

**DISABILITY INCOME
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 (in \$100 increments): \$ _____

Waiting Period: 30 Days 60 Days 90 Days

0 Days 65 Days

Benefit Period: 65-65 5-2

AD&D Principal Sum: \$ _____
(\$1,000 AD&D automatically included)

Optional Benefit Riders:

Residual (Partial) Disability Benefit Yes No

Recovery Benefit: Yes No

Guaranteed Purchase Option Yes No

Cost of Living Adjustment Rider (COLA) Yes No

Hospital Indemnity Protection Yes No

If Yes, indicate daily benefit amount: \$ _____

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

I am a member of the: Oklahoma Bar Association Oklahoma Society of Certified Public Accountants

Beneficiary: _____ Relationship: _____

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

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

- | | Yes | No |
|--|--------------------------|--------------------------|
| 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"/> | <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"/> |

S-10511 OK
Rev. 1100

Please continue this application on the reverse side

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.

2. 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 1 or 2, 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

3. What other Disability Insurance do you now carry or have an application pending for? (Give full details)

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

4 Are you replacing any current disability coverage you have Yes No
If Yes, furnish names of companies, policy numbers 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 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