

**AIG Life Insurance Company\***

Wilmington, Delaware

A member company of American International Group, Inc.

Administrative Office: PO Box 30081, Tampa, FL 33630-3081

\*This company does not solicit business in New York.

Please print or type all information requested. **Group Policy Number** \_\_\_\_\_ **Division** \_\_\_\_\_

**All applications missing information will be returned.** **Salary** \_\_\_\_\_ **Supplemental Life amount** \_\_\_\_\_ (if applicable)

**Job Title** \_\_\_\_\_ **Hire Date** \_\_\_\_\_

1. Name of Employer \_\_\_\_\_

2. Employee's/Member's full name \_\_\_\_\_  
FIRST MIDDLE LAST

3. Home Address \_\_\_\_\_  
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Complete the following for employee/member and dependents requesting coverage (Only complete for children if late entrants).

	Name	Age	Date of Birth MM/DD/YY	Sex	Place of Birth	Height ft. in.	Weight lbs.	Social Security #
EE								
SP								
CH								
CH								

5. Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver or lungs, cancer or other tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder?  Yes  No  Yes  No  Yes  No
- 6a. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?  Yes  No  Yes  No  Yes  No
- 6b. Are you presently taking any medication?  Yes  No  Yes  No  Yes  No
- 6c. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?  Yes  No

**If "yes" to any part of questions 5 and 6, give details below. Use a separate sheet of paper if more space is needed for answers:**

Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Name, Address & Phone # of Physicians Hospitals/Clinics Consulted

**SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE**



Statement of Insurability for Group Programs

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AUTHORIZATION

- 1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, Inc., to give such records or knowledge to any agency employed by the Company to collect and transmit such information.
2. I understand that this information will be used by the Company solely to determine eligibility for insurance.
3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which the Company has taken in reliance upon this authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.
4. I know that I should retain a copy of this authorization for my records.
5. I agree that a photocopy of this authorization is as valid as the original.
6. To the best of my knowledge and belief, all statements made above are true and complete.
7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.
8. I authorize deductions from earnings for the costs of this insurance.
9. I designate the beneficiary named on this form to receive the proceeds, if any, payable upon my death.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime.

(DATE SIGNED) (SIGNATURE OF EMPLOYEE/MEMBER)

(DATE SIGNED) (SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)

Witness to above Signature(s):

BENEFICIARY DESIGNATION (Complete only if applying for Life/AD&D benefits)

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and/or children's insurance applied for, and the spouse named in 4 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Table with 4 columns: First Name, Initial, Last Name, Relationship. Example row: Ex: Mary A. Jones, Wife / Not Mrs. John Jones