

AMERICAN GENERAL ASSURANCE COMPANY

Administrative Office: 3600 Rt. 66, PO Box 1580, Neptune, NJ 07754

APPLICATION FOR DISABILITY INCOME AND BUSINESS OVERHEAD EXPENSE INSURANCE

Name of Organization Oklahoma Bar Association

Your Name _____

Address _____

Street

Phone Number _____

City

State

Zip

This Address is my <input type="checkbox"/> Business <input type="checkbox"/> Home <input type="checkbox"/> Both	I wish to pay premiums: <input type="checkbox"/> Annually <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly
Please fill in your Daytime Phone Number to assist us in contacting you should the need arise in processing your application: ()	
Are you now working at least 30 hours per week with your present employer? <input type="checkbox"/> Yes <input type="checkbox"/> No	
I WOULD LIKE TO APPLY FOR DISABILITY INCOME INSURANCE	I WOULD LIKE TO APPLY FOR BUSINESS OVERHEAD EXPENSE INSURANCE
My annual earned income for the 12 months immediately preceding the date of this application is: \$ _____	Average monthly amount of eligible overhead expenses in the preceding six months? Per Month \$ _____ Type of Organization: <input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership If Corporation or Partnership, my share of the eligible expenses are _____ %
Indicate the monthly benefit desired: (in \$100 increments) \$ _____	Indicate the monthly benefit desired: (in \$100 increments) \$ _____
Indicate Waiting Period: <input type="checkbox"/> 30 Day <input type="checkbox"/> 60 Day <input type="checkbox"/> 90 Day <input type="checkbox"/> 180 Day <input type="checkbox"/> 365 Day Indicate Benefit Period: <input type="checkbox"/> 65/65 <input type="checkbox"/> 5/2	Waiting Period: <input type="checkbox"/> 30 Day Benefit Period: 24 MONTHS
Optional Benefit Riders: <input type="checkbox"/> Residual (Partial) Disability Benefit <input type="checkbox"/> Guaranteed Purchase Option <input type="checkbox"/> Recovery Benefit <input type="checkbox"/> Cost of Living Adjustment Rider (COLA) <input type="checkbox"/> Hospital Indemnity Protection-If yes, indicate daily benefit amount \$ _____ <input type="checkbox"/> AD&D Principal Sum \$ _____ (\$1,000 AD&D automatically included)	Optional Benefit Riders: <input type="checkbox"/> Guaranteed Purchase Option <input type="checkbox"/> Recovery Benefit <input type="checkbox"/> Retroactive Benefit

Occupation _____

Social Security Number _____

Beneficiary _____

Relationship _____

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

Height _____ Ft. _____ In. Weight _____ lbs Sex M F Date of Birth ____/____/____ Place of Birth _____

1. Have you ever had or been treated for: (Circle Specific disorders experienced)	
a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Arthritis, gout, bursitis or rheumatism?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disease or disorder of rectum or anus, Varicose veins, or other vascular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes? Sugar, albumin, or pus in urine? Thyroid or other glandular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Prostrate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Menstrual, uterine, or ovarian disorder, disorder of the breast?	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Mental or emotional problem requiring help of a physician or psychologist?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. A surgical operation? A surgical operation advised but not performed?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Have you consulted any hospital, institution, physician or practitioner within the past 5 years for any disease, disorder, or injury other than stated above?	<input type="checkbox"/> Yes <input type="checkbox"/> No

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE

Disclosure Notice - Medical Information Bureau

Information regarding your insurability will be treated as confidential. American General Assurance Company, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or submit a claim for benefits to such company, the Bureau, upon request, will supply such company with the information in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your files. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act.

The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112. Telephone number is (617) 426-2660.

American General Assurance Company, or its reinsurers, may also release information in its files to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

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

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Names Addresses And Phone Numbers of Hospitals, Physicians or Clinic Consulted

What other Disability Insurance or Business Overhead Expense Insurance do you now carry or have an application pending for? (Give Full Details)

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

Are you replacing any current disability income or business overhead expense coverage you have? Yes No If Yes, 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 to American General Assurance Company, 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 or supplies for any physical or mental 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 Assurance Company to determine eligibility for insurance.

I understand that I may revoke this authorization at any time. Notice of revocation may be sent, in writing, to the Company at its home office. I agree that such revocation will not affect any action that American General Assurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 24 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 injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Date _____ Signature of Member _____

Signature of Agent _____

Underwritten by: American General Assurance Company

Please return completed application to Beale Professional Services, PO Box 60809, Oklahoma City, OK 73146-0809, (405) 521-1600.