AG Quick Ticket Worksheet

For agent use only, please upload the completed form with agent signature to AG Quick Ticket

Proposed Insured

Full Name ____ Social Security # ____ Gender: ☐ M ☐ F

Date of Birth ____ Primary Phone ____ Alternate Phone ____ E-mail Address ____

Street Address ____ City ____ State ____ Zip Code ____

Birthplace ☐ USA ☐ Foreign Birth State (if USA chosen) ____ Birth Country (if Foreign chosen) ____

Personal Earned Income (Annual) $ ____ Household Income (Annual) $ ____ Net Worth $ ____

Would the Proposed Insured and the Policyowner like to electronically Sign? (Available on term, UL and VUL. Not available on IUL products. Not available in NY. Must provide an email address for the Insured and Owner.)................. ☐ Yes ☐ No

Would the Policyowner like to receive the policy electronically? (Only available for term products) .... ☐ Yes

Complete the following question(s) if the Proposed Insured is over the age of 66:

Will the premiums for the policy sought with the application be financed other than pursuant to a split dollar agreement? .... ☐ Yes ☐ No

If Yes, Within the past 24 months has the insured had a life expectancy calculation? .... ☐ Yes ☐ No

Is the Proposed Insured a U.S. Citizen or Permanent Card Holder? ☐ Yes ☐ No (if no, answer the following)

Does the Primary Proposed Insured have a SSN? .... ☐ Yes ☐ No

Country of Citizenship ____ Date of Entry ____ Visa Type ____

Does the Primary Proposed Insured own property or have a mortgage in the U.S.? .... ☐ Yes ☐ No

Does the Primary Proposed Insured plan to remain in the U.S.? .... ☐ Yes ☐ No

Plan of Insurance

☐ Select-a-Term ☐ QoL Flex Term Duration ____ years ☐ Secure Lifetime GUL 3 ☐ QoL Guarantee Plus GUL II

☐ Max Accumulator+ IUL ☐ QoL Max Accumulator+ IUL ☐ Value+ Protector IUL ☐ QoL Value+ Protector IUL

Application State ____ Face Amount $ ____

Premium Class Quoted: ☐ Preferred Plus ☐ Preferred Nontobacco ☐ Standard Plus ☐ Standard Nontobacco ☐ Preferred Tobacco ☐ Standard Tobacco ☐ Special Nontobacco ☐ Special Tobacco

Table Rating: ____ Reason: ____

Reason for Insurance: ____

Death Benefit Options: ☐ Level ☐ Increasing

Death Benefit Compliance Test: ☐ CVAT ☐ Guideline

Riders

☐ Waiver of Premium ☐ Accidental Death Benefit: Amount $ ____ ☐ Child Rider: Amount $ ____ ☐ No Current Children

☐ Terminal Illness Rider ☐ Waiver of Specified Premium ☐ Protected Premium Rider ☐ LIS Rider

☐ Select Income Rider: Benefit Duration ____ Monthly Benefit Amount $ ____

☐ Other Rider/Benefits ____ ☐ Waiver of Monthly Deduction ____

☐ AAS Rider: Maximum Monthly Benefit: 2%, 4%, Maximum Per Diem Allowable
Lifetime Maximum Benefit Percentage ____ % (50% - 100%)

☐ Monthly Guarantee Premium Rider ☐ Additional Insurance Option $ ____

Payment

Modal Premium $ ____ Additional Initial Premium $ ____

Payment Method: ☐ Direct Billing ☐ Bank Draft (authorization information will be collected by tele-interviewer)

Frequency of Payments: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (Bank Draft only)

Save Age? ☐ Yes ☐ No

Beneficiary(ies) Individual

Primary Beneficiary ____ DOB ____ SSN ____ Relationship ____ Share ____ %

Address ____ City ____ State ____ Zip ____ Phone ____

Primary Beneficiary ____ DOB ____ SSN ____ Relationship ____ Share ____ %

Address ____ City ____ State ____ Zip ____ Phone ____

Contingent Beneficiary ____ DOB ____ SSN ____ Relationship ____ Share ____ %

Address ____ City ____ State ____ Zip ____ Phone ____

AGLC106104 Rev0218

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Beneficiary/Owner Entity

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.) ______________

Owner Individual

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 ______________________________

Existing Insurance/Replacements

Does the proposed insured have any existing or Pending Insurance?.. ☐Yes ☐No

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 $ __________ Proposed Insured Name: ______________						
2						☐Y ☐N	☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________ Proposed Insured Name: ______________						
3						☐Y ☐N	☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________ Proposed Insured Name: ______________						
4						☐Y ☐N	☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________ Proposed Insured Name: ______________						

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

Note: If there is a 1035 Exchange please complete AGLC0010 and mail to
AIG Life Insurance ~ PO BOX 4077 ~ Houston, TX 77210
*1035 Exchanges are not available for the QoL products on AG Quick Ticket.

Reminder: Replacement situations can be submitted using AG Quick Ticket in all states except: NY.

Fund Allocation

Participation Rate Account _____ % Declared Interest Account _____% Blend Participation Rate Account _____%

Core Cap Rate Account _____ % High Cap Rate Account _____ % Cap Rate Account _____ %

AGLC106104 Rev0218