

**BUSINESS OVERHEAD EXPENSE  
INSURANCE APPLICATION**

New Application  
 Increasing Coverage

**American General Life Insurance  
Company of Pennsylvania**

For Office Use  
Only - Policy No.

Please print all answers in ink or type.

Name: \_\_\_\_\_  Male  Female Occupation: \_\_\_\_\_

Business Address: \_\_\_\_\_

Residence Address: \_\_\_\_\_

Business Phone: ( ) \_\_\_\_\_ Residence Phone: ( ) \_\_\_\_\_

Birthdate: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

S.S. #: \_\_\_\_\_ Premium Payable:  Annual  Semi-Annual  Quarterly  Monthly\*  
\*automatic bank debit only

**Coverage Selection:**

Monthly Benefit Amount: \$ \_\_\_\_\_ (in \$100 increments) Waiting Period: 30 Days Benefit Period: 24 months

**Optional Riders:**

Recovery Benefit:  Yes  No Guaranteed Purchase Option:  Yes  No Retroactive Benefit:  Yes  No

I am a member of the:  OBA  OSCP Annual Earned Income: \$ \_\_\_\_\_

Average monthly amount of eligible overhead expenses in preceding six months: \$ \_\_\_\_\_

1. Type of organization:  Sole Proprietorship  Corporation  Partnership My share of eligible expenses: \_\_\_\_\_ %

2. Are you now, and have you been for the last 30 days, performing all the duties of your occupation for 30 or more hours per week at your usual place of business?  Yes  No

**Health Section** (must be completed in full prior to any underwriting consideration.)

- | 3. Have you ever had or been treated for: (Circle specific disorders experienced)  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Arthritis, gout, bursitis or rheumatism?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Disease or disorder of rectum or anus, varicose veins, or other vascular disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Diabetes? Sugar, albumin, or pus in urine? Thyroid or other glandular disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> | <input type="checkbox"/> |
| h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection?   | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Menstrual, uterine, or ovarian disorder, disorder of the breast?  | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose?  | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Mental or emotional problem requiring help of a physician or psychologist?  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. A surgical operation? A surgical operation advised but not performed?   | <input type="checkbox"/> | <input type="checkbox"/> |

Please continue this application on the reverse side.

S-10711 OK  
Rev. 0498

Detach and keep the following disclosure for your records.

**Medical Information Bureau -- Disclosure Notice**

Information regarding your insurability will be treated as confidential. American General Life Insurance Company of Pennsylvania, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a nonprofit 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 Life Insurance Company of Pennsylvania, 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.

4. Have you ever had treatment by or consultation with, any hospital, institution, physician, or practitioner within the past 5 years?  Yes  No

If you answered "Yes" to any part of questions 3 or 4, please explain fully below. Please use a separate sheet of paper if additional space is needed. Sign, date and return it with this form.

Ques. No.	Condition	Date Occurred	Duration	Degree of Recovery	Names and Addresses of Physicians, Hospitals or Clinics Consulted

5. What other Business Overhead Expense Insurance do you have? (Give full details)

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

6. Is the policy being applied for to replace, modify or supplement any similar insurance you now have?  Yes  No  
If Yes, furnish names of companies and amounts. \_\_\_\_\_

**DECLARATION OF PERSON 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 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 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 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 not 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**

Warning: 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.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Agent

\_\_\_\_\_  
Date

Underwritten by: American General Life Insurance Company of Pennsylvania, Reading, Pennsylvania  
**Please sign and return to: Beale Professional Services - P.O. Box 60809 - Oklahoma City, OK 73146-0809**

If you have questions regarding this application please call 1-800-530-4863 or 405-521-1600