Supplemental Application for Chronic Illness Accelerated Death Benefit Rider

American General Life Insurance Company, Houston, TX

This is a supplement to the application for the Life Insurance for the Primary Proposed Insured. Please complete if the Chronic Illness Accelerated Death Benefit Rider is being elected.

(Check the box that applies)							
	☐ New Application ☐ Reinstatement ☐ Base Poli	icy Specified Amount Increa	se				
1.	Primary Proposed Insured						
	First Name MI	Last Name	Date of Birth				
	Benefits (Complete for New Application Only)						
	A. Maximum Monthly Benefit: 2% of Lifetime Maximum Benefit 4% of Lifetime Maximum Benefit Maximum Per Diem Allowable						
	B. Lifetime Maximum Benefit Percentage:%						
	Note: If the Chronic Illness Accelerated Death Benefit Rider is approved and added to your policy, the policy will also include, at no additional charge, a Terminal Illness Accelerated Death Benefit Rider. The Disclosure of Accelerated Death Benefits form must be completed for the Chronic Illness Accelerated Death Benefit rider, if required by the state of issue.						
3.	. Health Questions — In this section, "you" refers to the	Primary Proposed Insured.					
	A. During the last 12 months, have you:						
	 Required assistance or supervision of any kind t (including the use of a pronged cane), taking me 			🗆 Yes 🗀 No			
	Used a catheter, chair lift, dialysis, motorized sc respirator, walker, or wheelchair?			🗆 Yes 🗆 No			
	 Been advised to enter or reside in a nursing hon Continuing Care Retirement Community (CCRC), Skilled Nursing Facility (SNF) or an adult day car 	residential care facility, reha	bilitation facility,	🗆 Yes 🗀 No			
	B. During the last 3 years, have you used insulin to tre	•					
	Have you ever been diagnosed or treated by a licer	nsed health care provider for	r:				
	1. Diabetes WITH COMPLICATIONS (such as eye, I	kidney, or nerve damage)?		🗆 Yes 🗆 No			
	2. Diabetes AND Heart Disease, Stroke, or Periphe	eral Vascular Disease?		🗆 Yes 🗆 No			
	C. Have you EVER been diagnosed with, been treated from a licensed health care provider for any of the	for, tested positive for, or red					
	1. Alzheimer's disease, Dementia, Mild Cognitive I	Impairment (MCI), or Organic	Brain Syndrome (OBS)	🗆 Yes 🗆 No			
	2. Amputation due to disease			🗆 Yes 🗆 No			
	3. ALS (Lou Gehrig's disease)			🗆 Yes 🗆 No			
	4. Stroke, Cerebral Vascular Accident (CVA), or Tr	ansient Ischemic Attack (TIA	A)	🗆 Yes 🗆 No			
	5. Organ Transplant (other than corneal)			🗆 Yes 🗆 No			
	6. Multiple Sclerosis			🗆 Yes 🗆 No			
	7. Huntington's Chorea			🗆 Yes 🗆 No			
	8. Muscular Dystrophy			🗆 Yes 🗆 No			
	9. Myasthenia Gravis						
	10. Macular Degeneration						
	11. Blindness						
	12. Optic Neuritis						

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4. I	Remarks					
	J. Within the pas or chronic illne	et 5 years, have you been declined fo ess insurance provided by rider to a	r long term care insurance, including I life insurance or other policy including ate and the reason in Section 4, Rema	ong term care g annuities?		
- - -			g term care benefits, disability income			
-	Question #	Nature of Condition/Date of diagnosis	Date of last treatment or last medication taken	Name & address of Physician seen		
(Give details to al	I yes answers to questions 3. E-H.				
ı	cooking, laund	dry, meal preparation, managing finar	ce with shopping, arranging transporta nces, managing medications, using the	e telephone or		
G. In the last 24 months, have you had to limit or been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below)						
ı			or handicap license plate? (If yes, give			
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	•					
I	advice from a	licensed health care provider for any	treated for, tested positive for, or receive of the following conditions:			
		A-D was answered yes, the rider is i ot be completed or submitted.	not available for the Primary Proposed	d Insured and this supplemental		
	Huntington's c	horea or Polycystic Kidney Disease?	ed by a licensed health care provider to the second	🗆 Yes 🗆 N		
		-	the past 12 months			
	19. Unplanne	d weight loss greater than 15 pounds	s within the last 2 years	Yes N		
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I, the Primary Proposed Insured signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. 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 the contestable period.

I understand that benefits under the Chronic Illness and Terminal Illness riders are provided through an accelerated death benefit option, and that if I exercise the accelerated benefit option, any beneficiary I designate will receive a reduced death benefit.

Fraud Warning: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit, or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Primary Proposed Insured Signature	Licensed Writing Agent	
x	x	
Date	Date	
	Writing Agent Name	
	Writing Agent Number	
	Agency Number	

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