



**AMERICAN
GENERAL**

Insurance Specialties LLC
Highway 37 North
PO Box 275
Purdy MO 65734

Application for Cancer Insurance

American General Life Insurance Company, Houston, TX
A member company of American International Group, Inc.

1. Primary Proposed Insured (Please print full name) <hr/>			8. Plan <hr/> <hr/> <input type="checkbox"/> Rider _____	
2. Address <hr/> <p style="text-align: center;">Street</p> <hr/> <p>City _____ State _____ Zip Code _____</p>			<input type="checkbox"/> Individual <input type="checkbox"/> Parent and Children <input type="checkbox"/> Family <input type="checkbox"/> Other _____ <input type="checkbox"/> Other _____	
3. Social Security No. _____	4. Birth Date and Place Month Day Year State Country	5. Age _____	9. a. Modal Premium \$ _____ b. Payable <input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> Q <input type="checkbox"/> M <input type="checkbox"/> Other _____ <input type="checkbox"/> ABC Add to existing ABC account, policy no. _____ <input type="checkbox"/> PD Add to existing PD account no. _____	
6. Sex <input type="checkbox"/> M <input type="checkbox"/> F	7. Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Separated			

10. Owner (If other than Primary Proposed Insured)

Name _____ Relationship _____ Social Security No. _____

Address _____

Street _____ City _____ State _____ Zip Code _____

11. Premium Payor (If other than Primary Proposed Insured)

Name _____ Social Security No. _____

Address _____

Street _____ City _____ State _____ Zip Code _____

12. First Beneficiary _____ Relationship _____ Age _____

Second Beneficiary _____ Relationship _____ Age _____

13. Spouse (If coverage applied for)

Name _____

Birth Date and Place _____ Age _____

Month Day Year State Country

14. Enter names of unmarried dependent children and legally adopted children under age 18 for whom insurance coverage is being requested in this application.

	Full Name	Age	Relationship	Birth Date			Sex	
				Mo.	Day	Yr.	M	F
a.								
b.								
c.								
d.								

FOR HOME OFFICE USE ONLY

HEALTH HISTORY (Questions apply to all proposed insureds on whom insurance is applied for by this application.)

	YES	NO
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15. Does any proposed insured currently have any cancer insurance coverage through this company or any other company? YES NO
 If "Yes", Insured's Name _____ Co. Name _____

16. Will the policy applied for replace any existing health insurance? YES NO
 If "Yes", Insured's Name _____ Co. Name _____ Pol. No. _____

17. Has any proposed insured applied for or does any proposed insured currently receive Aid to Families with Dependent Children (AFDC) or Supplemental Security Income (SSI) benefits? YES NO
 If "Yes", Proposed Insured's Name _____ Type _____

18. Has any proposed insured ever been diagnosed or received medical advice for cancer, leukemia, melanoma, malignant tumor, Hodgkin's Disease or non Hodgkin's Lymphoma? YES NO

19. Has any proposed insured ever been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV)? YES NO

20. Within the past 6 months, has any proposed insured been advised by a member of the medical profession of any abnormal diagnostic test results, had treatment for sores that have not healed, had changes in the appearance of a mole, had any unexplained weight loss or fatigue or been advised to have any diagnostic tests, hospitalization, treatment, or surgery which was not completed? YES NO

21. **REMARKS** (Explain "Yes" answers to Questions 18-20)

Name of Person(s)	Date	Duration	Details of Illness Impairment or Checkup	Name and Addresses of Doctors or Hospitals

22. Owner's Certification of Social Security Number/Employer Identification Number
 The following number, _____, is my correct taxpayer identification number, and I am a U.S. person (including a U.S. resident alien).
 Under penalties of perjury, I certify that I am not subject to backup withholding because:

(a) I am exempt from backup withholding, or
 (b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
 (c) the IRS has notified me that I am no longer subject to backup withholding, AND
 (d) I am a U.S. person.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

X _____
 Signature of Owner _____ Date _____

AGREEMENT - AUTHORIZATION - ACKNOWLEDGEMENT - UNDERSTANDING
 I, the Primary Proposed Insured (and any Owner or Spouse signing below), by my signature set forth hereafter: **AGREE** that: (a) All statements and answers in this application are complete and true to the best of my knowledge and belief. (b) Except as stated in the Conditional Receipt, the insurance shall take effect on the Policy Date shown in the policy if the first full premium has been paid within 31 days of the Policy Date. (c) No agent has authority to waive any answer or otherwise modify this application, or to bind American General Life Insurance Company ("Company") in any way by making any promise or representation which is not set out in writing in this application. (d) Any temporary insurance shall become effective only if and when the Conditional Receipt is delivered to the Owner. It is further agreed by the undersigned that the terms of any Conditional Receipt are acknowledged and accepted. **AUTHORIZE** any physician, medical practitioner, hospital, clinic, other medical or medically related facility, insurance or reinsuring company, the Medical Information Bureau Inc. ("MIB"), consumer reporting agency, or any other organization, institution or person to give to the Company or its reinsurer(s) all information it holds that pertains to medical consultations, treatments, surgeries, and hospital confinements which relate to the physical and mental condition of myself or my minor children. This authorization also includes information about drugs or alcoholism or any other non-health (non-medical) history information. I understand that such information will be used to determine eligibility for insurance, or for benefits under existing insurance. I further authorize the Company to release any information obtained only to reinsuring companies, MIB, or other persons or organizations performing business or legal services in connection with my application or claim, or as may be otherwise lawfully required or as I may further authorize. As to this Authorization, I agree that a photocopy will be as valid as the original and that it will be valid for 30 months from the date shown below. I know that I or my representative may request a copy of this authorization. **ACKNOWLEDGE** receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes, and (b) MIB Pre-Notice, and (c) Outline of Coverage, if applicable. **UNDERSTAND** that: (a) I am applying for a cancer indemnity policy and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? Yes (Explain) No

Signed at _____, _____, _____ X _____
 City State Date Signature of Primary Proposed Insured (If Age 16 or Over)

X _____ X _____ X _____
 Signature of Licensed Agent Signature of Spouse (If Included as a Proposed Insured) Signature of Owner (If Other Than Primary Proposed Insured)

CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT

(see reverse side also)

American General Life Insurance Company has received \$ _____ from _____
(Name of Person Making Premium Deposit)

for insurance applied for on this date. We agree to provide temporary insurance as described below if both of the following conditions are met:

- (1) this premium deposit is at least equal to one twelfth (1/12) of the annual premium for the policy applied for; and
- (2) all persons for whom application is made are insurable in the opinion of the company's authorized persons in Houston, Texas, for the plan, insurance amount and premium applied for under the Company's underwriting rules and practices on the date of this premium deposit and on the date of any required medical examination.

NOT APPLICABLE

Any temporary insurance is subject to the amount and terms of the policy applied for. If temporary insurance exists, it will end when we deliver or tender delivery of a policy, or 60 days after the date of this receipt, if earlier. No agent has the authority to change the terms and conditions of this receipt. This receipt is not valid if its date differs from that in the application or if any check tendered as a premium deposit is not honored when presented for payment.

Date Local Office Agency No. Signature of Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AGLC 100443-2002

NOTICE OF INFORMATION PRACTICES

(see MIB pre-notice on reverse side)

American General Life Insurance Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes.)



NOTICE TO HOLDER OF CONDITIONAL RECEIPT

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit
(a) if we decline to issue insurance or
(b) if we issue a policy other than as applied for and you do not accept it.

NOT APPLICABLE

If you do not receive either a policy or the return of your premium deposit within 60 days from the date of premium deposit, return this receipt for refund to our Local Office or to our Home Office, American General Life Insurance Company, P.O. Box 1931, Houston, TX 77251-1931.

RECEIPT FOR REFUND OF PREMIUM DEPOSIT

I acknowledge the return of the premium deposit of \$_____ made to American General Life Insurance Company on an application for insurance for which no contract of insurance ever became effective.

(Date)

(Signature of person who made premium deposit or his personal representative)

AGLC 100443-2002

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. American General Life Insurance Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc. a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. American General Life Insurance Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.



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Acknowledgement of Delivery of a Buyer's Guide to Cancer Insurance

Proposed Insured Name: _____

For the Proposed Insured (Please fill out if you are present with the agent)

By signing below, I acknowledge that I have received a copy of the Buyer's Guide from the agent.

Proposed Policyowner Name: _____

Proposed Policyowner Signature: _____

Date: _____

For the Agent

Check one of the following to acknowledge your delivery of the Buyer's Guide:

_____ I have met with the client in person, have given the client a copy of the Buyer's Guide and have asked him or her to sign this acknowledgment form.

_____ I have mailed the Buyer's Guide to the client; therefore, no signature was obtained.

If mailed, date mailed to client: _____

Agent Name: _____

Agent Signature: _____ Date: _____

Client Copy

Agent Copy – retain this copy for your records