

Application for Group Voluntary Programs

American General Life Insurance Company of Delaware*

Wilmington, Delaware

Administrative Office: 3600 Route 66, Medical Underwriting 3-C, P.O. Box 1588, Neptune, NJ 07754-1588

*This company does not solicit business in New York.

These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that the Company may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files.

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 (866) 692-6901 [TTY (866) 346-3642].

The Company 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.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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Please print or type all information requested.

Group Policy Number V **Division** _____

All applications missing information, will be returned.

Employee's Annual Salary _____ **Hire Date** _____

Job Title _____

1. Name of Employer/Association _____

2. Employee's/Member's full name _____ Soc. Sec. No. _____
FIRST MIDDLE LAST

3. Home Address _____
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Life Insurance
Select specific Life amounts. Also select specific AD&D amounts if available under your group policy.
If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter.

	Life Amount	AD&D Amount
Employee:	\$ _____	\$ _____
Spouse:	\$ _____	\$ _____
Child(ren):	\$ _____	/ / / / / / / /

5. Complete the following for employee/member, spouse and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security #
EE						ft. in.	lbs.	
SP						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

If you are eligible for Guarantee Issue, do not complete question 6 and 7 unless you are applying for an amount in excess of the Guarantee Issue.

6. Have you ever been diagnosed with or treated for any disease of the heart, kidneys, liver or lungs, cancer or tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder?

 Yes No
 Yes No
 Yes No

7a. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?

 Yes No
 Yes No
 Yes No

7b. Are you presently taking any medication?

 Yes No
 Yes No
 Yes No

7c. Have you, in the past 12 months, missed more than 5 consecutive days of work due to illness or injury?

 Yes No

If "yes" to any part of questions 6 and 7, give details on following page (not required for child(ren) if employee or spouse is also applying). Use a separate sheet of paper if more space is needed for answers.

SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE

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Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names, Address and Phone # of Physicians Hospitals/Clinics Consulted

8. Complete this item only if the plan description material offers smoker/non-smoker rates for life insurance. If not completed, you will be billed using smoker rates.

Have you used tobacco in any form during the past 12 months?	EMPLOYEE	SPOUSE
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

AUTHORIZATION

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advise, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information. 2. I understand that this information will be used by the Company solely to determine eligibility for insurance. 3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which the Company has taken in reliance upon this authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier. 4. I know that I should retain a copy of this authorization for my records. 5. I agree that a photocopy of this authorization is as valid as the original. 6. To the best of my knowledge and belief, all the statements made above are true and complete. 7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application. 8. I authorize deductions from earnings for the costs of this insurance. 9. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.

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.

_____ _____
 (DATE SIGNED) (SIGNATURE OF EMPLOYEE/MEMBER)

_____ _____
 (DATE SIGNED) (SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)

Witness to above Signature(s): _____

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and/or children's insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Ex. Mary A Jones, Wife Not Mrs. John Jones	First Name	Initial	Last Name	Relationship