnaire)**

**4. Beneficiary - (If Beneficiary is a business, charitable entity or trust, answer question 5 below.)**

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
2	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
3	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent
	Address:		Email:				<input type="checkbox"/> Primary <input type="checkbox"/> Contingent



**5. Entity Information** - Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.

(Check the applicable boxes information applies to:  Owner and/or  Beneficiary. If also the Premium Payor, complete section 9E.)

Exact Name \_\_\_\_\_ Tax ID # \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
Current Trustee Name \_\_\_\_\_ Date of Trust \_\_\_\_\_  
Corporate Officer Name \_\_\_\_\_ Title \_\_\_\_\_  
Email Address of applicable Trustee or Corporate Signer \_\_\_\_\_  
Relationship to Proposed Insured \_\_\_\_\_ Type of Entity (SCorp, CCorp, DBA, etc.) \_\_\_\_\_

**6. Product** - Signed Illustration/Quotation is required for all UL & VUL products.

Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)

Term Duration\*\* \_\_\_\_\_ Premium Class Quoted \_\_\_\_\_  
Amount Applied For: Base Coverage \$ \_\_\_\_\_ Supplemental Coverage\*\* \$ \_\_\_\_\_  
Death Benefit Compliance Test Used\*\*:  Guideline Premium  Cash Value Accumulation | Automatic Premium Loan\*\*:  yes  no

**7. Death Benefit Options** - (For UL & VUL only)  Level  Increasing

**8. Riders/Benefits** - Refer to Rider Reference Page for riders and benefits available per product.

<input type="checkbox"/> Accidental Death Benefit \$ _____	<input type="checkbox"/> Waiver of Monthly Guarantee Premium	<input type="checkbox"/> Other #4 _____
<input type="checkbox"/> Child Rider <sup>1</sup> \$ _____ <input type="checkbox"/> No current children	<input type="checkbox"/> Waiver of Premium	Amount/Unit(s) _____
<input type="checkbox"/> Chronic Illness Rider (AAS) <sup>2</sup>	<input type="checkbox"/> Other #1 _____	1 - Complete Child Rider Supplement
<input type="checkbox"/> Lifestyle Income <sup>3</sup> Withdrawal Benefit Basis % _____	Amount/Unit(s) _____	2 - Complete Chronic Illness Supplement
<input type="checkbox"/> Terminal Illness	<input type="checkbox"/> Other #2 _____	3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product.
<input type="checkbox"/> Waiver of Monthly Deduction	Amount/Unit(s) _____	Complete Chronic Illness Supplement, if applicable.
	<input type="checkbox"/> Other #3 _____	
	Amount/Unit(s) _____	

**9. Premium Payment**  Modal \$ \_\_\_\_\_  Single \$ \_\_\_\_\_  Additional/Lump Sum \$ \_\_\_\_\_

**A. Frequency of modal premium:**  Annual  Semi-annual  Quarterly  Monthly (Bank Draft only)

**B. Method:**  Direct Billing  Bank Draft (Complete Bank Draft Authorization)  List Bill: Number \_\_\_\_\_  
 Credit Card - Initial Premium Only (Complete Credit Card Authorization)  Other (Please explain) \_\_\_\_\_

**C. Amount submitted with application \$** \_\_\_\_\_

**D. Special Dating** (not available for VUL products): Save Age .....  yes  no

**E. Premium Payor** (Complete if Payor is other than Owner or if Owner is Trustee.)

First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_ Gender  M  F  
SSN or Tax ID # \_\_\_\_\_ Relationship to Primary Proposed Insured \_\_\_\_\_  
Driver's License  yes  no License State \_\_\_\_\_ Number \_\_\_\_\_ DOB \_\_\_\_\_  
U.S. Citizen  yes  no If no, Country of Citizenship \_\_\_\_\_ Date of Entry \_\_\_\_\_  
Visa Type \_\_\_\_\_ Exp. Date \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

**10. Existing Coverage and Replacements**

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

**A. Does the Primary Proposed Insured have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?** .....  yes  no



**B. If question 10A 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						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____						Amount of Coverage \$ _____
2						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____						Amount of Coverage \$ _____
3						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____						Amount of Coverage \$ _____

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

**11. Background Information** - Provide details specified for all "Yes" answers or complete applicable questionnaires.

- A. In the past five years, has the Primary Proposed Insured flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? (If yes, complete the Aviation Questionnaire) . . . .  yes  no
- B. In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, aircraft, or other motorized vehicles); 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? (If yes, complete the Avocation Questionnaire) . . . . .  yes  no
- C. Has the Primary Proposed Insured ever had an application for insurance modified, rated, declined, postponed or withdrawn? (If yes, list type of coverage, date and reason) . . . . .  yes  no
- D. Has the Primary Proposed Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? (If filed, list chapter filed, date, reason, and discharge date) . . . . .  yes  no
- E. In the past five years, has the Primary Proposed Insured been convicted of any driving violations to include driving under the influence of alcohol or drugs? (If yes, list date, state, license #, and specific violation) . . . . .  yes  no
- F. Has the Primary Proposed Insured ever been convicted of a felony or misdemeanor, or currently incarcerated or on parole or probation? (If yes, list date, county, state, charge, and current status) . . . . .  yes  no
- G. Is the Primary Proposed Insured an active duty service member of the U.S. Armed Forces? (If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure) . . . . .  yes  no
- H. Within the next 2 years is there any intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application? . . . . .  yes  no
- I. Within the next 2 years does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? . . . . .  yes  no
- J. Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, or any other form of payment) as an incentive to enter into this transaction? (If yes, describe the incentive) . . . . .  yes  no

**12. The space below may also be used to elaborate on answers to any questions on this application.**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Agreement, Authorization to Obtain and Disclose Information and Signatures**

I, the Primary Proposed Insured (and any Owner 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 this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. 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.

Except as may be provided in any Limited Temporary Life Insurance Agreement ("LTLIA"), I understand and agree that, even if I paid a premium, no insurance will be in effect under this application or under any new policy or any rider(s) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answer to any question in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that, if all three conditions above are not met: (1) no insurance will be in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

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; the 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 items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; or court records, 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; the MIB; other persons or organizations performing business or legal services in connection with my application of 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. 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.

**Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

**TAX CERTIFICATION (Substitute Form W-9) – Applicable to U.S. persons (including U.S. citizens and resident aliens). If you are not a U.S. person, you are required to submit the applicable IRS Form W-8 series (BEN, BEN-E, ECI, EXP or IMY). Under penalties of perjury, I certify to the following:** 1. That the taxpayer identification number listed on this form is my correct SSN/TIN and I am a U.S. Citizen or other U.S. person (including resident aliens); 2. I further certify that I am exempt from and have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding. The Company is required to withhold income tax on any payments, which include interest and dividends when the owner is subject to backup withholding.; and 3. I am exempt from Foreign Account Tax Compliance Act ("FATCA") reporting. **Certification Instructions:** You must cross out any statement in 1-3 that does not apply to you. For any instructions on how to complete this certification, please see the General Instructions for the IRS Form W-9 on [www.irs.gov](http://www.irs.gov). If you can complete a Form W-9 (Request for Taxpayer Identification Number) and you are a U.S. Citizen or U.S. resident alien, FATCA reporting may not apply to you. **Please consult your own tax advisor with any questions you may have regarding this certification.**

**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**

**Owner Title** \_\_\_\_\_  
*(If Corporate Officer or Trustee)*

**Owner signed at** (city, state) \_\_\_\_\_

**Owner signed on** (date) \_\_\_\_\_

**Primary Proposed Insured Signature** (if other than Owner)

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

**Agent(s) Signature(s)**

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* \_\_\_\_\_

State License # \_\_\_\_\_

Writing Agent Signature  \_\_\_\_\_

**Other Parent or Guardian Signature**

*(If under age 16 and coverage exceeds \$150,000, signature of both parents required)*







**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**

**Relationship** \_\_\_\_\_

**Description of Authority of Personal Representative**

(if applicable) \_\_\_\_\_

\_\_\_\_\_

**Control Number/Policy Number** \_\_\_\_\_

**Signed on (date)** \_\_\_\_\_

**Signor name (printed)** \_\_\_\_\_

\_\_\_\_\_





**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) even if such debits differ in amount from those specified in this form. 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.**

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

**American General Life  
Insurance Company, Houston, TX**

**The United States Life Insurance  
Company in the City of New York, New York, NY**

You have applied for life insurance with one of the insurance companies identified above ("Company"). This notice is provided on behalf of that Company.

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**FAIR CREDIT REPORTING ACT**

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931  
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

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**MIB, LLC**

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of its members of MIB Group, Inc. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901. If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

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**INSURANCE INFORMATION PRACTICES**

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and, if necessary, correct, amend, or delete personal information, except information that relates to a claim or a civil or criminal proceeding. This requires a written request to access your personal information and to request correction, an amendment, or deletion. We do not have to change our records if we do not agree with your request, but we will place your statement in our file. You have the right to receive a response within 30 business days of submitting a request to access, correct, amend, or delete your personal information.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access, correct, amend, or delete information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: P.O. Box 1931, Houston, TX 77251-1931.

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**TELEPHONE INTERVIEW INFORMATION**

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

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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.



Limited Temporary Life Insurance Agreement (Agreement)

**THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.**

**1. Check appropriate Company:**

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

In this Agreement, "Company" refers to the insurance company whose name is checked above, which is 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. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

**2. Complete the following: (please print)**

Primary Proposed Insured _____
Other Proposed Insured _____ <i>(applicable only for a joint life or survivorship policy)</i>
Owner (if other than Primary Proposed Insured) _____
Modal Premium Amount Received _____
Date of Policy Application _____

**3. Answer the following questions:**

	Yes	No
a. Has any Proposed Insured ever been diagnosed with or sought treatment from a member of the medical profession for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or disorder of the immune system, (excluding AIDS, ARC and HIV)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Has any Proposed Insured ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	<input type="checkbox"/>	<input type="checkbox"/>
c. Has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use from a member of the medical profession or a substance abuse counselor; or (3) been advised by a member of the medical profession to have any diagnostic test or surgery not yet performed?	<input type="checkbox"/>	<input type="checkbox"/>
d. Is any Proposed Insured either less than 14 days old or over age 70 1/2?	<input type="checkbox"/>	<input type="checkbox"/>

**STOP** If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

**4. Complete and sign this section:**

Any misrepresentation contained in this Agreement and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

*I, the Owner, have received a copy of this two-page Agreement and read it or have had it read to me and agree to be bound by the terms and conditions stated herein on the following page.*

**Owner Signature**

X

**Owner signed on** (date) \_\_\_\_\_

**Primary Proposed Insured (PPI) Signature** (if other than Owner)

X

*(If under age 16, signature of parent or Guardian)*

**PPI signed on** (date) \_\_\_\_\_

**Agent Instructions:** Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

**Other Proposed Insured (OPI) Signature** (if other than Owner)

X

*(If under age 16 and coverage exceeds \$150,000, signature of both parents required)*

**OPI signed on** (date) \_\_\_\_\_

**Writing Agent Name** (please print) \_\_\_\_\_

**State License #** \_\_\_\_\_



## TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

**A. Eligibility for Coverage:** If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

**B. When Coverage Will Begin:**

COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

***Coverage under this Agreement will not exist until all of the conditions listed above have been met.***

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Bank Draft Authorization; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

**C. When Coverage Will End:**

COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
  - The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
  - The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
  - The date the Company mails or otherwise provides notice to the Owner or his/her agent that the application will not be considered on a prepaid basis;
  - The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
  - [60]calendar days from the date coverage begins under this Agreement.
- D.** The Company will pay the death benefit amount described below to the beneficiary named in the application if:
- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
  - All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- \$1,000,000 plus the amount of any premium paid for coverage in excess of \$1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

**Agent Instructions:** Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.



# HIV Testing and Consent Florida Version

**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, NY 10005-1400

## Notice and Consent for Bodily Fluids Testing Which May Include AIDS Virus (Antibody) Testing

To evaluate your insurability, the Insurer named above has requested that you provide a sample of your bodily fluids (blood, urine, and/or oral fluid) for testing and analysis to determine the presence of human immunodeficiency virus (HIV) antibodies. By signing and dating this form you agree that this test may be done and that underwriting decisions will be based on the test result. A series of tests will be performed by a certified laboratory through a medically accepted procedure.

### Pre-Testing Considerations

Many public health organizations have recommended that before taking an AIDS-related bodily fluids test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

### Meaning of Positive Test Results

The test is not a test for AIDS. It is a test for antibodies to the HIV virus, the causative agent for AIDS, and shows whether you have been exposed to the virus. A positive test result does not mean that you have AIDS but that you are at significantly increased risk of developing problems with your immune system. The test for HIV antibodies is very sensitive. Errors are rare, but they do occur. Your private physician, a public health clinic, or an AIDS information organization in your city might provide you with further information on the medical implications of a positive test.

**Positive HIV antibody test results will adversely affect your application for insurance.**

### Confidentiality of Test Results

All test results are required to be treated confidentially. They will be reported by the laboratory to the Insurer. The test results may be disclosed as required by law or may be disclosed to employees of the Insurer who have the responsibility to make underwriting decisions on behalf of the Insurer or to outside legal counsel who needs such information to effectively represent the Insurer in regard to your application. The results may be disclosed to a reinsurer, if the reinsurer is involved in the underwriting process. The test may be released to an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular person.

### Notification of Test Results

A positive test result will be disclosed to a physician you designate. If you do not designate a physician, a positive test result will be disclosed to the Florida Department of Health and Rehabilitation. Because a trained person should deliver that information so that you can understand clearly what the test result means, please list your private physician so that the Insurer can have him or her tell you the test result and explain its meaning.

Name of physician for reporting a positive test result: \_\_\_\_\_

Address: \_\_\_\_\_

### Consent

I have read and I understand this Notice and Consent for AIDS-Related Bodily Fluid Testing. I voluntarily consent to the withdrawal of blood from me and/or collection of other bodily fluids, the testing of bodily fluids, and the disclosure of the test results as described above. I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

### Signature of Proposed Insured or Parent/Guardian

X \_\_\_\_\_

Date signed \_\_\_\_\_

Name of Proposed Insured (printed) \_\_\_\_\_

Address of Proposed Insured \_\_\_\_\_

Submit this form with the application



**Secondary Addressee Designation  
Florida Version**

**American General Life Insurance Company**  
**The United States Life Insurance Company in the City of New York**  
Service Center: P.O. Box 818005, Cleveland, OH 44181

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You have the right to designate one person, in addition to the applicant or policyowner, to receive notice of lapse or cancellation of a policy for nonpayment of premium. What does this mean? It means that a copy of the notice of lapse or cancellation that is sent to the policyowner will also automatically be sent to a second person, selected by you, who can assist you in making timely payments in order to prevent a lapse in coverage.

You are under no obligation to designate a secondary addressee, however if you would like to do so, please complete the information below and submit it with your application for life insurance or at such time as you may choose to designate a secondary addressee. **Customer Instruction:** If this designation form is for an existing policy that you own, please send the form to the following address: PO Box 818005 • Cleveland, OH 44181.

The policyowner may change the designation at any time the policy is in force by submitting a written notice to the Company containing the name and address of the secondary addressee.

Note: Your designation on this form will replace and revoke any prior designations of secondary addressees previously made by you.

**Secondary Addressee:**

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_

Home Phone: \_\_\_\_\_

**Applicant/Policyowner's Signature**

**Applicant/Policyowner signed on** (date) \_\_\_\_\_

**Applicant/Policyowner's name** (printed) \_\_\_\_\_

**Policy Number(s), if known:** \_\_\_\_\_



**Notice to Applicant  
Regarding Replacement of  
Life Insurance  
Florida Version**

**American General Life Insurance Company**, 2727-A Allen Parkway, Houston, TX 77019

A decision to buy a new policy and discontinue or change an existing policy may be a wise choice or a mistake.

Get all the facts. Make sure you fully understand both the proposed policy and your existing policy or policies. New policies may contain clauses which limit or exclude coverage of certain events in the initial period of the contract, such as the suicide and incontestable clauses which may have already been satisfied in your existing policy or policies.

Your best source for facts on the proposed policy is the proposed company and its agent. The best source on your existing policy is the existing company and its agent.

Hear from both before you make your decision. This way you can be sure your decision is in your best interest.

If you indicate that you intend to replace or change an existing policy, Florida regulations require notification of the company that issued the policy.

Florida regulations give you the right to receive a written Comparative Information Form which summarizes your policy values. Indicate whether or not you wish a Comparative Information Form from the proposed company and your existing insurer by placing **your initials in the appropriate box below**.

Yes

No

**DO NOT TAKE ACTION TO TERMINATE YOUR EXISTING POLICY UNTIL YOUR NEW POLICY HAS BEEN ISSUED AND YOU HAVE EXAMINED IT AND FOUND IT ACCEPTABLE.**

I have read this notice and received a copy of it.

**Applicant's Signature**

**Applicant signed on** (date) \_\_\_\_\_

**Applicant's name** (printed) \_\_\_\_\_

**Agent's Signature**

X \_\_\_\_\_

**Agent signed on** (date) \_\_\_\_\_

**Agent's name** (printed or typed) \_\_\_\_\_

**Agent's company** (printed or typed) \_\_\_\_\_

**Agent's address** (printed or typed) \_\_\_\_\_

Information on policies which may be replaced:

<b>Company Name</b>	<b>Policy Number</b>	<b>Name of Insured</b>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____



**Comparative Information Form  
for Proposed Insured**  
(Please return one copy of this form to  
the Home Office with the application)

**American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019**

Proposed Insurer \_\_\_\_\_  
(Replacing Agent's Name) \_\_\_\_\_

Insurer's Address \_\_\_\_\_

**APPLICANT INFORMATION**

Name \_\_\_\_\_  
Address \_\_\_\_\_  
Telephone \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**POLICY INFORMATION**

Policy Generic Name \_\_\_\_\_  
Policy Number \_\_\_\_\_  
Date of Issue \_\_\_\_\_ Issue Age \_\_\_\_\_  
Contestable Period Expires \_\_\_\_\_  
Suicide Period Expires \_\_\_\_\_  
Policy Loan Rate \_\_\_\_\_

**POLICY/RIDER DESCRIPTION**

POLICY/RIDER NAME	INITIAL/CONTINUING BENEFIT	BENEFIT (Age)		INITIAL/RENEWAL ANNUAL PREMIUM	PAYABLE (Age)	
		FROM	TO		FROM	TO

TOTAL INITIAL ANNUAL PREMIUM \$ \_\_\_\_\_ MODE OF PYMT. \_\_\_\_\_ AMOUNT \$ \_\_\_\_\_  
TOTAL RENEWAL ANNUAL PREMIUM \$ \_\_\_\_\_ AMOUNT \$ \_\_\_\_\_

**COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED**

YR.	AGE	GUARANTEES				PROJECTIONS*			
		ANNUAL PREMIUM	CUMULTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULTV VALUE	CASH BENEFIT	DEATH PREMIUM
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
	55								
	60								
	65								
	75								
	85								
	95								

\* Projections include dividends and current interest rates which are not guaranteed.  
IMPORTANT NOTICE: The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.



Existing Insurer \_\_\_\_\_

Insurer's Address \_\_\_\_\_

**APPLICANT INFORMATION**

Name \_\_\_\_\_

Address \_\_\_\_\_

Telephone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**POLICY INFORMATION**

Policy Generic Name \_\_\_\_\_

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

Date of Issue \_\_\_\_\_ Issue Age \_\_\_\_\_

Contestable Period Expires \_\_\_\_\_

Suicide Period Expires \_\_\_\_\_

Policy Loan Rate \_\_\_\_\_

**POLICY/RIDER DESCRIPTION**

POLICY RIDER NAME	INITIAL/CONTINUING BENEFIT	BENEFIT (Age)		INITIAL/RENEWAL ANNUAL PREMIUM	PAYABLE (Age)	
		FROM	TO		FROM	TO

TOTAL INITIAL ANNUAL PREMIUM \$ \_\_\_\_\_ MODE OF PYMT. \_\_\_\_\_ AMOUNT \$ \_\_\_\_\_

TOTAL RENEWAL ANNUAL PREMIUM \$ \_\_\_\_\_ AMOUNT \$ \_\_\_\_\_

**COMPOSITE DISCLOSURE OF PROPOSED INSURANCE FOR PRIMARY INSURED**

YR.	AGE	GUARANTEES				PROJECTIONS*			
		ANNUAL PREMIUM	CUMULTV PREMIUM	CASH VALUE	DEATH BENEFIT	ANNUAL PREMIUM	CUMULTV VALUE	CASH BENEFIT	DEATH PREMIUM
Current									
2 <sup>nd</sup>									
3 <sup>rd</sup>									
4 <sup>th</sup>									
5 <sup>th</sup>									
6 <sup>th</sup>									
7 <sup>th</sup>									
8 <sup>th</sup>									
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19 <sup>th</sup>									
20 <sup>th</sup>									
55									
60									
65									
75									
85									
95									

\* Projections include dividends and current interest rates which are not guaranteed.  
 IMPORTANT NOTICE: The income tax treatment of the benefits illustrated above may significantly affect their magnitude. Competent tax advice should be secured to clarify income tax implication.



## INSTRUCTIONAL NOTES FOR COMPLETION OF COMPARATIVE INFORMATION FORM

1. Existing life insurance must be identified by name of insurer and the policy number. In the event that a policy number has not been assigned by the existing insurer, an alternative identification form such as an application or receipt number must be shown.
2. If more than one existing life insurance policy is to be replaced, a separate Comparative Information Form is to be provided for each such policy.
3. In the disclosure of values premiums shall be shown only if they increase the cash value or death benefits for the primary insured.
4. Any benefits for secondary insureds shall be shown on a supplementary exhibit.
5. Values will be shown for each year in which either an initial change in face value or premium payment occurs.
6. Values will be shown in the disclosure for the maximum duration policy guarantees permit. If this benefit extension requires that guaranteed policy options be utilized, the option to be used will be that (those) automatically utilized by the issuing insurer. However, if the policy application provides for applicant election, then the extension of benefits will employ the option actually elected by the applicant. Any option utilized for extension of benefits must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form.
7. The dividend option elected-by an insured or applicant must be identified and briefly explained in the "Policy/Rider Description" section of the Comparative Information Form. The dividend option elected by the insured or applicant must be employed in completing the disclosure of values.



**Addendum to Application**  
**Policy # (if known):** \_\_\_\_\_

- 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, NY 10005-1400

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.

This addendum is part of the application to which it is attached. Addendum to (Part A, Part B, etc.): \_\_\_\_\_

**Primary Proposed Insured**

First Name \_\_\_\_\_ MI \_\_\_\_ Last Name \_\_\_\_\_ SSN \_\_\_\_\_

*(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)*

**Primary Proposed Insured (PPI) Signature**

X

**PPI signed on (date)** \_\_\_\_\_

**Other Proposed Insured (OPI) Signature**

X

**OPI signed on (date)** \_\_\_\_\_

**Owner Signature**

X

*(If other than Primary Proposed Insured)*

**Owner signed on (date)** \_\_\_\_\_



# Agent Certification Form

- American General Life Insurance Company**  
 **The United States Life Insurance Company in the City of New York**

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.

Insured's Social Security Number \_\_\_\_\_ Policy Number \_\_\_\_\_

Additional Insured's Social Security Number \_\_\_\_\_

This form must be completed prior to taking any application for life insurance on an individual age 67 or older. The Company may also request agents to complete this Form in other situations where it is deemed appropriate.

Carefully review this Form and Company Field Bulletins regarding Investor Owned Life Insurance and Stranger Owned Life Insurance, and complete the certification below that applies to the transaction; except, however, if part or all of the premium paid toward this policy is being financed and you cannot sign the certification, you must not take the application.

### Non-Premium Financing Certification

None of the premiums for the policy sought with the application for (Insured) \_\_\_\_\_ or for \_\_\_\_\_ (Additional Insured) dated \_\_\_\_\_ will be financed other than pursuant to a split dollar agreement, including a family's private split dollar agreement.

**Agent's Signature X** \_\_\_\_\_ **Agent signed on (date)** \_\_\_\_\_

### Premium Financing Certification

- 1) I have reviewed and am familiar with all aspects of the premium financing proposal.
- 2) Based upon my review of the financing proposal, I believe that the costs associated with this premium financing proposal are such that assuming no change in the insured/additional insured's health, it is more likely than not that the insured/additional insured will maintain the policy in force for the benefit of his/her beneficiaries and those beneficiaries will receive more than 50% of the policy death benefit.
- 3) The insured/additional insured is not receiving any cash payment, borrowing funds in excess of those required to pay the scheduled premiums and interest, or receiving any other consideration as an inducement to participate in this transaction.
- 4) Within the past 24 months has the insured/additional insured had a life expectancy calculation?  Yes  No  
All life expectancy calculations performed on any proposed insured during the past 24 months must be submitted with any application for review and consideration.
- 5) There is no prearranged agreement to transfer the policy nor will the policyholder have a prearranged option or right of first refusal to transfer the policy to a third party.
- 6) All sales materials used in connection with the solicitation and sale of this policy were either produced by the life insurance company or have been submitted and approved by the Company.
- 7) I have read the Field Bulletins regarding Investor Owned Life Insurance, Stranger Owned Life Insurance and Viatical Transactions, and believe this transaction is in compliance with the company policies as set forth in those Bulletins regardless of whether the lending program is a recourse or non-recourse transaction.

All or part of the premiums paid towards this policy are being financed. I have read the statements set forth above and hereby certify that the statements are all true with regard to the application for (Insured) \_\_\_\_\_ and \_\_\_\_\_ (Additional Insured) dated \_\_\_\_\_.

**Agent's Signature X** \_\_\_\_\_ **Agent signed on (date)** \_\_\_\_\_



# Premium Financing Disclosure for Proposed Insureds

**American General Life Insurance Company**, 2727-A Allen Parkway, Houston, TX 77019

In this form, the "Company" refers to the insurance company name listed 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.

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We are providing this notice to all insureds age 67 or older who have applied for life insurance policies, as we have seen unprecedented growth in premium financing for policies in this demographic.

Premium financing is a practice that has been used in connection with the sale of life insurance policies for many years. If you are contemplating financing the purchase of life insurance or participating in the acquisition of a life insurance policy acquired with funds from a source outside your control, please consider the following issues:

- All the questions on the life insurance application should have been answered accurately and completely. Misrepresentations about your health, your financial resources or the purpose for acquiring the policy may result in claims disputes rather than payment of insurance benefits.
- Be sure you understand the transaction. Some transactions are established with a trustee or other third party who obtains financing from a lender on terms that may not be to the insured's advantage. Ask yourself, are the parties involved looking out for your best interest?
- Will a significant portion of your policy death benefit reach your beneficiaries? If most of the death benefits are not going to your beneficiaries, perhaps you should consider acquiring a more affordable policy that you control for your beneficiaries.

**IMPORTANT:** Any payments received as an inducement for entering into a life insurance transaction are taxable as ordinary income. Also, if you have financed premiums to pay for a policy with the understanding that you can walk away after the initial term with no personal obligation to repay the loan or loan interest, it is possible that forgiveness of debt can also create taxable income for you. If you sell your policy the gain is taxable to you. You should consult with your personal tax advisor about any questions you may have regarding the tax consequences of this transaction.

- It is important to know the lender, the trustee or other parties participating in the transaction. Ask whether you are comfortable participating in a transaction where investors or entities you do not know may end up owning a large insurance policy on your life.

This is not a complete list of all the issues that you should consider when contemplating a new life insurance transaction. If you have any questions or concerns, you can contact your Agent or call our Company at 1-800-247-8837, prompt 1.

Please acknowledge that you have received this disclosure by signing a copy of this form and returning it to the Company. Retain a copy for your records.

## Proposed Insured's Signature

X

Proposed Insured signed on (date) \_\_\_\_\_



**Certification of Trust**

- American General Life Insurance Company**
- The United States Life Insurance Company in the City of New York**

**1. Account Information** *(Indicate one of the following)*

This form is being completed for an:

- Existing life insurance policy       Existing annuity contract       Mutual Fund Account

Existing Policy/Contract/Account Number(s) \_\_\_\_\_

- Application for life insurance policy       Application for an annuity contract

**2. Trust Information**

Full legal name of Trust \_\_\_\_\_

Date on which Trust was executed \_\_\_\_\_

Trust's tax identification number \_\_\_\_\_

State where Trust established \_\_\_\_\_  Revocable Trust     Irrevocable Trust

**3. Grantor Trust Information** *(complete only for annuities and modified endowment contracts)*

Is this Trust a Grantor Trust pursuant to IRC Sections 671 to 678?     Yes     No

A grantor trust is a trust under which the Grantor or someone other than the Grantor is treated as the owner of the trust assets for tax purposes under IRC Sections 671-678.

If yes, provide the following:

Grantor Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Grantor Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Address \_\_\_\_\_

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

**4. Trustee Authority**

Names of all Trustees authorized to act on behalf of the Trust \_\_\_\_\_

If more than one Trustee:

- Any Trustee is able to act independently     All Trustees must act jointly     Other (please specify) \_\_\_\_\_

**5. Trustee Declaration and Signature Information**

All currently acting trustees must sign. This form will supersede any previously provided certifications.

By signing below, each and all of the undersigned hereby:

- (a) represent they constitute all of the currently acting trustees of the Trust and that the Trust authorizes the Trustee(s) to purchase, own, and administer life insurance policies and/or annuity contracts on the life of the Insured(s)/Annuitant(s);
- (b) declare that the Trust has not been revoked, modified, or amended in any manner that would cause the representations contained herein to be incorrect and agree to provide a new Certification of Trust if the Trust is amended in any manner that changes any representations made in this Certificate, including any changes to the acting Trustees;
- (c) understand and agree that the life insurance company named above ("Life Company") (i) does not review trust documents, (ii) will administer the policy or contract in accordance with its standard procedures and has no obligation to administer in accordance with any terms of the Trust, (iii) may rely on the instructions and representations of the Trustee(s), and (iv) will have no responsibility to determine whether any instructions or representations of the Trustee(s) are consistent with the authorities granted to the Trustee(s) by the Trust document;



**5. Trustee Declaration and Signature Information (cont)**

- (d) agree to defend, indemnify and hold the Life Company, its parents, subsidiaries, and affiliates, and their directors, officers, employees and agents harmless for and against any and all claims, demands, liabilities, damages, costs or expenses, including, but not limited to, reasonable attorney's fees, which it may suffer or incur by reason of its reliance upon any statements contained herein;
- (e) agree to provide additional information regarding the Trust if required by the Life Company;
- (f) acknowledges that the Trustee(s) have had an opportunity to consult with its own legal and/or tax counsel in preparation of the Certification of Trust and that the Trustee(s) are solely responsible for the tax consequences arising from this Policy/Contract being held by a trust;
- (g) represent that no trustee of the Trust is an agent of record, servicing agent, solicitor, insurance producer, financial representative, investment advisor or related financial institution, broker/dealer or insurance agency or any individual or entity acting in a similar capacity involved in the sale, solicitation or placement of this contract/policy (such individuals and entities collectively "Distributor"), unless such Distributor is a member of Insured's/Annuitant's immediate family;\*
- (h) represent and certify that (i) the Trust and each beneficiary under the Trust has an insurable interest\*\* in the Insured(s)/Annuitant(s) listed on this form, (ii) is not aware of any agreement or arrangement whereby the Insured(s)/Annuitant(s) has received a payment or anything else of value in exchange for permission to use his/her life on the Policy/Contract, and (iii) understand that the Life Company reserves the right to terminate the contract consistent with applicable law if it discovers a misstatement with respect to the insurable interests between the Trust and the Insured(s)/Annuitant(s).

This paragraph (h) does not apply because:

- Trust was designated as beneficiary for an Individual Retirement Annuity and/or employer sponsored retirement plan or program (such as 401(a)/(k), 403(b), or 457(b)).
- This Certification of Trust is being submitted solely for a Change of Ownership on an existing policy.

*\*If the distributor is NOT a member of the insured's immediate family, then such Distributor and the Insured/Annuitant must complete an Acknowledgment and Release Form and submit same to the Company.*

*\*\*Generally, an interest is insurable if a familial relationship and/or economic interest exists. A familial relationship can only exist between individuals, and the relationship generally includes those persons related by blood or by law. An economic interest exists when the contract owner has a lawful and substantial economic interest in having the life, health, or bodily safety of the life that triggers the death benefit preserved. Charitable and not-for-profit organizations are exempt from insurable interest requirements.*

**Trustee #1**

Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Date \_\_\_\_\_ Phone \_\_\_\_\_ State of \_\_\_\_\_ County of \_\_\_\_\_

**Trustee #2**

Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Date \_\_\_\_\_ Phone \_\_\_\_\_ State of \_\_\_\_\_ County of \_\_\_\_\_

**Trustee #3**

Name \_\_\_\_\_ Signature \_\_\_\_\_  
 Date \_\_\_\_\_ Phone \_\_\_\_\_ State of \_\_\_\_\_ County of \_\_\_\_\_

**6. Insured/Annuitant Information** (This section not required where annuitant designates a trust as beneficiary for an Individual Retirement Annuity and/or employer-sponsored retirement plan or program (such as 401(a)/(k), 403(b) or 457(b)) or (2) with a permissible explanation under Section 5(h) of this form.)

By signing below, each and all of the undersigned hereby:

- (a) certifies that his/her life is being used as the insured for the life insurance policy or measuring life for the annuity contract, as applicable, and consents to the use thereof;
- (b) certifies that he/she has not entered into any agreement or arrangement whereby he/she has been paid, or received any other benefit, in exchange for permission to use his/her life for the life insurance policy or annuity contract, as applicable. Such an arrangement or agreement may be deemed a fraudulent act.

**Insured/Annuitant's Signature**

X

**Insured/Annuitant Name** (printed) \_\_\_\_\_

**Insured/Annuitant signed on** (date) \_\_\_\_\_



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# LIFE INSURANCE BUYER'S GUIDE

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This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

**Prepared by the National Association of Insurance Commissioners**

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

**THIS GUIDE DOES NOT ENDORSE ANY COMPANY OR POLICY.**

Reprinted by  
American General Life Insurance Company

## **IMPORTANT THINGS TO CONSIDER**

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1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

## BUYING LIFE INSURANCE

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When you buy life insurance, you want coverage that fits your needs.

**First**, decide how much you need—and for how long—and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of the many ways you plan for the future.

**Next**, learn what kinds of policies will meet your needs and pick the one that best suits you.

**Then**, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

### What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

### How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

## What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance. Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

**Term Insurance** covers you for a term of one or more years. It pays a death benefit only if you die in the term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period—even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

**Cash Value Life Insurance** is a type of insurance where the premiums charges are higher at the beginning than they would be for the same amount of the term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of the several types; whole life, universal life and variable life are all types of cash value insurance.

**Whole Life Insurance** covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

**Universal Life Insurance** is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

**Variable Life Insurance** is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and **STUDY IT CAREFULLY**. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

## LIFE INSURANCE ILLUSTRATIONS

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You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what could happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as show in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

## FINDING A GOOD VALUE IN LIFE INSURANCE

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After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for the selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.