



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 _____



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						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____ Amount of Coverage \$ _____ Proposed Insured Name: _____						
2						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____ Amount of Coverage \$ _____ Proposed Insured Name: _____						
3						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
	Company Name: _____ Amount of Coverage \$ _____ Proposed Insured Name: _____						
4						<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> 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 _____%
 High Cap Rate Account _____% Global Blend Participation Rate Account _____% High Bonus Rate Account _____%
 Cap Rate Account _____%