AIG

Effective January 1, 2025

AIG Benefit Solutions
Underwritten by
American General Life Insurance Company
Houston, Texas

Application for Life Insurance

Administrative Office: Mail Stop 6-G2, P.O. Box 4373, Houston, TX 77210-9739
Phone: 866-242-2737 Fax: 713-831-3249

This application is for:
❑ New Coverage ☒ Increase in Coverage (UL only)

Universal Life
Employee Policy # _____ Spouse Policy # _____
Child #1 Policy # _____ Child #2 Policy # _____ Child #3 Policy # _____

Level Term
Employee Policy # _____ Spouse Policy # _____

Employee/Member Information (Employee/Member will be the owner of all coverage applied for.)

1. Employee/Member/Proposed Insured Name
Last First Middle

2. Address
Street
City State Zip Code
E-mail Address
Day Phone Number

3. Employer/Group
UHS - E0505184

4. Employee No./ID

5. Social Security No.

6. Birth Date
Month Day Year

7. Age Nearest Birthday _____

8. Gender ❑ M ❑ F

9. Annual Salary $ _____

10. Is the Employee/Member a U.S. Citizen? ❑ Yes ❑ No
If no, date of entry _____ (Month Day Year) visa type _____

11. Payroll Deduction Frequency
❑ 52 Pay (weekly) ❑ 26 Pay (Bi-weekly) ☒ 24 Pay (Semi-Monthly)
❑ Other _____

12. Hire Date: Month Day Year

13. Is the Employee/Member actively at work today, the usual number of hours without limitation? ❑ Yes ❑ No

14. Number of work hours per week? _____

Other Proposed Insured Information

15. Spouse Name _____
Last First Middle
Gender ❑ M ❑ F Birth Date Month Day Year
Age Nearest Birthday _____

16. Child #1 Name _____
Last First Middle
Gender ❑ M ❑ F Birth Date Month Day Year
Relationship _____ Full Time Student ❑ Yes ❑ No Age Nearest Birthday _____

17. Child #2 Name _____
Last First Middle
Gender ❑ M ❑ F Birth Date Month Day Year
Relationship _____ Full Time Student ❑ Yes ❑ No Age Nearest Birthday _____

18. Child #3 Name _____
Last First Middle
Gender ❑ M ❑ F Birth Date Month Day Year
Relationship _____ Full Time Student ❑ Yes ❑ No Age Nearest Birthday _____

Tobacco Usage Question (Only applies to any Proposed Insured age 18 or over.)

	Employee		Spouse		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
19. Has any Proposed Insured used tobacco and/or other products that contain nicotine in the past 24 months?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑

Insured Plans

Universal Life

	Employee	Spouse	Child #1	Child #2	Child #3
Amount of Insurance/Increase By:	$_____	$_____	$_____	$_____	$_____
Death Benefit Option (Level-1, Increasing-2)	☒ 1 ❑ 2	☒ 1 ❑ 2	❑ 1 ❑ 2	❑ 1 ❑ 2	❑ 1 ❑ 2
Additional Benefits:					
Accidental Death Benefit (ADB)	❑ ADB	❑ ADB	❑ ADB	❑ ADB	❑ ADB
Waiver of Monthly Deduction (WMD)	❑ WMD	❑ WMD			
Future Guaranteed Insurability Rider (FGIR)	❑ FGIR	❑ FGIR			
Children's Insurance Benefit (CIB)	CIB _____ units	CIB _____ units			
Terminal Illness Benefit (TIB)	☒ TIB	☒ TIB	☒ TIB	☒ TIB	☒ TIB
Other Rider _____	❑ _____	❑ _____	❑ _____	❑ _____	❑ _____
Other Rider _____	❑ _____	❑ _____	❑ _____	❑ _____	❑ _____
Other Rider _____	❑ _____	❑ _____	❑ _____	❑ _____	❑ _____
Payroll Deduction Amount: Increase Premium	$_____	$_____	$_____	$_____	$_____

Universal Life Beneficiary (Payment will be made in equal shares unless otherwise designated.)

20. Employee/Member Primary Beneficiary
    1. Name _____ Relationship _____ % _____
    2. Name _____ Relationship _____ % _____

    Employee/Member Contingent Beneficiary
    1. Name _____ Relationship _____ % _____
    2. Name _____ Relationship _____ % _____

The beneficiary for the spouse/child coverage applied for will be the Employee/Member.

Term Life

	Employee	Spouse
Level Term Life Insurance	❑ 10 Year Level ❑ 15 Year Level ❑ 20 Year Level	❑ 10 Year Level ❑ 15 Year Level ❑ 20 Year Level
Amount of Insurance:	$_____	$_____

Additional Benefits:	Employee	Spouse
Accidental Death Benefit (ADB)	❑ ADB	❑ ADB
Waiver of Premium (WP)	❑ WP	❑ WP
Children's Insurance Benefit (CIB)	CIB _____ units	CIB _____ units
Terminal Illness Benefit (TIB)	❑ TIB	❑ TIB
Other Rider _____	❑ _____	❑ _____
Other Rider _____	❑ _____	❑ _____
Other Rider _____	❑ _____	❑ _____
Payroll Deduction Amount:	$_____	$_____

Term Life Beneficiary (Payment will be made in equal shares unless otherwise designated.)

21. Employee/Member Primary Beneficiary
    1. Name _____ Relationship _____ % _____
    2. Name _____ Relationship _____ % _____

    Employee/Member Contingent Beneficiary
    1. Name _____ Relationship _____ % _____
    2. Name _____ Relationship _____ % _____

The beneficiary for the spouse coverage applied for will be the Employee/Member.

Health Questions

Part A (Complete for Simplified Issue or Contingent Guaranteed Issue only)

	Employee		Spouse		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
22. Has any Proposed Insured ever been diagnosed as having or been treated by any member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or any disorder of the immune system, or tested positive for the Human Immunodeficiency Virus (HIV)?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
23. In the 180 days prior to the date of this application, has any Proposed Insured consulted with a physician, or received treatment for, cancer, disease or disorder of the heart, heart attack, stroke, or drug or alcohol dependency?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
24. In the 90 days prior to the date of this application, has any Proposed Insured missed more than 3 consecutive days of work due to injury or illness other than cold, flu or maternity?	❑	❑	❑	❑						

Part B (Complete for Simplified Issue only)

	Employee		Spouse		Child #1		Child #2		Child #3	
	YES	NO	YES	NO	YES	NO	YES	NO	YES	NO
25. Has any Proposed Insured participated within the last 3 years in: flying in any type of aircraft as a student pilot or crew member; parachute jumping; auto, boat or motorcycle racing; hang gliding or scuba diving?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
26. Has any Proposed Insured within the last 5 years been diagnosed as having, been treated for, or consulted a licensed health care provider for:										
a. mental or nervous disorder, epilepsy, convulsions, paralysis, stroke or transient ischemic attack?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b. disease or disorder of the heart or blood vessels, heart attack or uncontrolled high blood pressure?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
c. disease or disorder of the lungs, emphysema or tuberculosis?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
d. disease or disorder of the kidney, bladder or prostate?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
e. disease or disorder of the stomach, intestines, rectum or liver?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
f. sugar, albumin, or blood in urine?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
g. cancer (other than basal cell skin cancer), tumor, syphilis, diabetes, gland or blood disorder?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
h. disease or disorder of breast or reproductive organs?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
i. organ transplant?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
j. multiple sclerosis, Crohn's disease or ulcerative colitis?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
27. Has any Proposed Insured in the last 3 years had fainting spells, pain or discomfort in chest, or shortness of breath?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
28. Has any Proposed Insured within the last 10 years:										
a. sought or received advice, counseling or treatment by a medical professional for the use of alcohol or drugs including the use of prescription drugs?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
b. used cocaine, marijuana, heroin, controlled substance, or any other drug except as legally prescribed by a physician?	❑	❑	❑	❑	❑	❑	❑	❑	❑	❑
29. Height	_____ft. _____in.		_____ft. _____in.		_____ft. _____in.		_____ft. _____in.		_____ft. _____in.	
30. Weight	_____lbs.		_____lbs.		_____lbs.		_____lbs.		_____lbs.	

Other Life Insurance or Annuities *(Indicate life insurance policies or annuities in force or pending for the proposed insured(s).)*

Does any proposed insured have any existing or pending annuity or life insurance contracts? ☒ Yes ☐ No

(If yes, indicate life insurance policies or annuities in force or pending for the proposed insured(s).)

Type: i = individual, b = business, g = group, p = pending life insurance or annuity

Name of Proposed Insured	Policy Number	Insurance Company	Type(s) (see above)	Year of Issue	Face Amount	Replace*
	GLD0001181	Aflac	Group Term		$25,000	☐ Yes ☒ No
						☐ Yes ☐ No

* **Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. **Please note: certain states require completion of replacement related forms even when other life insurance or annuities are not being replaced by the policy being applied for.**

Agent Information

To the best of your knowledge, will the insurance herein applied for replace or change existing insurance in this or any other company? ☐ Yes ☒ No

If "yes," submit complete requirements of state where the application was signed.

The undersigned agent hereby confirms that:

1) no illustration was used in connection with soliciting the application for Life Insurance, and,

2) all of the applicant's answers to the questions in the application, if applicable, were accurately and truthfully recorded by the Writing Agent.

Writing Agent Signature	Writing Agent Number	Date
	ZI4281L	

Authorization and Temporary Insurance

Agreement and Authorization to Obtain and Disclose Information and Declaration

I, the Employee/Member signing below, agree that 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 shall be the basis for any policy issued. I understand that any misrepresentation made in this application and relied on by the insurer issuing the policy 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.

I understand and agree that no agent may: accept risks or pass upon insurability; make or modify contracts; or waive any of the insurers rights or requirements. I acknowledge that: 1) no illustration conforming to the term life or universal life policy was provided; and 2) an illustration conforming to the universal life policy as issued, if any, will be provided by the time the policy is delivered.

I have received a copy of the Notices to the Proposed Insured.

I understand any information obtained will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. The Company may disclose any information gathered during its evaluation of my application to: its reinsurers; other persons or organizations performing business or legal services in connection with my application or claim; 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 from American General Life Companies, LLC. I understand this consent may be revoked at any time by sending a written request to American General Life Companies, LCC., 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.

Premium Payment Authorization

I authorize my employer to deduct the required premium from my pay for the coverage applied for in this enrollment and forward same to the Company. Premium for this coverage is considered paid if the first full modal premium (including signed Payroll Deduction Authorization or Automatic Bank Check) is submitted with this application. If the form of payment is Automatic Bank Check, payment must be honored upon its first presentation.

TEMPORARY INSURANCE AGREEMENT (TIA)

Subject to the terms of the policy applied for and this TIA, the Company agrees to pay the lesser of the Amount of Insurance applied for or $100,000, upon receipt of due proof that the Proposed Insured died while Temporary Insurance was in effect. Temporary Insurance will begin on the date the Proposed Insured signed this application (Signature Date). I understand and agree that Temporary Insurance will only begin for any Proposed Insured if: (1) I am actively at work on the Signature Date, the usual number of hours, without limitation; and (2) I have answered "No" to all applicable health questions in the application.

Temporary Insurance automatically ends on the earliest of the following: (1) the date this application is approved; (2) the date the Company sends notice to the Proposed Insured at the address shown in the application that the Company has declined to issue insurance; or (3) 60 days after the Signature Date.

If this application is approved as applied for, the policy will be effective on the date this application is approved by the Company. Otherwise, any insurance issued other than applied for will be effective upon delivery and acceptance of the policy.

Fraud

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or a statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).

Employee/Member Signature

Signed at San Antonio, Texas _____ On _____

(City, State) *(Date)*

X _____

Employee/Member

Detach this page and leave it with the proposed insured

NOTICES TO THE PROPOSED INSURED

American General Life Insurance Company, Houston, TX

"Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies LLC, an affiliated service company.

TEMPORARY INSURANCE AGREEMENT (TIA)

Subject to the terms of the policy applied for and this TIA, the Company agrees to pay the lesser of the Amount of Insurance applied for or $100,000, upon receipt of due proof that the Proposed Insured died while Temporary Insurance was in effect. Temporary Insurance will begin on the date the Proposed Insured signed this application (Signature Date). It is understood and agreed that Temporary Insurance will only begin for any Proposed Insured if the Proposed Insured is actively at work on the Signature Date, the usual number of hours, without limitation; and all applicable health questions in the application have been answered "No".

Temporary Insurance automatically ends on the earliest of the following: (1) the date this application is approved; (2) the date the Company sends notice to the Proposed Insured at the address shown in the application that the Company has declined to issue insurance; or (3) 60 days after the Signature Date.

If this application is approved as applied for, the policy will be effective on the date this application is approved by the Company. Otherwise, any insurance issued other than applied for will be effective upon delivery and acceptance of the policy.

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.

American General
Life Companies

DISCLOSURE OF ACCELERATED DEATH BENEFITS

American General Life Insurance Company

DISCLOSURE STATEMENT FOR ACCELERATED DEATH BENEFITS REQUIRED AT TIME OF APPLICATION FOR POLICY

Limitations of the Accelerated Benefit:
You may use the money you receive from the Terminal Illness Accelerated Benefit Rider for any purpose. Unlike conventional life insurance proceeds, accelerated benefits payable under this rider COULD BE TAXABLE IN SOME CIRCUMSTANCES. We recommend that you contact a tax advisor when making tax-related decisions about electing to receive and use benefits from this accelerated benefit product.

A. Consequences of This Benefit:
Receipt of accelerated benefits MAY AFFECT YOUR ELIGIBILITY FOR MEDICAID and SUPPLEMENTAL SECURITY INCOME ("SSI"), or other government programs. In addition, exercising the option to accelerate death benefits and receiving those benefits before you apply for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Contact the Medicaid Unit of your local Division of Medical Assistance and the Social Security Administration for more information.

Effects of the benefit payment:

1. We will defer premiums on the policy and any attached riders;
2. A lien against future policy benefits will be established;
3. Any unpaid policy loan will be added to the lien;
4. The amount of the lien and any policy loan will be deducted from the Death Benefit;
5. Interest will accrue daily on paid out benefits and any deferred premiums.

B. Medical Condition(s) Enabling Accelerating of Life Benefit:
Terminal Illness means a condition that a physician certifies will reasonably be expected to result in death in 12 months or less as specified in the Terminal Illness Accelerated Benefit Rider.

C. Option:
The Terminal Illness Benefit is a one time acceleration of up to 50% of the death benefit proceeds payable under the base policy, but not to exceed $250,000.

D. Premium for Accelerated Benefit:
NONE, there is no additional charge for the Terminal Illness Accelerated Benefit Rider.

E. Administrative Expense Charge:
On the date the accelerated benefit is paid under this rider, an administrative fee not to exceed $250.00 will be established as a lien against future policy benefits.

X _____ _____

Signature of Applicant | Signature of Agent

_____ _____

Date | Date