AGENCY: 5M34V
AGENT: JENNIFER L FITZGERALD
MAIL TO: 5M35V
POLICY: 4200125254

SIG

JENNIFER L FITZGERALD
50 W 23RD ST FL 9
NEW YORK, NY 10010

December 14, 2020

JOHN STEIN
136 N NEVADA AVE
Montrose, CO 81401

Re: JOHN STEIN
Policy Number: 4200125254
Product Name: Select-a-Term

Dear JOHN STEIN:

Congratulations on taking this important step toward financial protection for yourself and your loved ones. For nearly 100 years, AIG has been a trusted insurance provider and now serves 90 million clients in more than 100 countries. Thank you for choosing us[1]!

Enclosed is your new insurance policy. We recommend that you carefully review all documents and store them in a safe place. Your policy package includes the following important information:

- Policy conversion information (if applicable)
- List of requirements needed to be returned to us in order to activate your policy (if applicable)
- Your policy contract
- Important information per your state of residence
- Our privacy policy and additional information

For added convenience, we encourage you to visit **www.aig.com/eservice** to securely manage your policy online. eService allows you to view policy documents, make payments, set up recurring payments, contact customer service and more.

If you have questions after reading your policy, please contact your agent directly or the AIG Contact Center at 1-844-452-3832 (Life Insurance) or 1-800-340-2765 (Variable Universal Life only).

Thank you again for your business. We look forward to serving you.

Sincerely,

Adam Winslow
Chief Executive Officer
Life Insurance, Life & Retirement

[1]Policies issued by American General Life Insurance Company (AGL) except in New York, where issued by The United States Life Insurance Company in the City of New York (US Life). Issuing companies AGL and US Life are responsible for financial obligations of insurance products and are members of American International Group, Inc. (AIG).

The following item(s) require your immediate attention. To avoid policy cancellation, please respond by **February 12, 2021**.

Your policy details:

Policy Number:	4200125254
Owner:	JOHN STEIN
Insured:	JOHN STEIN
Policy Effective Date:	January 4, 2021
Billing Frequency:	Monthly
Billing Type:	Bank Draft
Mode Premium:	$133.76

To complete the delivery of your policy, the following items MUST be submitted:

Signatures Required:

Bank Draft Auth

Short Health Statement - Delivery

Initial Payment:

Monthly premium in the amount of $133.76 will be drafted for each outstanding premium at the time delivery requirements are received. These premiums can be drafted once a new bank draft authorization is received.

Total Modal Premium Due:	$133.76
Cash Received:	$0.00
Balance Due:	**$133.76**

NOTE: Any changes made to the above listed requirements are subject to policy reissue.

Please respond by **February 12, 2021** using the submission instructions on the next page.

Agent: 5M35V
Agency: 5M34V

REQUIREMENT SUBMISSION INFORMATION

Please return delivery requirements in the envelope provided or refer to your agent website for the most accurate overnight delivery information. You may also fax requirements without money to the numbers below.

Delivery Requirements Fax Lines 1-877-713-6354
1-877-713-6355

Helpful hints:

- If you fax - don't mail, and if you mail - don't fax.
- Clearly write the policy number(s) on the first page of all correspondence.
- Be sure payment form is signed by account holder or cardholder.
- Need more time to deliver your policy? Additional money may be due.

Any questions concerning your delivery requirements, call your Case Manager:

Case Manager Name: Sandra Tomlin
Case Manager Phone Number:
Case Manager Email Address:

AIG

Short Health Statement
Policy # (if known): 4200125254

☑ American General Life Insurance Company, 2727-A Allen Parkway, Houston, Texas 77019
☐ The United States Life Insurance Company in the City of New York, 175 Water Street, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #
JOHN		STEIN	12/23/1964	254-37-6151

I represent, on behalf of myself and any person who may have been proposed for insurance, that to the best of my knowledge and belief:

1. There have been no changes to my occupation nor have I become unemployed since the date of the application; or
2. Neither I nor any other proposed insured has, since the date of the application:
   a. Consulted a licensed health care provider or received medical or surgical advice or treatment; or
   b. Acquired any knowledge or belief that any representation in the application, including information provided or an answer to a question, is now inaccurate, incomplete, or untrue.

Exceptions

In the event any exception is noted herein, the policy referenced above must not be delivered and will not be in force. The Company reserves the right to receive, review, and act upon this Short Health Statement and any other requirements.

Agent Instructions: If exceptions or changes are noted above, do not deliver the policy and consult with the Home Office.

Agreement: All of the above answers are full, complete and true to the best of my knowledge and belief, and are a continuation of, and form a part of, the application for insurance.

Owner Signature

X

Owner signed on (date) _____

Owner signed at (city, state) _____

Proposed Insured (PI) Signature

X

PI signed on (date) _____
(If under age 16, signature of parent or guardian)

ICC15-108098

Signed by: JOHN STEIN
Date: 2020.12.29 13:26:37 -06:00

Your Insurance Policy Contract

Policies issued by American General Life Insurance Company (AGL) except in New York, where issued by The United States Life Insurance Company in the City of New York (US Life). Issuing companies AGL and US Life are responsible for financial obligations of insurance products and are members of American International Group, Inc. (AIG).

AMERICAN GENERAL LIFE
Insurance Company
A Stock Company

Home Office:
Houston, Texas

2727-A Allen Parkway
Houston, Texas 77019

(713) 522-1111

JOHN STEIN
POLICY NUMBER: 4200125254

WE WILL PAY THE DEATH BENEFIT to the Beneficiary if the Insured dies while this policy is in force. Payment will be made after We receive Due Proof of Death of the Insured, and will be subject to the terms of this policy.

The consideration for this policy is the application and payment of the first premium. The first premium must be paid on or before delivery of this policy.

This is an INDETERMINATE PREMIUM TERM LIFE INSURANCE POLICY WITH A CHANGE IN THE FACE AMOUNT AFTER THE LEVEL PREMIUM PERIOD. A Death Benefit is payable upon the Insured's death while this policy is in force prior to the Termination Date of the Last Renewal Term Period. Premium payments are payable for the term period shown on the Policy Schedule. This policy is ANNUALLY RENEWABLE, CONVERTIBLE and contains RE-ENTRY OPTION. NONPARTICIPATING - THIS POLICY WILL NOT PAY DIVIDENDS.

NOTICE OF RIGHT TO EXAMINE POLICY

You may return this policy within ten* days after delivery if You are not satisfied with it for any reason. This policy may be returned to Us or to the agent through whom it was purchased. Upon surrender of this policy within the ten* day period, it will be void from the beginning, and We will refund any premium paid.

* If the application for this policy indicates a replacement, the number of days is thirty days or longer if required by the applicable law in the state where this policy is issued for delivery.

SIGNED AT THE HOME OFFICE ON THE DATE OF ISSUE.

Julie Cotton Hearne

Secretary

President

INDETERMINATE PREMIUM TERM LIFE INSURANCE POLICY
CHANGE IN FACE AMOUNT AFTER LEVEL PREMIUM PERIOD
ANNUALLY RENEWABLE AND CONVERTIBLE
20 YEAR LEVEL PREMIUM PERIOD
NONPARTICIPATING
READ YOUR POLICY CAREFULLY

INDEX

Beneficiary and Proceeds	6, 7	Incontestability	9, 10
Change in Face Amount	6	Owner	5
Change of Ownership or Beneficiary	7	Payment Options	7-9
Contract	5	Premium Payments	5, 6
Conversion and Renewal Provisions	12-13	Re-Entry Option	11, 12
Date of Issue	3, 5	Reinstatement	10, 11
Death Benefit	6	Suicide Exclusion	10
Definitions	2	Table of Premiums and Face Amounts	4
General Provisions	9-11	When this Policy Terminates	10
Grace Period	6		

DEFINITIONS

Company Reference. The words "We", "Our", "Us", or "Company" mean American General Life Insurance Company.

"You", "Your." The words "You" or "Your" mean the Owner of this policy.

Home Office. Our office at 2727-A Allen Parkway, Houston, Texas 77019; Mailing Address P.O. Box 1931, Houston, Texas 77210-1931.

Written, In Writing. A written request or notice in acceptable form and content, which is signed and dated, and received at Our Administrative Center.

Premium Class. The risk classification assigned to the Insured under this policy. The Premium Class is shown on the Policy Schedule.

Administrative Center. The term "Administrative Center" means Our service center to which You should direct all requests, instructions and other communications. Our Administrative Center is located at 2727-A Allen Parkway, Houston, Texas 77019.

Age. The word "Age" means the Insured's age nearest birthday as of the Date of Issue.

Attained Age. The term "Attained Age" means the Insured's Age plus the number of years and completed months from the Date of Issue.

Initial Face Amount. The term "Initial Face Amount" means the Face Amount of this policy on the Date of Issue.

Level Premium Period. The term "Level Premium Period" means the period of time during which premiums cannot change. The Level Premium Period is shown on the Policy Schedule.

Renewal Term Period. The term "Renewal Term Period" means each one-year period after the Level Premium Period for which this policy may be renewed but premiums can change.

NOTICE

This Policy Is A Legal Contract Between
The Policy Owner And The Company.

POLICY SCHEDULE

Insured:	JOHN STEIN	Policy Number:	4200125254
Insurance Age:	56	Date of Issue:	January 4, 2021
Sex:	Male	Initial Face Amount:	$500,000.00
This Is A Sex Distinct Policy		Premium Class:	Preferred Plus Non-Tobacco

SCHEDULE OF BENEFITS AND PREMIUMS

Benefits	Benefit Amounts	Annual Premium	Level Premium Period
Life Insurance:	$500,000.00	$1,564.50*	20 Years*
Terminal Illness Accelerated Death Benefit Rider Providing For Payment Of Accelerated Benefits Terminal Illness Percentage: 50.00% Maximum Benefit Amount: $250,000.00 Maximum Administrative Fee: $500.00		None	---
Total Initial Annual Premium:		$1,564.50	

*For Level Premium Period. The Annual Premium shown above includes a policy fee of $64.00. January 4, 2041 is the Termination Date of the Level Premium Period. For future term periods, see the Table of Premiums and Face Amounts.

After the Level Premium Period, this policy may be renewed for Renewal Term Periods of one-year. January 4, 2060 is the Termination Date of the Last Renewal Term Period referred to in the Renewal Option provision.

On the twentieth policy anniversary and any later policy anniversary, We have the right to change the premium of this policy. See Right to Change Premium provision.

The Face Amount of this policy on each policy year is shown in the Table of Premiums and Face Amounts.

Premiums payable other than annually are equal to a percentage of the Annual Premium and include additional premium charges. These percentages are shown in the Table of Premiums and Face Amounts. The initial Premium Payment Interval is Monthly. The first Monthly premium is $133.76.

Colorado Insurance Department Telephone: (303) 894-7499

Re-Entry Option. This policy may be exchanged for a new policy as specified in the Re-Entry Option provision. This option is available only on the twentieth policy anniversary, provided that a renewable level term policy is made available by Us at the Attained Age of the Insured at re-entry.

Conversion Option. This policy may be converted to a new policy as specified in the Conversion Option provision. Conversions are allowed prior to the Conversion Expiry Date. The Conversion Expiry Date is January 4, 2035. The Minimum Face Amount required for this policy after conversion is $100,000.00.

TABLE OF PREMIUMS AND FACE AMOUNTS

Policy Year	Maximum* Annual Life Insurance Premium	Face Amount	Policy Year	Maximum* Annual Life Insurance Premium	Face Amount
1	$1,564.50	$500,000.00	21	$2,679.10	$25,000.00
2	$1,564.50	$500,000.00	22	$2,679.10	$25,000.00
3	$1,564.50	$500,000.00	23	$2,679.10	$25,000.00
4	$1,564.50	$500,000.00	24	$3,444.44	$25,000.00
5	$1,564.50	$500,000.00	25	$3,921.46	$25,000.00
6	$1,564.50	$500,000.00	26	$4,468.52	$25,000.00
7	$1,564.50	$500,000.00	27	$5,087.79	$25,000.00
8	$1,564.50	$500,000.00	28	$5,812.15	$25,000.00
9	$1,564.50	$500,000.00	29	$6,657.73	$25,000.00
10	$1,564.50	$500,000.00	30	$7,646.68	$25,000.00
11	$1,564.50	$500,000.00	31	$8,799.24	$25,000.00
12	$1,564.50	$500,000.00	32	$10,132.75	$25,000.00
13	$1,564.50	$500,000.00	33	$11,654.66	$25,000.00
14	$1,564.50	$500,000.00	34	$13,320.69	$25,000.00
15	$1,564.50	$500,000.00	35	$15,113.28	$25,000.00
16	$1,564.50	$500,000.00	36	$17,016.81	$25,000.00
17	$1,564.50	$500,000.00	37	$18,946.73	$25,000.00
18	$1,564.50	$500,000.00	38	$20,885.12	$25,000.00
19	$1,564.50	$500,000.00	39	$22,737.00	$25,000.00
20	$1,564.50	$500,000.00			

*See Right To Change Premium provision.

Premiums payable other than annually are computed by multiplying the applicable Annual Premium by the Premium Percentages shown below.

Premium Payment Interval	Premium Percentage
Semi-annual:	52.00%
Quarterly:	26.50%
Monthly (Pre-authorized checking):	8.55%

Contract. Your policy is a legal contract that You have entered into with Us. You have paid the first premium and have submitted an application, a copy of which is attached. In return, We promise to provide the insurance coverage described in this policy.

The entire contract consists of:

1. This policy; and
2. The attached riders, if any, that add benefits to this policy; and
3. The attached endorsements, if any; and
4. The attached copy of Your application, and any attached amendments or attached supplemental applications.

Date of Issue. The Date of Issue of this policy is the date on which the first premium is due. The Date of Issue is also the date from which all policy years and anniversaries are determined.

Owner. The Owner is as stated in the application unless later changed. During the Insured's lifetime, the Owner may exercise every right this policy confers or We allow (subject to the rights of any assignee of record or irrevocable beneficiary). You may have multiple Owners of this policy. In that case, the authorizations of all Owners are required in Writing for all policy changes. The Owner may be the same as the Insured but does not have to be. If an Owner dies while this policy is in force and the Insured is living, ownership rights pass to the successor Owner documented in Our records, if any; otherwise ownership rights pass to the estate of the Owner.

PREMIUM PAYMENTS

Premium Payment. The first premium is due on the Date of Issue. Subsequent premiums for each Renewal Term Period are due on the first day of each Premium Payment Interval shown on the Policy Schedule. Each premium must be paid on or before its due date.

You may change the Premium Payment Interval for this policy, subject to Our rules at the time of change.

Where to Pay. You may make Your payments to Us at Our Administrative Center or to an agent authorized by Us to receive such payment. All premium checks must be made payable to the Company. A receipt signed by an officer of the Company will be furnished upon request.

Annual Life Insurance Premium. The Maximum Annual Life Insurance Premium is shown in the Table of Premiums and Face Amounts. We may charge an annual premium lower than the Maximum Annual Life Insurance Premium. No annual premium charge can be higher than the Maximum Annual Life Insurance Premium.

Right To Change Premium. We reserve the right to change the premium for this policy on the policy anniversary shown on the Policy Schedule and on any later policy anniversary, subject to the following terms:

1. The Annual Premium will not exceed the applicable Maximum Annual Life Insurance Premium shown in the Table of Premiums and Face Amounts.
2. Any change in premium for this policy will apply to all Insureds with the same policy benefits and provisions and with the same Date of Issue, Age at issue, Sex (if this policy was issued on a Sex Distinct basis) and Premium Class. We will not change the premium because of a change in an Insured's health, occupation or avocation.
3. Any change in premium for this policy will take effect only after 30 days prior notice has been given to the Owner of this policy.
4. Any change in premium for this policy will be based upon factors and considerations including, but not limited to, Our future expectations as to mortality, persistency, expenses, reinsurance costs, and any local, state and federal taxes. We will not change the premium in order to recoup any prior losses.

PREMIUM PAYMENTS (Cont'd)

5. Any change in premium for this policy will be determined in accordance with procedures and standards on file with the Interstate Insurance Product Regulation Commission.

This provision does not apply to any rider attached to this policy.

Grace Period. The Grace Period is the 31-day period that follows the due date of any premium other than the first premium.

Any payments sent by U.S. mail must be postmarked within the Grace Period in order to keep Your policy in force. If the amount of premium required to keep Your policy in force is not paid by the end of the Grace Period, this policy will terminate.

CHANGE IN FACE AMOUNT

The Face Amount of this Policy will change after the Level Premium Period. The Face Amount of this Policy on each policy year is shown in the Table of Premiums and Face Amounts.

DEATH BENEFIT

If the Insured dies before this policy's Termination Date shown on the Policy Schedule and while this policy is in force, We will pay the Death Benefit to the Beneficiary after We receive Due Proof of Death and proper written claim showing proof of the claimant's interest in the Death Benefit.

The Death Benefit will be equal to:

1. The Face Amount of the policy in the current policy year plus;
2. Any insurance on the Insured's life that is payable under any attached riders; less
3. Any premium amount due if the Insured's death occurs during the Grace Period; plus
4. Any part of a premium paid for coverage beyond the policy month in which the Insured dies; plus
5. Any interest as described in the Interest Payable on Death Benefit provision.

BENEFICIARY AND PROCEEDS

Beneficiary. The Beneficiary as named in the application, or later changed by You, will receive the proceeds upon the death of the Insured. Unless You have stated otherwise, proceeds will be paid as follows:

1. If any Beneficiary dies while the Insured is living, that Beneficiary's interest will pass to any other Beneficiaries of the Insured We determine are entitled to payment; or
2. If there is no Beneficiary upon the death of the Insured (and there is no provision to the contrary), proceeds will be paid in one lump sum to the Owner, if living; otherwise proceeds will be paid to the Owner's estate.

BENEFICIARY AND PROCEEDS (Cont'd)

Common Disaster. If We cannot determine whether a Beneficiary or the Insured died first in a common disaster, We will assume that the Beneficiary died first. Proceeds will be paid on this basis unless We receive Your Written request prior to the death of the Insured that provides otherwise.

Proceeds. Proceeds mean the amount payable on the Insured's death.

The proceeds payable on the Insured's death will be the Death Benefit, after refunding any premium received on or after the date of death and will be subject to the other provisions of the Beneficiary and Proceeds section.

All proceeds are subject to the provisions of the Payment Options section and the other provisions of this policy. Full payment of policy proceeds to the person(s) designated to receive such policy proceeds discharges Us from all claims.

Due Proof of Death. Due Proof of Death means any written proof which includes a copy of the death certificate or other lawful evidence providing equivalent information.

CHANGE OF OWNERSHIP OR BENEFICIARY

You may change the Owner or the Beneficiary at any time during the lifetime of the Insured unless the previous designation provides otherwise. However, an irrevocable beneficiary cannot be changed without the written consent of such irrevocable beneficiary. To do so, send a Written request to Our Administrative Center. The change will go into effect when We have received the change. However, after the change is received, it will be deemed effective as of the date You signed the Written request for change, unless You specify otherwise. The change will be subject to any payment made or action taken by Us before We receive the request.

PAYMENT OPTIONS

Proceeds are payable in one sum. Instead of being paid in one sum, all or part of the proceeds may be applied under any of the Payment Options described below. In addition to these options, other methods of payment may be chosen with Our consent. The amount applied to purchase a Payment Option will not be less than would be provided by immediate annuity purchase rates offered by the Company at the time the Payment Option payments are to begin.

The monthly payment for each $1,000 of proceeds applied to purchase a Payment Option will be furnished upon request.

Payment Contract. When proceeds become payable under a Payment Option, a Payment Contract will be issued to each payee. The Payment Contract will state the rights and benefits of the payee. It will also name those who are to receive any balance unpaid at the death of the payee.

PAYMENT OPTIONS (Cont'd)

Election of Options. The Owner may elect or change any Payment Option while the Insured is living, subject to the provisions of this policy. This election or change must be In Writing. Within 60 days after the Insured's death, a payee entitled to proceeds in one sum may elect to receive proceeds under any option, subject to the limitations stated in the "Availability of Options" provision.

Option 1. Payments for a Specified Period: Equal monthly payments will be made for a specified period.

Option 2. Payments of a Specified Amount: Equal monthly payments of a specified amount will be made. If You select this Payment Option each payment must be at least $60 a year for each $1,000 of proceeds applied. Payments will continue until the amount applied, with interest, has been paid in full.

Option 3. Payments for Life with Period Certain: Equal monthly payments will be made for a specified period, and will continue after that period for as long as the payee lives. The specified period may be 10, 15 or 20 years. If issued on a Sex Distinct basis, payments are calculated based on the Annuity 2000 Male or Female Tables adjusted by projection scale G (adjusted by 50% of projection scale G for females and 100% of projection scale G for males) for 20 years. If issued on a Unisex basis, payments are calculated based on the Annuity 2000 Male and Female Tables adjusted by projection scale G (adjusted by 50% of projection scale G for females and 100% of projection scale G for males) for 20 years, with Unisex rates based on 40% female and 60% male.

Option 4. Proceeds Left at Interest: Proceeds may be left on deposit for any period up to 30 years. Interest earned on the proceeds may be:

1. Left on deposit to accumulate with interest; or
2. Paid in installments at the rate for each $1,000 of proceeds of $10.00 annually, $4.99 semiannually, $2.49 quarterly or $0.83 monthly.

Upon the death of the payee, or at the end of the specified period, any balance left on deposit will be paid in a lump sum or under Options 1, 2 or 3.

Interest Rates. Proceeds held under all Payment Options receive interest at Our current rate for funds left on deposit, which will be no less than the guaranteed rate. The guaranteed rate of interest for proceeds held under all Payment Options is 1.00% compounded annually. We may use a higher rate of interest. We determine the higher rate.

Payments. The first payment under Options 1, 2 and 3 will be made when the claim for settlement has been approved. Payments after the first will be made according to the manner of payment chosen. Interest under Option 4 will be credited from the date of death and paid or added to the proceeds as provided in the Payment Contract.

Availability of Options. If the proposed payee is not a natural person, payment options may be chosen only with Our consent.

If this policy is assigned, We will have the right to pay the assignee in one sum the amount to which the assignee is entitled. Any balance will be applied according to the option chosen.

The amount to be applied under any one option must be at least $2,000. The payment elected under any one option must be at least $20. If the total policy proceeds are less than $2,000, payment will be made in one lump sum.

Evidence That Payee is Alive. Before making any payment under a Payment Option, We may ask for proof that the payee is alive. If proof is requested, no payment will be made or considered due until We receive proof.

PAYMENT OPTIONS (Cont'd)

Death of a Payee. If a payee dies, any unpaid balance will be paid as stated in the Payment Contract. If there is no surviving payee named in the Payment Contract, We will pay the estate of the payee:

1. Under Options 1 and 3: The value of the remaining payments for the specified period as of the date We receive Written notification of death, discounted at the rate of interest used in determining the amount of the monthly payment.

2. Under Options 2 and 4: The balance of any proceeds remaining unpaid with accrued interest, if any.

Withdrawal of Proceeds Under Options 1 and 2. If provided in the Payment Contract, a payee will have the right to withdraw the entire unpaid balance under Options 1 and 2. Under Option 1, the amount will be the value of the remaining payments for the specified period discounted at the rate of interest used in determining monthly income. Under Option 2, the amount will be the entire unpaid balance.

Withdrawal of Proceeds Under Option 4. A payee will have the right to withdraw proceeds left under Option 4 subject to the following rules:

1. The amount to be withdrawn must be $500 or more; and

2. A partial withdrawal must leave a balance on deposit of $1,000 or more.

Withdrawals May Be Deferred. We may defer payment of any withdrawal for up to 6 months from the date We receive a withdrawal request.

Assignment. Payment Contracts may not be assigned.

Change in Payment. The right to make any change in Your manner of payment is available only if the Payment Contract provides for a change in payment.

Claims of Creditors. To the extent permitted by law, proceeds will not be subject to any claims of a payee or a Beneficiary's creditors.

GENERAL PROVISIONS

Changing the Terms of Your Policy. Any change in Your policy must be approved in writing by the President, a Vice President, an Administrative Officer or the Secretary of the Company. No agent has the authority to make any changes or waive any of the terms of Your policy.

Assigning Your Policy. During the lifetime of the Insured, unless restricted by federal tax law, You may assign this policy as security for an obligation. We will not be bound by an assignment unless it is received In Writing at Our Administrative Center. Your rights and those of any other person referred to in this policy will be subject to the assignment. The assignment, unless You specify otherwise, will take effect on the date that You signed the notice of assignment, subject to any payments made or actions taken by Us before We receive such assignment. We will not be responsible for the validity or tax consequences of any assignment.

Incontestability. We rely on the statements made in the application for this policy and any amendments of applications, supplemental applications, and applications for any reinstatements. These statements, in the absence of fraud, are considered representations and not warranties. No statement may be used in defense of a claim under this policy unless it is in such applications attached to this policy.

We cannot contest this policy after it has been in force during the Insured's lifetime for two years from the Date of Issue. If this policy is reinstated, We cannot contest this policy during the Insured's lifetime after it has been in force for two years from the date of such reinstatement.

Exceptions:

We can contest a reinstatement for a two-year period following the date of such reinstatement solely on the basis of the information furnished in the application for such reinstatement.

If all or part of this policy is converted to a new policy before the two-year contestable period has expired, the remaining contestable period will apply to the amount of death benefit under the new policy attributable to the part of this policy that was converted.

The two-year contestable limitation does not apply to benefits provided by any disability or accidental death benefit rider, or to the nonpayment of premium.

Suicide Exclusion. If the Insured takes his or her own life, while sane or insane, within two years from the Date of Issue or the date We approve Your reinstatement application, We will limit the Death Benefit to the premiums paid. If all or part of this policy is converted to a new policy, the remaining part of the original two year suicide exclusion on this policy will apply to the new policy.

Age or Sex Incorrectly Stated (Age Incorrectly Stated if Issued on a Unisex Basis). If the: (1) age or sex of the Insured (if this policy was issued on a Sex Distinct basis); or (2) age of the Insured (if this policy was issued on a Unisex basis) has been misstated to Us, We will adjust the Death Benefit on the date of death to that which the most recent premium paid would have purchased.

Conformity With Interstate Insurance Product Regulation Commission Standards. This policy was approved under the authority of the Interstate Insurance Product Regulation Commission and issued under the Commission Standards. Any provision of this policy that is in conflict with Interstate Insurance Product Regulation Commission Standards for this product type is hereby amended to conform to the Interstate Insurance Product Regulation Commission Standards for this product type as of the provision's effective date.

No Dividends. This policy will not pay dividends. It will not participate in any of Our surplus or earnings.

When This Policy Terminates. This policy will terminate on the earliest of:

1. Any date on which You request that this policy be terminated; or
2. The date on which the Insured dies; or
3. The date on which the Grace Period ends; or
4. The Termination Date of the Last Renewal Term Period shown on the Policy Schedule; or
5. The date on which the current term period terminates if this policy is not renewed for a subsequent term period; or
6. The date on which this policy is wholly replaced by a new policy issued by Us.

Reinstatement. "Reinstating" means placing Your policy in force after it has terminated at the end of the Grace Period. We will reinstate this policy if We receive:

1. Your Written request within five years after the end of the Grace Period and before the Termination Date of the Last Renewal Term Period; and

GENERAL PROVISIONS (Cont'd)

2. Evidence of insurability satisfactory to Us; and

3. Payment of the premium for the Grace Period with interest at the rate of 6% per year compounded annually plus the premium due for the current policy month.

If a person other than the Insured is covered by an attached rider, coverage will be reinstated according to that rider.

Rights Reserved By Us. Upon notice to You, this policy may be modified by Us, if such modification is necessary as required by the Internal Revenue Code or by any other applicable law, regulation or interpretation in order to continue treatment of this policy as life insurance.

When required by law, We will obtain Your approval of changes and We will obtain approval from any appropriate regulatory authority.

Correspondence. Any request, notice or proof shall be filed with Our Administrative Center.

Policy Settlement. In any settlement, We may require the return of this policy.

Interest Payable on Death Benefit. Interest is paid on the Death Benefit as follows:

1. Interest will accrue and be payable from the date of death.

2. Interest will accrue at the rate or rates applicable to this policy for funds left on deposit. In determining the effective annual rate or rates, We will use the rate in effect on the date of death.

3. Interest will accrue at the effective annual rate determined in item 2 above, plus additional interest at a rate of 10% annually beginning with the date that is 31 calendar days from the latest of items a, b and c below to the date the claim is paid, where it is:

   a. The date that Due Proof of Death is received by the Company;

   b. The date the Company receives sufficient information to determine its liability, the extent of the liability, and the appropriate payee legally entitled to the proceeds; and

   c. The date that legal impediments to payment of proceeds that depend on the action of parties other than the Company are resolved and sufficient evidence of the same is provided to the Company. Legal impediments to payment include, but are not limited to: (1) the establishment of guardianships and conservatorships; (2) the appointment and qualification of trustees, executors and administrators; and (3) the submission of information required to satisfy any state and federal reporting requirements.

RE-ENTRY OPTION

If a renewable level term policy is made available by Us at the Attained Age of the Insured at re-entry, then this option will be available.

This option is available only on the policy Anniversary shown on the Policy Schedule. We agree to exchange this policy for a new renewable level term life insurance policy on the life of the Insured. We will require evidence of insurability satisfactory to Us. Such evidence will be paid for by Us and will be based on Our then current underwriting rules.

RE-ENTRY OPTION (Cont'd)

Exchange will be subject to the following conditions:

1. A properly completed application must be submitted to Us within 60 days prior to the date of exchange, along with payment of the initial premium for the new policy.

2. This policy must be in force and all premiums due prior to the date of exchange must be paid. Insurance under this policy will cease when this policy is exchanged.

3. The Age at issue for the new policy will be the Attained Age of the Insured under this policy on the date of exchange.

4. The new policy will be on the same plan of insurance as this policy or, if such plan is not available, on a plan of insurance made available by Us that We determine to be reasonably similar to this plan. Alternatively, the Owner may elect any other plan, if available, with a shorter renewable term period then being issued on this policy form. The Date of Issue of the new policy will be the date of exchange. The Face Amount of the new policy may not exceed the Initial Face Amount of this policy and must meet or exceed the minimum then in effect for the plan elected.

5. Any benefits or riders in force under this policy on the date of exchange will be included in the new policy and will be subject to Our then current rules and rates.

6. The new policy, excluding any accidental death rider, will not have a suicide exclusion provision.

7. The contestable period of the new policy will start on the date of exchange, with respect to the evidence of insurability used to qualify the Insured for the new policy. However, We may contest only the difference between the face amount of the new policy and the face amount that the premium for the new policy, excluding the premium for any riders, would have purchased on the date of exchange had this policy remained in force.

8. The premium rates for the new policy will be Our then current rates applicable to a new purchase of the plan elected.

CONVERSION AND RENEWAL PROVISIONS

Conversion Option. We agree to convert all or part of this policy to a new policy on the life of the Insured. We will not require evidence of insurability.

You must submit a written application and pay the first premium for the new policy:

1. While the Insured is alive;

2. While this policy is in force; and

3. Before the Conversion Expiry Date for this policy shown on the Policy Schedule.

You must submit this policy for cancellation.

However, if You convert less than the Face Amount of this policy in the current policy year, You may continue the unconverted Face Amount under this policy if it is at least as much as the Minimum Face Amount shown on the Policy Schedule. The premiums for this policy thereafter will be the same as the premiums that would be payable if it had been originally issued for the unconverted Face Amount.

New Policy. You may select the plan and amount of insurance for the new policy. The plan must be:

1. A permanent individual life insurance plan;

2. A plan that is then regularly issued at the Insured's Attained Age, Premium Class of the new policy and for the amount of insurance selected; and

3. Issued by Us or by one of Our affiliated companies and made available to Our policyowners for conversion purposes.

You may elect from all policies made available by Us for conversion purposes, whether issued by Us or by one of Our affiliated companies, the policy to which You wish to convert.

The amount of insurance cannot be more than the Face Amount of this policy in the current policy year or less than the minimum face amount for the plan selected.

The premium for the new policy will be determined by Our published rates, or by the published rates of Our affiliated company if You convert to such a company's available plan, for the Insured's Attained Age and the Premium Class of the new policy.

The Premium Class of the new policy will be the same as the Premium Class of this policy. If the plan and amount selected are not available in that Premium Class at the Insured's Attained Age, the Premium Class will be the Premium Class which We, or Our affiliated company if applicable, determine to be the most nearly comparable.

The suicide and contestable periods of the new policy will be measured from the Date of Issue of this policy.

The new policy will not include any riders unless agreed to by Us or Our affiliated company, if applicable.

Renewal Option. If this policy is in force on the Termination Date for the Level Premium Period, You may renew it for a Renewal Term Period of one year. If this policy is in force on the termination date for each subsequent Renewal Term Period, You may renew it for similar successive Renewal Term Periods of one year until the Termination Date of the Last Renewal Term Period shown on the Policy Schedule. Any renewal of this policy will be effective as of the renewal date if the first renewal premium is paid on such date or within a Grace Period of 31 days thereafter.

The amount of the premium payable during each Renewal Term Period is shown in the Table of Premiums and Face Amounts.

We will automatically renew this policy on any renewal date if premiums for this policy are being waived for total disability. We will continue to waive premiums during the Renewal Term Period, subject to the terms of a waiver of premium rider.

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AMERICAN GENERAL LIFE INSURANCE COMPANY

TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER

This Rider is issued as part of the Policy to which it is attached.

IF YOU RECEIVE AN ACCELERATED BENEFIT YOUR DEATH BENEFIT WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFIT PAYMENTS MAY BE TAXABLE. YOU SHOULD CONTACT YOUR PERSONAL TAX ADVISOR FOR SPECIFIC ADVICE BEFORE EXERCISING THIS BENEFIT. PAYMENTS RECEIVED UNDER THIS TERMINAL ILLNESS ACCELERATED DEATH BENEFIT RIDER ARE NOT PART OF A HEALTH, LONG TERM CARE, OR NURSING HOME INSURANCE POLICY AND MAY NOT BE SUFFICIENT TO COVER MEDICAL, NURSING HOME OR OTHER BILLS.

ALL PROVISIONS OF THE POLICY THAT DO NOT CONFLICT WITH THE RIDER APPLY TO THIS RIDER. WHERE THERE IS ANY CONFLICT BETWEEN THE RIDER PROVISIONS AND THE POLICY PROVISIONS, THE RIDER PROVISIONS PREVAIL.

Accelerated Benefit (AB). While the Policy to which this Rider is attached is in force, You may request an AB if the Insured has a Terminal Illness as defined below. Only the Insured under the base Policy is covered by this Rider. An AB is an amount paid to You, or Your estate, prior to the death of the Insured. The AB payment may be used for any purpose. No AB will be payable on the basis of any other rider attached to the Policy. Only one AB is payable under this Rider or any other accelerated benefit rider attached to the Policy.

Terminal Illness. A Terminal Illness is an illness that is expected to result in the death of the Insured in 24 months or less from the date of the request for the AB. Before any AB is paid under this Rider, We will require You to provide proof, satisfactory to Us, of the Insured's Terminal Illness.

Physician. The term “Physician” (as defined in section 1861(r)(1) of the Social Security Act) means a doctor of medicine or osteopathy legally authorized to practice medicine or surgery by the state in which he or she performs such function or action. Physician does not mean:

1. You; or
2. The Insured; or
3. A person who lives with You or the Insured; or
4. A person who is an Immediate Family Member.

Immediate Family Member. The term "Immediate Family Member" means Your or the Insured's:

1. Spouse; or
2. Parents; or
3. Brother and sisters; or
4. Children by blood, adoption or marriage.

Terminal Illness Benefit Amount. The maximum AB amount that You may request is the lesser of A or B where:

A equals the Specified Amount multiplied by the Terminal Illness Percentage shown on the Policy Schedule; and

B equals the Maximum Benefit Amount shown on the Policy Schedule.

The AB amount payable is equal to:

1. The amount of the AB You requested; less
2. The sum of any outstanding loans and accrued loan interest; less
3. An administrative fee, not to exceed the Maximum Administrative Fee shown on the Policy Schedule.

This amount will be paid to You in a lump sum.

Interest. After payment of the Terminal Illness Benefit, interest will accrue daily on paid out benefits at an annual effective interest rate. Interest on the lien described in the Impact on Policy Values provision will be payable in advance on each policy anniversary. For the portion of the lien up to and including the Cash Value of the Policy on the date the AB is paid, the interest rate, set by Us on the date the AB is paid and thereafter adjusted, will be no more than the policy loan interest rate stated in the Policy. We will determine at the end of each calendar year the interest rate for the amount of the lien in excess of such Cash Value on the date the AB is paid. Such rate will be effective on the policy anniversary occurring in the following calendar year.

The maximum interest rate for the portion of the lien in excess of the Cash Value of the Policy on the date the AB is paid will not exceed the greatest of:

1. The current yield on 90-day U.S. Treasury Bills; or
2. The Moody's Corporate Bond Yield Average – Monthly Average Corporates (hereafter referred to as "Moody's Bond Yield Average") for the month of October preceding the calendar year for which the loan interest rate is determined; or
3. The interest rate used to calculate Cash Values under the Policy during the period for which the interest rate is being determined, plus 1%.

If the Moody's Bond Yield Average is discontinued or if its composition or calculation is changed, or if We are unable to secure a license to continue using it, We may substitute a comparable average or index, subject to approval by the Interstate Insurance Product Regulation Commission (IIPRC). Before an alternative rate is used, We will provide notification in writing to You at Your last known address and to the assignee(s) of record, if any, at the last known address of the assignee(s). Any change in the interest rate will be subject to the following:

1. No change in the interest rate will be made unless the difference in rates is one-half (½) percentage point or more.
2. If the difference is one-half (½) percentage point or more and the legal maximum interest rate is lower, We will lower the interest rate to be equal to or less than the legal maximum interest rate.

3. If the difference is one-half (½) percentage point or more and the legal maximum interest rate is higher, We may increase the interest rate by at least one-half (½) percentage point but not more than the legal maximum interest rate.

We will notify the Owner of the initial interest rate. If there is a benefit that has been paid on the Policy, We will give the Owner advance notice of any increase in the interest rate.

Impact on Policy Values. The AB plus accrued interest on the AB will be treated as a lien against the Policy's Death Benefit Amount. There will be no reduction or lien against any term or accidental death benefit riders attached to the Policy. Once a lien has been established it cannot be repaid. The DEATH BENEFIT AMOUNT WILL BE REDUCED by the amount of the AB plus accrued interest on the AB and the sum of any other outstanding loans plus accrued loan interest made after the AB is paid.

The Cash Value available for full and partial surrenders or additional loans will be the amount by which (1) exceeds (2) where:

(1) Is the Cash Value less the sum of outstanding loans; and

(2) Is the sum of the AB plus accrued interest on the AB.

The POLICY AND THIS RIDER WILL TERMINATE and NO DEATH BENEFIT WILL BE PAID if the AB plus accrued interest on the AB and the sum of any other outstanding loans plus accrued loan interest exceed the Death Benefit Amount of the Policy.

Effects of AB Payments. You should consider that receiving or having the contractual right to receive an AB may affect Your eligibility for Medicaid, supplemental security income (SSI), or other government benefits or entitlements. **You are advised to contact the Medicaid Unit of Your local Department of Public Welfare and Social Security Administration for more information. If You initiate an AB claim during the contestability period of the Policy to which this Rider is attached, a rescission of the entire Policy may result if any material misrepresentation of any information was made on the insurance application for the Policy.**

Prior to or concurrent with the election to accelerate the policy death benefit, You and any irrevocable beneficiary will be given a statement demonstrating the effect of the acceleration of the payment of the death benefit on the cash value, death benefit, premium, cost of insurance charges, and policy loans (including Policy liens) of the particular policy to which this Rider is attached.

Not Contestable after Two Years. We will not contest payment of an AB after the Policy to which this Rider is attached has been in force during the Insured's lifetime for 2 years from the Date of Issue of the Policy. If the Policy to which this Rider is attached is reinstated, this Rider will not be contested after it has been in force during the Insured's lifetime for 2 years following the date We approve Your reinstatement application.

Suicide Exclusion. If You exercise Your right to an AB payment and the Insured subsequently commits suicide, while sane or insane, within 2 years from the Date of Issue or the date We approve Your reinstatement application, the amount payable will be that described in the Suicide Exclusion provision of the Policy less any AB and accrued interest, and may be zero.

Reinstatement. If the Policy and this Rider terminate at the same time, and the Policy is reinstated, this Rider will also be reinstated, subject to evidence of insurability provided to Us.

Conditions. The AB will be subject to the following conditions:

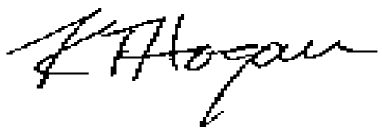
1. Written consent by any irrevocable Beneficiary or assignee must be received by the Company before the AB payment is made.
2. We reserve the right to obtain a second medical opinion from a Physician and/or additional medical records of the Insured at Our expense. In the event of conflicting opinions, eligibility for benefits shall be determined by a third medical opinion from a Physician who is mutually acceptable to both the Insured and the Company.
3. This benefit is not intended to allow third parties to cause You to involuntarily access the policy proceeds payable to the named Beneficiary. Therefore, the AB will not be available if You are required to request it for any third party, including any creditor, governmental agency, trustee in bankruptcy or any other person or as the result of a court order.
4. The request must be submitted to the Company. Upon receipt of the request, We will mail a claim form to You within 15 working days. If the claim form is not sent within this 15-day period, and You provide proof that the Insured has a Terminal Illness in a format other than Our claim form, You will be deemed to have complied with the claim requirement.
5. Proof of a Terminal Illness must include, but is not limited to, a completed claim form and a statement signed by a Physician certifying that the Insured has been diagnosed with a Terminal Illness that will result in a life expectancy of 24 months or less. When We receive proof acceptable to Us, We will pay the AB immediately.
6. If the Insured dies after a request for an AB has been submitted and before You receive the AB payment, such request will be voided and the policy's Death Benefit will be payable, subject to all other Policy provisions.

Termination. This Rider will terminate upon the earliest of:

1. The date the Policy terminates for any reason; or
2. The date the AB plus accrued interest on the AB and the sum of any other outstanding loans plus accrued loan interest exceed the Death Benefit Amount of the Policy. In this case coverage under both the Policy and this Rider will terminate; or
3. Upon Your Written request that this Rider be terminated.

Termination of this Rider shall not preclude the payment of benefits if the covered loss is sustained and all of the requirements in the Conditions provision are met while this Rider is in force.

The effective date of this Rider is the Date of Issue of the Policy.



President

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AIG

Short Health Statement
Policy # (if known): 4200125254

☑ American General Life Insurance Company, 2727-A Allen Parkway, Houston, Texas 77019
☐ The United States Life Insurance Company in the City of New York, 175 Water Street, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #
JOHN		STEIN	12/23/1964	254-37-6151

I represent, on behalf of myself and any person who may have been proposed for insurance, that to the best of my knowledge and belief:

1. There have been no changes to my occupation nor have I become unemployed since the date of the application; or
2. Neither I nor any other proposed insured has, since the date of the application:
   a. Consulted a licensed health care provider or received medical or surgical advice or treatment; or
   b. Acquired any knowledge or belief that any representation in the application, including information provided or an answer to a question, is now inaccurate, incomplete, or untrue.

Exceptions

In the event any exception is noted herein, the policy referenced above must not be delivered and will not be in force. The Company reserves the right to receive, review, and act upon this Short Health Statement and any other requirements.

Agent Instructions: If exceptions or changes are noted above, do not deliver the policy and consult with the Home Office.

Agreement: All of the above answers are full, complete and true to the best of my knowledge and belief, and are a continuation of, and form a part of, the application for insurance.

Owner Signature

X

Owner signed on (date) _____

Owner signed at (city, state) _____

Proposed Insured (PI) Signature

X

PI signed on (date) _____
(If under age 16, signature of parent or guardian)

ICC15-108098

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AIG

Individual Life Insurance Application
Single Insured – Part A

☒ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

The insurance company checked above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

1. Primary Proposed Insured

First Name John MI ___ Last Name Stein Gender ☒ M ○ F
SSN 254-37-6151 Birthplace* *(US State, or country)* NY USA DOB 12/23/1964 Current Age 55
Tobacco Use Has the Primary Proposed Insured ever used any form of tobacco or nicotine products? ☒ yes ○ no
Type and *Quantity* Used If yes, see details on overflow page If yes, a current user? ☐ yes ☐ no If no, date of last use ___
Driver's License ☒ yes ○ no License State CO Number Unknown
If over age of 16 and no license, please explain. ___
Address 136 N NEVADA AVE City MONTROSE State CO ZIP 81401
Primary Phone (303) 590-5271 Alternate Phone ___ Email steinbusiness@gmail.com
Employer Concept 32 Design Occupation VP Business Development Date of Employment (mm/dd/yy) 11/13/90
Job Duties VP Business Development Average No. of hours worked per week 40
Actively at work? ☒ yes ☐ no Able to perform all job duties? ☒ yes ☐ no If either is no, explain ___
Personal Earned Income (Annual): $ 100,000 Household Income (Annual): $ 140,000 Net Worth $ 0
Personal Earned Income means monies received for work performed.
If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $ ___ Spouse $ ___ Father $ ___ Mother $ ___ Siblings $ ___ Premium Payor $ ___
Citizenship U.S. Citizen or Permanent Resident Card holder ☒ yes ○ no If no, answer the following:
Country of Citizenship USA Date of Entry ___ Visa Type ___ (Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☐ yes ☐ no Plan to remain in the U.S.? ☐ yes ☐ no Visa #:

2. Owner - Complete if Primary Proposed Insured is not the Owner - *(If Owner is a business, charitable entity or trust, answer question 5 below.)*

First Name ___ MI ___ Last Name ___ Gender ○ M ○ F
SSN ___ DOB ___ Relationship to Proposed Insured ___
Driver's License ☐ yes ☐ no License State ___ Number ___
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship ___ Date of Entry ___
Visa Type ___ Exp. Date ___
Address ___ City ___ State ___ ZIP ___
Primary Phone ___ Email ___
(If contingent Owner is required, use question 12.)

3. Reason for Insurance - *(If Business, complete Financial Questionnaire)* personal

4. Beneficiary - *(If Beneficiary is a business, charitable entity or trust, answer question 5 below.)*

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1	Jennifer Stein	10/17/1965			Spouse	100 %	☒ Primary ○ Contingent
	Address:		Email:				
2	John Stein Jr.	10/08/1996			Son	50%	○ Primary ☒ Contingent
	Address:		Email:				
3	Jordan Leigh Paul	03/08/1994			Daughter	50%	○ Primary ☒ Contingent
	Address:		Email: See overflow page for additional information if applicable.				

**for identification purposes only*

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5. Entity Information - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*

(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary. If also the Premium Payor, complete section 9E.)

Exact Name _____ Tax ID # _____

Address _____ City _____ State_____ ZIP _____

Current Trustee Name _____ Date of Trust _____

Corporate Officer Name_____ Title _____

Email Address of applicable Trustee or Corporate Signer_____

Relationship to Proposed Insured _____ Type of Entity (SCorp, CCorp , DBA, etc.) _____

6. Product - *Signed Illustration/Quotation is required for all UL & VUL products.*

Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)
Select-a-Term 20

Term Duration** 20 Premium Class Quoted Preferred Plus

Amount Applied For: Base Coverage $ 500,000 Supplemental Coverage** $ _____

Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation I Automatic Premium Loan**: ☐ yes ☐ no

7. Death Benefit Options - *(For UL & VUL only)* ☐ Level ☐ Increasing

8. Riders/Benefits - *Refer to Rider Reference Page for riders and benefits available per product.*

☐ Accidental Death Benefit $ _____
☐ Child Rider[1] $ _____
☐ No current children
☐ Chronic Illness Rider (AAS)[2]
☐ Lifestyle Income[3]
Withdrawal Benefit Basis % _____
☑ Terminal Illness
☐ Waiver of Monthly Deduction

☐ Waiver of Monthly Guarantee Premium
☐ Waiver of Premium
☐ Other #1 _____
Amount/Unit(s) _____
☐ Other #2 _____
Amount/Unit(s) _____
☐ Other #3 _____
Amount/Unit(s) _____

☐ Other #4 _____
Amount/Unit(s) _____

1 - Complete Child Rider Supplement
2 - Complete Chronic Illness Supplement
3 - Chronic Illness Rider (AAS) required with Lifestyle Income when AAS is approved. This requirement varies by product. Complete Chronic Illness Supplement, if applicable.

9. Premium Payment ☒ Modal $ _____ ☐ Single $_____ ☐ Additional/Lump Sum $ _____

A. Frequency of modal premium: ☐ Annual ☐ Semi-annual ☐ Quarterly ☒ Monthly *(Bank Draft only)*

B. Method: ○ Direct Billing ◉ Bank Draft (*Complete Bank Draft Authorization)* ☐ List Bill: Number_____
○ Credit Card - Initial Premium Only *(Complete Credit Card Authorization)* ☐ Other *(Please explain)* _____

C. Amount submitted with application $ _____

D. Special Dating *(not available for VUL products):* Save Age ..... ☐ yes ☒ no

E. Premium Payor *(Complete if Payor is other than Owner or if Owner is Trustee.)*

First Name _____ MI ___ Last Name _____ Gender ☐ M ☐ F

SSN or Tax ID # _____ Relationship to Primary Proposed Insured _____

Driver's License ☐ yes ☐ no License State _____ Number _____ DOB _____

U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship _____ Date of Entry_____

Visa Type _____ Exp. Date _____

Address _____ City _____ State_____ ZIP_____

If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

10. Existing Coverage and Replacements

"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If the transaction is a replacement, also complete the replacement-related form for the state where the application is signed.

A. Does the Primary Proposed Insured have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?..... ☐ **yes** ☒ **no**

***Complete only if applicable*

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B. If question 10A is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced?	1035 Exchange?
1						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		
2						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		
3						☐Y ☐N	☐Y ☐N
	Company Name: _____				Amount of Coverage $ _____		

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending

11. Background Information - *Provide details specified for all "Yes" answers or complete applicable questionnaires.*

A. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? *(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire)* ..... ○ yes ◉ no

B. In the past five years, has the Primary Proposed Insured flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? *(If yes, complete the Aviation Questionnaire)* .. ○ yes ◉ no

C. In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years? *(If yes, complete the Avocation Questionnaire)* .... ○ yes ◉ no

D. Has the Primary Proposed Insured ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* ..... ○ yes ◉ no

E. Has the Primary Proposed Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? (*If filed, list chapter filed, date, reason, and discharge date)* ..... ○ yes ◉ no
If yes, see overflow page

F. In the past five years, has the Primary Proposed Insured pled guilty or been convicted of any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* ... ○ yes ◉ no

G. Has the Primary Proposed Insured ever been convicted of, or is currently charged with, a felony or misdemeanor? (If yes, list date, county, state, charge, current status and if currently incarcerated or on parole or probation.) ..... ○ yes ◉ no

H. Is the Primary Proposed Insured an active duty service member of the U.S. Armed Forces? *(If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure)* ..... ○ yes ◉ no

I. Is there an intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application? ..... ○ yes ◉ no

J. Does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? ..... ○ yes ◉ no

K. Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, or any other form of payment) as an incentive to enter into this transaction? *(If yes, describe the incentive)* ..... ○ yes ◉ no

12. The space below may also be used to elaborate on answers to any questions on this application.

battery misdemeanor in 1987. It was a frat party fight and it was tossed out; he just paid a fine as a college student

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Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement ("LTLIA"), I understand and agree that, even if I paid a premium, no insurance will be in effect under this application or under any new policy or any rider(s) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answer to any question in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that, if all three conditions above are not met: (1) no insurance will be in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to accept risks or pass upon insurability, make or modify contracts, or waive any of the Company's rights or requirements.

I have received a copy of or have been read the Notices to the Proposed Insured(s).

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; the Medical Information Bureau (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health or insurability, or that of any minor child for whom application for insurance is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions; use of drugs or alcohol; drug prescriptions; or any other information concerning me, or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Owner Signature

X DocuSigned by: John Stein 2BDB7F1EA6484E1...

Owner Title _____
(If Corporate Officer or Trustee)

Owner signed at (city, state) MONTROSE, CO

Owner signed on (date) 11/13/2020

Primary Proposed Insured Signature (if other than Owner)

X

(If under age 16, signature of parent or guardian)

Agent(s) Signature(s)

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)* Jennifer Fitzgerald - PolicyGenius

Writing Agent # 5M35V

Writing Agent Signature X DocuSigned by: Jennifer Fitzgerald 33B1897F0C8F4D1...

Other Parent or Guardian Signature

X

(If under age 16 and coverage exceeds $150,000, signature of both parents required)

AIG

Life Insurance Application
Part B (Medical History)
Policy # (if known): _____

☒ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

(Complete separate Part B for each Proposed Insured.)

First Name	MI	Last Name	Date of Birth	Social Security #
JOHN		STEIN	12/23/1964	254-37-6151

Medical History

(Instructions: Please answer ALL medical history questions. Do not leave any questions blank.)

1. Physician Information

Name, address and phone number of the Proposed Insured's personal physician(s). *(If no personal physician, provide name, address and phone number of last doctor consulted or medical facility visited or to which admitted.)*

Name NONE Phone _____

Address _____ City, State _____ ZIP _____

Date of last office visit, reason, findings and treatment: _____

2. Pending Medical Appointments

Does the Proposed Insured have a medical appointment scheduled within the next three months? ..... ☐ yes ☒ no

(If yes, provide date, name, address and phone number of physician, and reason for visit.) _____

3. Build

A. Admitted Height and Weight 5 ft 09 in 190 lbs
(Examiners: Also record measured height and weight on Exam page 1.)

B. Birth Weight (if Proposed Insured is less than 1 year old) _____ lbs _____ oz

C. Has the Proposed Insured had any weight change in excess of 10 lbs in the **past year**?..... ☐ yes ☒ no
If yes, complete the following: Loss _____lbs Gain _____lbs Reason* _____

*If weight change was due to pregnancy, provide due/delivery date and pre-pregnancy weight:
Due/Delivery Date _____ Pre-Pregnancy Weight _____lbs

4. Family History

A. Complete the information in the grid below.

Age if Living	Age at Death	Cause of Death	History of heart disease treated or diagnosed by a member of the medical profession (Coronary Artery Disease or Heart Attack)?	History of cancer treated or diagnosed by a member of the medical profession?
Father 79			☒ no ☐ yes Age of Onset _____ Details _____	☒ no ☐ yes Age of Onset _____ Type _____
Mother 76			☒ no ☐ yes Age of Onset _____ Details _____	☒ no ☐ yes Age of Onset _____ Type _____
Siblings 53			☒ no ☐ yes Age of Onset _____ Details _____	☒ no ☐ yes Age of Onset _____ Type _____

(CONTINUED ON SUPPLEMENT)

B. Other than as stated in 4A, has any immediate family member of the Proposed Insured (parents, siblings or children), been diagnosed with heart disease prior to age 50, Amyotrophic Lateral Sclerosis (ALS), polycystic kidney disease, porphyria, cardiomyopathy, sickle cell anemia, Huntington's disease, aneurysm, or cancer? ☐ yes ☒ no

(Please provide details including type, age of onset, and relationship(s) to Proposed Insured.)

Details: _____

_____

C. Is there a family history (parents and siblings only) of mental illness, suicide, or substance abuse, any of which was diagnosed or treated by a member of the medical profession? ☐ yes ☒ no

(Please provide details including diagnosis and relationship(s) to Proposed Insured.)

Details: _____

5. Personal Health History

A. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) high cholesterol? ☐ yes ☒ no

Date of diagnosis _____ most recent level _____treatment _____

2) high blood pressure? ☐ yes ☒ no

Date of diagnosis _____ most recent reading _____treatment _____

3) diabetes? ☐ yes ☒ no

Date of diagnosis _____ most recent HgbA1c _____treatment _____

B. Has the Proposed Insured **ever** been diagnosed as having, been treated for, or consulted a member of the medical profession for:

1) coronary artery disease, heart attack, chest pain, shortness of breath, irregular heartbeat, heart murmur, or other disorder or disease of the heart? ☐ yes ☒ no

2) blood clot, clotting disorder, aneurysm, stroke, transient ischemic attack (TIA), peripheral vascular disease, or other disease, disorder or blockage of the arteries or veins? ☐ yes ☒ no

3) cancer, leukemia, lymphoma, tumors or growths, masses, cysts or other similar abnormalities? ☐ yes ☒ no

4) pituitary, thyroid, adrenal, or disease or disorder of any other glands? ☐ yes ☒ no

5) anemia, hemophilia, sickle cell anemia, or other disease or disorder of the blood, lymphatic system or immune system? ☐ yes ☒ no

6) colitis, Crohn's disease, hepatitis, colon polyps, or any disorder of the throat, esophagus, gall bladder, stomach, liver, pancreas or intestine? ☐ yes ☒ no

7) disorder of the kidneys, bladder, prostate or reproductive organs or protein or blood in the urine? ☐ yes ☒ no

8) asthma, chronic bronchitis, emphysema, chronic obstructive pulmonary disease (COPD), cystic fibrosis, sleep apnea or other breathing or lung disorder? ☐ yes ☒ no

9) seizures, cerebral palsy, Down syndrome, autism spectrum disorder, Parkinson's disease, multiple sclerosis, severe headaches, disorder or injury of the brain, spinal cord or nervous system? ☐ yes ☒ no

10) attention deficit hyperactivity disorder (ADHD), memory loss, dementia or Alzheimer's disease? ☐ yes ☒ no

11) anxiety, eating disorder, depression, suicide attempt, bipolar disease, post-traumatic stress disorder (PTSD), hallucinations, psychosis, schizophrenia, or other psychiatric conditions? ☐ yes ☒ no

12) arthritis, muscle disorders, Amyotrophic Lateral Sclerosis (ALS), fibromyalgia, muscular dystrophy, chronic pain, connective tissue disease, autoimmune disease or other bone or joint disorders? ☐ yes ☒ no

13) glaucoma, macular degeneration, optic neuritis or any disorder of the eyes, ears or skin? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis, date of last treatment; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details _____

_____

_____

_____

_____

C. **Other than previously stated,** has the Proposed Insured taken any medications, had treatment or therapy or been under medical observation within the **past 12 months**? ☐ yes ☒ no

(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications or recommended treatment.)

Details _____

D. Within the **past 5 years**, has the Proposed Insured used alcoholic beverages? ☒ yes ☐ no

If yes, Average number of drinks per week 1 Maximum number of drinks per day 0

Type (Beer, Wine, Liquor) WINE Date of last use 11/2020

E. Has the Proposed Insured **ever**:

1) used cocaine, heroin, methamphetamine, hallucinogens, stimulants or any other habit-forming drug except as prescribed by a medical professional? ☐ yes ☒ no

2) used marijuana (prescribed or otherwise) in any form? ☒ yes ☐ no

3) used a controlled substance or prescription drug in a manner other than prescribed by a physician? ☐ yes ☒ no

4) sought or received medical advice, counseling or treatment by a medical professional to discontinue or reduce the use of alcohol or drugs, including prescribed controlled substances? ☐ yes ☒ no

If answered "Yes" to E1 through E4, please provide details below. (CONTINUED ON SUPPLEMENT)

Type of drug(s) and/or alcohol MARIJUANA Date last used UNKNOWN

Frequency of use: ☐ Daily ☐ Weekly ☒ Monthly Amount typically used: 1 OR 2 TIMES AT BEST

Name(s) of doctor/facility _____ Phone _____

Address _____ City, State _____ ZIP _____

Treatment Dates NONE

Support group(s) NONE

Was treatment or support group attendance court ordered? ☐ yes ☐ no

Details of any drug or alcohol related arrests NONE

F. Has the Proposed Insured **ever** tested positive for the Human Immunodeficiency Virus (HIV) or been diagnosed or treated by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS)? ☐ yes ☒ no

(If yes, provide details such as: date of diagnosis; name, address, and phone number of doctor.)

Details _____

G. Other than previously stated, in the **past 5 years**, has the Proposed Insured:

1) been hospitalized, consulted a member of the medical profession or had any illness, injury or surgery? ☒ yes ☐ no

2) been advised by a member of the medical profession concerning any abnormal diagnostic test results, been advised to see a specialist, or been advised to have any diagnostic test, hospitalization, surgery, or treatment that was NOT completed (except for those tests related to the Human Immunodeficiency Virus), or does the proposed insured have any test results pending? ☐ yes ☒ no

3) undergone any self-administered laboratory test prescribed by a member of the medical profession other than those for pregnancy or Human Immunodeficiency Virus (HIV)? ☐ yes ☒ no

4) made a claim for or received benefits, compensation, payment or pension for any injury, sickness, disability, or impaired condition? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details DETAILS FOR 5G1: BROKE RIGHT FOOT, DIAGNOSIS DATE: 2016, TREATMENT DATE: 2016, DOCTOI UNKNOWN, TESTS PERFORMED: XRAYS, TEST RESULTS: BROKEN FOOT, MEDICATIONS: NO MEDICATIONS PRESCRIBED, HOSPITALIZATION REQUIRED: NO, ER VISIT REQUIRED: DATE: 2016, FACILITY: VANDERBUILD UNIVERSITY, TN, USA, TREATMENT RECEIVED: CAST, TREATMENT: CAST.

H. Has the Proposed Insured had any emergency room, emergency clinic, walk-in clinic, or free clinic visits during the **past 5 years**? ☐ yes ☒ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details

I. Has the Proposed Insured **ever** been advised to or chosen to enter a nursing home, hospice, or assisted living facility? ☐ yes ☒ no

(If yes, provide details such as: reason for visit; date; name, address, and phone number of facility; resolution of condition; or any other pertinent details.)

Details

J. Within the **last 2 years** has the Proposed Insured:

1) been diagnosed or treated by a member of the medical profession for fainting, stumbling or falling while walking, problems with balance, deterioration in vision or hearing, or shortness of breath? ☐ yes ☒ no

2) received home health care services, physical therapy or rehabilitation therapy? ☐ yes ☒ no

3) required the use of a cane, walker, wheelchair, other assistive device, or resided in an assisted living facility? ☐ yes ☒ no

4) required assistance or supervision with or had any limitations in performing any of the following daily activities: bathing, bladder and/or bowel control, eating, dressing, toileting or transferring (moving into or out of a bed, chair or wheelchair)? ☐ yes ☒ no

5) required assistance with routine activities such as: using the phone, taking medications, paying bills, shopping, driving a car, traveling outside of the home or preparing meals? ☐ yes ☒ no

(For any yes answers, provide details such as: date of diagnosis; name, address, and phone number of doctor; tests performed; test results; medications, hospitalization, ER visit, recommended treatment or any other pertinent details.)

Details

K. Within the **last 5 years** has the Proposed Insured been treated for or been diagnosed by a member of the medical profession for any other medical, physical, or psychological condition **NOT** disclosed above? ☒ yes ☐ no

(If yes, list condition and details such as: date of first occurrence; symptoms; and how treated.)

Details DETAILS: VERTIGO, OCCURRENCE DATE: 2015, SYMPTOMS: DIZZYNESS, TREATMENT: NOTHING PRESCRIBED, DID NOTHING.

Agreement and Signatures

I, the Proposed Insured signing below, acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Fraud

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

SIGNATURE OF PROPOSED INSURED

Signed at *(city, state)* MONTROSE, CO On *(date)* 12/4/2020

X eSigned by JOHN STEN on 12/4/2020 at 5:34 PM CST

(If under age 16, signature of parent or guardian)

SIGNATURE(S) OF INTERVIEWER(S) – TO BE SIGNED BY ALL INTERVIEWERS, AS APPLICABLE

I certify that the information supplied by the Proposed Insured has been truthfully and accurately recorded on the Part B application.

If Agent recorded information

Writing Agent Name *(Please print)* | Writing Agent # | Date

X

Writing Agent Signature

If Tele-interviewer recorded information

Name *(Please print)* | Company | Date

If Paramedical Examiner/Medical Doctor recorded information

Examiner Address 7384 SOUTH ALTON WAY, CENTENNIAL, CO 80112

Examiner Phone # 303 706-9336

Examiner Name CRYSTAL HELLEGAARD

Paramed: Use company stamp below.

EXAMONE
400
7384 SOUTH ALTON WAY, CENTENNIAL, CO 80112
303-706-9336

X eSigned by CRYSTAL HELLEGAARD on 12/4/2020 at 5:35 PM CST

Examiner Signature

Date 12/4/2020

AIG

Addendum to Application

Policy # (if known): _____

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)*: See Section(s) Below

Primary Proposed Insured

First Name JOHN MI ____ Last Name STEIN SSN 254-37-6151

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

4. SIBLING INFORMATION	SIBLING #2: IS THE SIBLING ALIVE?: YES; AGE: 51; HISTORY OF HEART DISEASE?: NO; HISTORY OF CANCER?: NO
5.E.	2. MARIJUANA, DETAILS: SMOKED MARIJUANA.

Primary Proposed Insured (PPI) Signature

eSigned by JOHN STEIN on 12/4/2020 at 5:34 PM CST
X

PPI signed on (date) 12/4/2020

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) _____

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) _____

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AIG

Addendum to Application

Policy # (if known): _____

☑ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 175 Water St, New York, NY 10038
A member of American International Group, Inc. (AIG)

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This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)*: _____

Primary Proposed Insured

First Name John MI ____ Last Name Stein SSN 254-37-6151

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

TOBACCO ---------- History of tobacco use: true CIGARS Date of last use: 11/01/2020 Number per month: 3

FINANCIAL HISTORY ----------

Primary Proposed Insured (PPI) Signature

X DocuSigned by: John Stein BBDB7F1EA6484E1...

PPI signed on (date) 11/13/2020

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) _____

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) _____

AMERICAN GENERAL LIFE
Insurance Company
A Stock Company

This is an INDETERMINATE PREMIUM TERM LIFE INSURANCE POLICY WITH A CHANGE IN THE FACE AMOUNT AFTER THE LEVEL PREMIUM PERIOD. A Death Benefit is payable upon the Insured's death while this policy is in force prior to the Termination Date of the Last Renewal Term Period. Premium payments are payable for the term period shown on the Policy Schedule. This policy is ANNUALLY RENEWABLE, CONVERTIBLE and contains RE-ENTRY OPTION. NONPARTICIPATING - THIS POLICY WILL NOT PAY DIVIDENDS.

For Information, Service or to make a Complaint

Contact Your Servicing Agent, or Our Policyowner Service Department

P.O. Box 9000
Amarillo, Texas 79105-9000
1-844-452-3832

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ICC19-19311

December 14, 2020

Statement Of Policy Cost And Benefit Information
20 Year Renewable Level Benefit Premium Period
Change in Face Amount After Level Premium Period
Term Life Insurance

American General Life Insurance Company
2727-A Allen Parkway
Houston, Texas 77019

JENNIFER L FITZGERALD
50 W 23RD ST FL 9
NEW YORK, NY 10010

Policy Number: 4200125254 Insured: JOHN STEIN Age 56/Male

Policy Year	Maximum Annual Life Insurance Premium (Annual Life Insurance Premium Shall Not Exceed Premiums Shown Below)	Guaranteed Face Amount
1	$1,564.50	$500,000.00
2	$1,564.50	$500,000.00
3	$1,564.50	$500,000.00
4	$1,564.50	$500,000.00
5	$1,564.50	$500,000.00
6	$1,564.50	$500,000.00
7	$1,564.50	$500,000.00
8	$1,564.50	$500,000.00
9	$1,564.50	$500,000.00
10	$1,564.50	$500,000.00
11	$1,564.50	$500,000.00
12	$1,564.50	$500,000.00
13	$1,564.50	$500,000.00
14	$1,564.50	$500,000.00
15	$1,564.50	$500,000.00
16	$1,564.50	$500,000.00
17	$1,564.50	$500,000.00
18	$1,564.50	$500,000.00
19	$1,564.50	$500,000.00
20	$1,564.50	$500,000.00
At Age 60	$1,564.50	$500,000.00
At Age 62	$1,564.50	$500,000.00
At Age 65	$1,564.50	$500,000.00
At Age 94	$22,737.00	$25,000.00

Cost Indexes	Life Insurance Net Payment Cost Index		Life Insurance Surrender Cost Index	
	10 Year	20 Year	10 Year	20 Year
Maximum Rates	3.13	3.13	3.13	3.13

The columns of this representation do not reflect the fact that, because of interest, a dollar in the future has less value than a dollar today.

Important Notice - During the ten day period from the date of delivery of this policy, it may be surrendered to the company for cancellation and a full refund of any money paid.

American General Life Insurance Company
2727-A Allen Parkway
Houston, Texas 77019

For Additional Information
About This Policy Contact:
JENNIFER L FITZGERALD
50 W 23RD ST FL 9
NEW YORK, NY 10010

Prepared For: JOHN STEIN

Terminal Illness Accelerated Benefit Rider

Provides for a one-time payment in advance of the death benefit under the base contract if the Insured is terminally ill with 24 months or less to live. The amount advanced will be carried as a lien against future contract benefits. There is no charge for the rider. However, there is a one-time charge of up to $500.00 if you choose to activate the rider.

Additional Important Information Regarding Your Policy

Policies issued by American General Life Insurance Company (AGL) except in New York, where issued by The United States Life Insurance Company in the City of New York (US Life). Issuing companies AGL and US Life are responsible for financial obligations of insurance products and are members of American International Group, Inc. (AIG).

Bank Draft Authorization

c **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, Texas 77019
c **The United States Life Insurance Company in the City of New York,** 175 Water Street, New York, NY 10038

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Policy Number, if available	Name of Insured/Applicant

Policy Number, if available	Name of Insured/Applicant

PAYMENT OPTIONS: Please select ONLY one payment option:

c Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $ _____ c At Issue c At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $ _____

c Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

c Check submitted with application in the amount of $ _____.

c Check submitted on delivery.

DRAFT DETAILS: Please provide the requested details.

Preferred Withdrawal Date (1st-28th) _____ **Please debit my account for all outstanding premiums due.**
If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.
Frequency: c Monthly c Quarterly c Semi-annual c Annual

Financial Institution Name _____

Financial Institution Address _____ City, State _____ ZIP _____

Type of Account: c Checking c Savings

Routing Number _____ (For checking account draft use routing # listed on check)

Account Number _____ (Do NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) _____ Last Name _____

Email Address 1 _____

Date of Birth 1 (MM-DD-YYYY) _____ SSN1 / TIN 1 _____

Name 2 First Name (Please Print) _____ Last Name _____

Email Address 2 _____

Date of Birth 2 (MM-DD-YYYY) _____ SSN2 / TIN 2 _____

Bank Account Owner's Address: (For business accounts, list Business Address)

Street _____ City _____ State _____ ZIP _____

AGREEMENT:

I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Signature of Bank Account Owner

X

Date _____

Signature of Bank Account Owner, if joint account

X

Date _____

Please attach voided check for checking account draft or deposit slip for savings account draft.

FACTS

WHAT DO AMERICAN GENERAL LIFE INSURANCE COMPANY (AGL) AND THE UNITED STATES LIFE INSURANCE COMPANY IN THE CITY OF NEW YORK (US Life) DO WITH YOUR PERSONAL INFORMATION?

Why?

Financial companies choose how they share your personal information. Federal law gives consumers the right to limit some but not all sharing. Federal law also requires us to tell you how we collect, share, and protect your personal information. Please read this notice carefully to understand what we do.

What?

The types of personal information we collect and share depend on the product or service you have with us. This information can include:

- Social Security number and Medical Information
- Income and Credit History
- Payment History and Employment Information

When you are *no longer* our customer, we continue to share your information as described in this notice.

How?

All financial companies need to share customers' personal information to run their everyday business. In the section below, we list the reasons financial companies can share their customers' personal information; the reasons AGL & US Life choose to share; and whether you can limit this sharing.

Reasons we can share your personal information	Do AGL & US Life share?	Can you limit this sharing?
For our everyday business purposes — such as to process your transactions, maintain your account(s), respond to court orders and legal investigations, conduct research including data analytics, or report to credit bureaus	Yes	No
For our marketing purposes — to offer our products and services to you	Yes	No
For joint marketing with other financial companies	Yes	No
For our affiliates' everyday business purposes — information about your transactions and experiences	Yes	No
For our affiliates' everyday business purposes — information about your creditworthiness	No	We don't share
For nonaffiliates to market to you	No	We don't share

Questions?

For AGL / US Life Insurance Customers: call 844-452-3832, go to www.aig.com/lifeinsurance or write to us at P.O. Box 818005, Cleveland, OH 44181.

For AGL / US Life Accident & Health Customers: call 800-811-2696, go to www.aig.com/lifeinsurance or write us at Customer Service, P.O. Box 818005, Cleveland, OH 44181.

For AGL / US Life Individual Annuities Customers: call 800-242-4079, go to https://www.aig.com/individual/investments/annuities or write to us at P.O. Box 2708, Amarillo, TX 79105-2708.

For AGL / US Life Group Annuities Customers: call 877-299-1724, email us at immediateannuity@aig.com or write to us at Group Annuity Administration, P.O. Box 1277, Wilmington, DE 19899-1277.

For AGL / US Life Group Benefit Business Customers: call 800-346-7692, email us at www.aig.com/lifeinsurance or write to us at 3600 Route 66, 4th Floor, Neptune, NJ 07753.[1]

Who we are

Who is providing this notice?	American General Life Insurance Company and The United States Life Insurance Company in the City of New York.

What we do

How do AGL & US Life protect my personal information?	To protect your personal information from unauthorized access and use, we use security measures that comply with federal law. These measures include computer safeguards and secured files and buildings. We restrict access to employees, representatives, agents, or selected third parties who have been trained to handle nonpublic personal information.
How do AGL & US Life collect my personal information?	We collect your personal information, for example, when you • apply for insurance or pay insurance premiums • file an insurance claim or give us your income information • provide employment information We also collect your personal information from others, such as credit bureaus, affiliates, or other companies.
Why can't I limit all sharing?	Federal law gives you the right to limit only • sharing for affiliates' everyday business purposes—information about your creditworthiness • affiliates from using your information to market to you • sharing for nonaffiliates to market to you State laws and individual companies may give you additional rights to limit sharing. See below for more on your rights under state law.

Definitions

Affiliates	Companies related by common ownership or control. They can be financial and nonfinancial companies. • *Our affiliates include the member companies of American International Group, Inc.*
Nonaffiliates	Companies not related by common ownership or control. They can be financial and nonfinancial companies. • *AGL and US Life do not share with nonaffiliates so they can market to you.* A formal agreement between nonaffiliated financial companies that together market financial products or services to you. • *Our joint marketing partners include companies with which we jointly offer insurance products, such as a bank.*

Other important information

For Vermont Residents only. We will not disclose information about your creditworthiness to our affiliates and will not disclose your personal information, financial information, credit report, or health information to nonaffiliated third parties to market to you, other than as permitted by Vermont law, unless you authorize us to make those disclosures. Additional information concerning our privacy policies can be found using the contact information above for Questions.

For California Residents only. We will not share information we collect about you with nonaffiliated third parties, except as permitted by California law, such as to process your transactions or to maintain your account.

For Nevada Residents only. We are providing this notice pursuant to Nevada state law. You may elect to be placed on our internal Do Not Call list by calling the numbers referenced in the Questions section. Nevada law requires that we also provide you with the following contact information: Bureau of Consumer Protection, Office of the Nevada Attorney General, 555 E. Washington Street, Suite 3900, Las Vegas, NV 89101; Phone number: 702-486-3132; email: aginfo@ag.nv.gov. You may contact our customer service department by using the contact information referenced in the Questions section.

You have the right to see and, if necessary, correct personal data. This requires a written request, both to see your personal data and to request correction. We do not have to change our records if we do not agree with your correction, but we will place your statement in our file. If you would like a more detailed description of our information practices and your rights, please write to us at the addresses indicated on the first page.

[1]AIG's Group Benefits Business is the marketing name of the following insurance company subsidiaries of American International Group, Inc. (AIG) underwriting property-casualty, accident & health, and life insurance: American General Life Insurance Company, and The United States Life Insurance Company in the City of New York.

LIFE INSURANCE BUYER'S GUIDE

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

Prepared by the National Association of Insurance Commissioners

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various Insurance Departments to coordinate insurance laws for the benefit of all consumers.

This Guide Does Not Endorse Any Company Or Policy

Reprinted by American General Life Insurance Company

May, 2015

Important Things to Consider

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all *the* answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance may be costly.
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of the many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasizes protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.

- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: term insurance and cash value insurance**.** Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs, such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are non-guaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

American General Life Insurance Company

Policyowner Acknowledgement of Policy Delivery or Producer's Certification of Mailing of Policy to the Policyowner

Policyowner: JOHN STEIN Policy Number: 4200125254

Insured/Annuitant: JOHN STEIN

Policyowner Acknowledgement of Policy Delivery

Execution of this receipt by the Policyowner constitutes an acknowledgement of delivery.

Policy provisions regarding the right to return the policy and receive a refund of premiums will become effective as of the date this Policyowner Acknowledgement of Policy Delivery is signed.

Terms of this acknowledgement are subject to the provisions of the policy contract and any applicable laws and regulations.

By signing below you attest to the following:

I was physically located in the United States of America when all solicitation activities regarding Policy No. 4200125254 occurred and when all medical examination, telephone interviews and other application-related events, ***including all signatures required to complete the application*** *for the policy occurred.*

Policyowner Signature: _____ Date: _____

Agent Name: _____

Agent Signature: _____ Date: _____

Location Signed: _____ _____
City State

Agent Certification of Mailing of Policy to the Policyowner

This section is not applicable for Foreign National policy contracts. The above section must be signed by both Policy Owner and Agent for all Foreign National contracts.

Because the policy referenced above was mailed to the Policyowner, no Policyowner signature was obtained. However, I hereby declare that the policy contract was mailed to the Policyowner on the date entered below and that I have retained in my files evidence of the mailing.

Date Mailed to Policyholder: _____

Agent Name: _____

Agent Signature: _____ Date: _____

American General Life Insurance Company

Policyowner Acknowledgement of Policy Delivery or Producer's Certification of Mailing of Policy to the Policyowner

Policyowner: JOHN STEIN Policy Number: 4200125254

Insured/Annuitant: JOHN STEIN

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Date Mailed to Policyholder: _____

Agent Name: _____

Agent Signature: _____ Date: _____

NOTICE OF
PROTECTION PROVIDED BY
LIFE AND HEALTH INSURANCE PROTECTION ASSOCIATION

This notice provides a **brief summary** of the Life and Health Insurance Protection Association ("the Association") and the protection it provides for policyholders. This safety net was created under Colorado law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Colorado law, with funding from assessments paid by other insurance companies.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $500,000 in hospital, medical and surgical insurance benefits
  - $300,000 in disability insurance benefits
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in withdrawal and cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $300,000. Special rules may apply with regard to hospital, medical and surgical insurance benefits.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Colorado law.

To learn more about the above protections, as well as protections relating to group contracts or retirement plans, please visit the Association's website http://colorado.lhiga.com, email jkelldorf@gmail.com or contact:

Colorado Life and Health *Insurance Protection Association* *P. O. Box 36009* *Denver, CO 80236* *(303) 292-5022*	*Colorado Division of Insurance* *1650 Broadway, Suite 850* *Denver, CO 80202* *(303) 894-7499*

Insurance companies and agents are not allowed by Colorado law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance. When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Colorado law, then Colorado law will control.

For AIG Home Office Use Only

Policies issued by American General Life Insurance Company (AGL) except in New York, where issued by The United States Life Insurance Company in the City of New York (US Life). Issuing companies AGL and US Life are responsible for financial obligations of insurance products and are members of American International Group, Inc. (AIG).