Application For Life Insurance
LERA Insurance Services. Inc.
2829 West Burbank Blvd. CA, 91505

1. a. Primary Proposed Insured Name (Print full name) _____

b. Address _____
Street City State Zip Code Country

Birth Date and Place Age Gender
Month Day Year State Country ☐ Male ☐ Female

c. SSN: _____

d. Marital/Domestic Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Other _____

e. Driver's License No. _____ f. State of Issue _____

If over age 16 and no license, please explain. _____

g. Annual Earned Income _____ h. Other Sources of Income _____

i. Occupation _____ j. How long in occupation _____

k. Employer _____ l. Job duties _____

m. Length of time employed by current employer _____ n. Average No. of hours worked per week in occupation _____

o. Is Primary Proposed Insured actively at work and able to perform all regular job duties? ☐ Yes ☐ No

If "No," explain: _____

p. If no earned income, provide details of prior employment and job duties _____

q. If unemployed, retired prior to age 55, disabled or receiving Supplemental Security Income (SSI), provide explanation _____

_____

	YES	NO
27. Does any proposed insured have diabetes?	☐	☐

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes

If "Yes," Name _____
Date of diagnosis _____
Describe treatment _____
List any disability related to diabetes _____
Last blood sugar or HA1C reading and date _____
Has the proposed insured experienced diabetic coma, or vascular, kidney, heart, eye or other problems related to diabetes? ☐ Yes ☐ No
If "Yes," provide details _____
Name and address of physician treating diabetes

28. Within the past 5 years, has any proposed insured consumed alcoholic beverages?	☐	☐

If "Yes," Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____
Name _____ Average No. of drinks per week _____
Maximum No. of drinks per day _____ Type (Beer, Wine, Liquor) and Date of last use _____

29. Has any proposed insured ever received medical treatment or counseling from a physician for, or been advised by a physician to discontinue or reduce, the use of alcohol or prescribed or non-prescribed drugs (cocaine, marijuana, heroin, methamphetamine) or other controlled substances, or has any proposed insured used such a non-prescribed drug or controlled substance, or any prescription medication other than as prescribed by a physician?	☐	☐

If "Yes," Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____
Name _____ Date(s) _____ Duration _____ Type _____
Details (including name, address and telephone number of the doctor, hospital, clinic or treatment facility) _____

30. Within the past 10 years, has any proposed insured been diagnosed as having or been treated for Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐

If "Yes," Name _____ Details _____
Name and Address of Physician _____
If "Yes," Name _____ Details _____
Name and Address of Physician _____

31. Within the past 12 months, has any proposed insured had one or more sores that have not healed, had changes in the appearance of a mole, experienced bleeding, chest pain, convulsions, dizziness, fatigue, hoarseness, numbness, or paralysis for which the cause is not known and for which a doctor has not been consulted?	☐	☐

If "Yes," Name _____ Date(s) _____ Duration _____ Type _____
Details _____
Name _____ Date(s) _____ Duration _____ Type _____
Details _____

OWNER'S CERTIFICATION

Under penalties of perjury, I certify that the following number, _____ , is my correct taxpayer identification number, AND

Under penalties of perjury, I certify that I am not subject to backup withholding because:
(a) I am exempt from backup withholding, or
(b) I have not been notified by the Internal Revenue Service that I am subject to backup withholding as a result of failure to report all interest or dividends, or
(c) the IRS has notified me that I am no longer subject to backup withholding, AND

Under penalties of perjury, I certify that I am a U.S. person (including a U.S. resident alien).

You must cross out item (b) 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 in your tax return.

X _____ _____
Signature of Owner — Date

Consent to Insurance on Life of Minor Primary Proposed Insured

I hereby consent to the insurance plan, amount and beneficiary designation shown on the application and also reaffirm the answers to the health questions as they pertain to the Minor Primary Proposed Insured.

X _____ _____
Signature of Biological/Adoptive Father or Mother or of Legal Guardian — Date

X _____ _____
Signature of Biological/Adoptive Father or Mother or of Legal Guardian — Date

---

Consent to Children's Term Rider on Life of Minor Stepchild of Primary Proposed Insured or Additional Proposed Insured

I hereby consent to the insurance plan and amount shown on this application as to any biological and adopted child(ren) of mine listed in this application. I understand that the beneficiary of such applied-for coverage on such child(ren) will be the Owner of the policy. I affirm the answers to the health questions on this application as to such child(ren).

X _____ _____
Signature of Biological/Adoptive Father or Mother — Date

AGENT'S CERTIFICATION

I certify that I have asked each question and that the answers have been truly and accurately recorded as given. I have recorded any unfavorable information which I have knowledge of concerning any proposed insured. I confirm that any and all signatures of the Primary Proposed Insured, Additional Proposed Insured, Owner and Witness(es) in this application were signed in my presence.

_____ _____
Date — Signature of Licensed Agent

ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZATION – NOTICE

I, the Primary Proposed Insured (and any Owner or Additional Proposed Insured signing below), by my signature set forth hereafter:

Acknowledge that, if a Conditional Receipt was issued to me as a result of this application, I have read, or have been given the opportunity to read or to have read to me, all terms and provisions of such Conditional Receipt.

Agree that, under the Conditional Receipt, if any, given to me as the result of this application and under any additional pending application for other life, accident and/or health insurance coverage from American General Life Insurance Company ("the Company"), the aggregate liability on account of all coverages applied for with the Company will be the amount of coverage applied for or $250,000, whichever is less.

Agree that any temporary insurance arising under the terms of any Conditional Receipt given to me as a result of this application shall become effective only if and when such Conditional Receipt is delivered to the Owner.

Agree that all statements and answers in this application are complete and true to the best of my knowledge and belief and are the basis for any policy issued by the Company and agree that no information shall be deemed to have been given to the Company unless it is set forth in this application or in any supplemental application.

Agree that, except as stated in any Conditional Receipt, if such Conditional Receipt was given to me as a result of this application, the insurance will take effect on the Policy Date shown in the Policy if (a) the Policy has been delivered to me; (b) the first full modal premium for the Issued Policy has been paid while each proposed insured is alive; and (c) there has been no change in the health of any proposed insured that would change the answer to any question in this or any supplemental application before the conditions in items (a) and (b) above are met.

Agree that no agent of the Company or Medical Examiner has authority to waive any answer or otherwise modify this or any supplemental application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application.

Authorize: (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, the Medical Information Bureau ("MIB"), and any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the Company to any person or organization, except to the Company's reinsurers, the MIB, other companies to whom I have applied or may apply for insurance coverage, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for insurance policy, and (3) the duration of a claim for benefits.

ACKNOWLEDGE receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; and (c) Investigative Consumer Report.

NOTICE: 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.

NOTICE: If a proposed insured's answers on this application are incorrect or untrue, the Company may have the right to deny benefits and/or rescind coverage.

PRIMARY PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.

ADDITIONAL PROPOSED INSURED - If an investigative consumer report is prepared in connection with this application:
☐ I elect to be interviewed. ☐ I elect NOT to be interviewed.

AGENT - To the best of your knowledge, is the insurance applied for intended to replace any existing insurance? ☐ Yes (Explain) ☐ No

Signed at _____ (City) _____ (State) _____ (Date), _____

X _____
SIGNATURE OF PRIMARY PROPOSED INSURED

X _____
SIGNATURE OF ADDITIONAL PROPOSED INSURED
(IF APPLICABLE)

X _____
SIGNATURE OF OWNER
(IF OTHER THAN PRIMARY PROPOSED INSURED)

X _____
SIGNATURE OF WITNESS (IF APPLICABLE)

X _____
SIGNATURE OF LICENSED AGENT

(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES) CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT

This Receipt is Valuable. Keep It in a Safe Place.

On this date, American General Life Insurance Company ("the Company") has received $_____ for life insurance applied for on _____. We agree to provide temporary insurance if (a) this deposit is equal to at least
(Primary or Additional Proposed Insured)

one twelfth (1/12) of the annual premium for the policy applied for and (b) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters for the plan, insurance amount, and premium applied for on the date of this premium deposit and on the date of any required medical examination.

ANY TEMPORARY INSURANCE UNDER THIS CONDITIONAL RECEIPT IS SUBJECT TO THE AMOUNT AND TERMS OF THE POLICY APPLIED FOR EXCEPT THAT THE AGGREGATE LIABILITY FOR TEMPORARY INSURANCE FOR EACH PROPOSED INSURED UNDER THIS CONDITIONAL RECEIPT AND UNDER CONDITIONAL RECEIPT FOR ANY ADDITIONAL, PENDING APPLICATION FOR OTHER LIFE, ACCIDENT AND/OR HEALTH INSURANCE COVERAGE FROM THE COMPANY WILL BE THE AMOUNT OF COVERAGE APPLIED FOR OR $250,000.00, WHICHEVER IS LESS. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT, IF EARLIER.

No agent has authority to change or waive the terms and conditions of this Receipt. This receipt is not valid if its date differs from that in the application or if any check tendered as a premium deposit shown above is not honored when presented for payment.

_____ , _____	_____	_____	_____
Date	Local Office	Agency No.	Signature of Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AGLA1000-CA REV0213 CR

NOTICE TO HOLDER OF CONDITIONAL RECEIPT

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:
(a) decline to issue insurance; or
(b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our office at American General Center, Nashville, TN 37250-0001.

AGLA1000-CA REV0213 CR

(NOT TO BE COMPLETED FOR PAYROLL DEDUCTION MODES) CONDITIONAL RECEIPT FOR PREMIUM DEPOSIT

This Receipt is Valuable. Keep It in a Safe Place.

On this date, American General Life Insurance Company ("the Company") has received $_____ for life insurance applied for on _____. We agree to provide temporary insurance if (a) this deposit is equal to at least
(Primary or Additional Proposed Insured)

one twelfth (1/12) of the annual premium for the policy applied for and (b) all persons for whom application is made are insurable in the opinion of the Company's authorized underwriters for the plan, insurance amount, and premium applied for on the date of this premium deposit and on the date of any required medical examination.

ANY TEMPORARY INSURANCE UNDER THIS CONDITIONAL RECEIPT IS SUBJECT TO THE AMOUNT AND TERMS OF THE POLICY APPLIED FOR EXCEPT THAT THE AGGREGATE LIABILITY FOR TEMPORARY INSURANCE FOR EACH PROPOSED INSURED UNDER THIS CONDITIONAL RECEIPT AND UNDER CONDITIONAL RECEIPT FOR ANY ADDITIONAL, PENDING APPLICATION FOR OTHER LIFE, ACCIDENT AND/OR HEALTH INSURANCE COVERAGE FROM THE COMPANY WILL BE THE AMOUNT OF COVERAGE APPLIED FOR OR $250,000.00, WHICHEVER IS LESS. IF TEMPORARY INSURANCE EXISTS UNDER THIS CONDITIONAL RECEIPT, IT WILL END UPON DELIVERY OF A POLICY OR 60 DAYS AFTER THE DATE OF THIS RECEIPT, IF EARLIER.

No agent has authority to change or waive the terms and conditions of this Receipt. This receipt is not valid if its date differs from that in the application or if any check tendered as a premium deposit shown above is not honored when presented for payment.

_____ , _____ _____ _____ _____
Date Local Office Agency No. Signature of Licensed Agent

ALL PREMIUM CHECKS MUST BE MADE PAYABLE TO THE COMPANY. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

AGLA1000-CA REV0213 CR

NOTICE TO HOLDER OF CONDITIONAL RECEIPT

This Receipt is Valuable. Do Not Destroy or Lose.

We will refund the premium deposit if we:
(a) decline to issue insurance; or
(b) issue a policy other than as applied for and you do not accept it.

If you do not receive a policy within 60 days from the date of deposit, return this Receipt for refund to our Local Office or to our office at American General Center, Nashville, TN 37250-0001.

AGLA1000-CA REV0213 CR

Submit Form