



DISABILITY INSURANCE APPLICATION

For Office Use Only - Policy No.

Name of Organization _____

Your Name _____ Male Female Soc. Sec. No. _____

Birth Date _____ Birth Place _____ Height Ft. _____ In. _____ Weight Lb. _____

Billing Address _____ Employer _____

STREET

Phone No. _____

CITY

STATE

ZIP

This address is my: Business Home Both

Occupation (specialty): _____ Beneficiary _____ Relationship _____

I WOULD LIKE TO APPLY FOR DISABILITY INSURANCE. Indicate the monthly benefit desired: (in \$100 increments) \$ _____

Are you now working at least 30 hours per week with your present employer? Yes No

My annual income for the 12 months immediately preceding the date of this application is: \$ _____

I wish to pay premiums: Annually Semi-Annually

Indicate waiting period: 30 day 60 day 90 day 180 day 365 day

Indicate benefit period: _____ Principal sum: \$ 1,000 (included)

Optional riders: (check if desired) Residual Disability Recovery Benefit Cost of Living Guaranteed Purchase

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

1. Have you ever had or been treated for (circle specific disorders experienced)

- a. Hearth trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? Yes No
- b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes No
- c. Arthritis, gout, bursitis, rheumatism? Yes No
- d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? Yes No
- e. Disease or disorder of the rectum or anus, Varicose veins, or other vascular disorder? Yes No
- f. Diabetes? Sugar, albumin or pus in the urine? Thyroid or other glandular disorder? Yes No
- g. Duodenal or stomach ulcer, or other disorder of stomach, liver, or gull bladder? Colitis, diverticulitis or other disorder of small or large intestine Yes No
- h. Prostate disorder? Kidney stone or colic, nephritis, or other kidney disorders? Urinary infection? Yes No
- i. Menstrual, uterine, or ovarian disorder, disorder of the breast? Yes No
- j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? Yes No
- k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes No
- l. Mental or emotional problem requiring the help of a physician or psychologist? Yes No
- m. A surgical operation? A surgical procedure advised but not performed? Yes No

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE

"MIB" DISCLOSURE NOTICE (This notice must be detached and retained by the applicant)

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 American General Life Insurance Company of Pennsylvania may, however, make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request be 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 the 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 PO Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

American General Life Insurance Company of Pennsylvania may also release information in its file to other life insurance companies to whom you are apply for life or health insurance to whom a claim for benefits may be submitted.

2. Have you ever had treatment by a or consultation with , any hospital, institution, Physician or practitioner within the past five years

Yes No

If you answered "Yes" to questions 1 a-m or 2, please explain fully in the chart below. Should you require additional space, please use a separate sheet of paper, sign and date it, and attach it to this form.

Question #	Condition	Date Occured	Duration	Degree of Recovery	Name and Address of Hospitals, Physicians or Clinic Consulted

What other Disability Insurance do you have? (Give full details)

Insurance Company	Amount of Monthly Benefit	Accident	How Long are Benefits Payable?	Sickness

Are you replacing any current disability coverage you have? Yes No

If yes, please provide name of insurance company and policy number: _____

DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

- To the best of my knowledge and belief, all statements made on this application are true and complete.
- I understand that my application for insurance will be accepted or declined on the basis of these statements.

AUTHORIZATION

I authorize the sources stated on the MIB disclosure to give American General Life Insurance Company of Pennsylvania, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment for supplies for any physical or medical condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any Insurer, the Medical Information Bureau; any consumer reporting agency; any employer. I understand that this information will be used by American General Life Insurance Company of Pennsylvania to determine eligibility for insurance.

I understand that i may revoke this authorization at any time. I agree that such revocation will no affect any action which American General Life Insurance Company of Pennsylvania has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier. I know that I have the right to receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original.

FRAUD STATEMENT

Any person who knowingly and with intent to defraud any insurance company or other person files 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 act, which may be a crime. This notice does not apply in Virginia.

Signed at _____ on _____

by _____

Date _____ Signature of Agent _____