American General Assurance Company
A member company of American International Group, Inc.

APPLICATION FOR DISABILITY INCOME INSURANCE

For Monthly Benefit Amounts up to $10,000 Per Month

Important Notice — Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be a crime.

MEMBER DATA *Please print or type all information requested.*

Name of Association: **The Iowa State Bar Association**

Your Full Name ______________ ☐ Male ☐ Female

Birth Date ____ / ____ / ____ Birth Place ______________

Height ___ ft. ___ in. Weight ___ lbs. Social Security No. ______________

Billing Address ______________
Street

____
City *State* *ZIP*

( ) ______________ ( ) ______________
Work Phone Number *Home Phone Number*

____
E-mail Address

PERSONAL DATA

Employer Name ______________
Company Name

Employer Address ______________ ( ) ______________
Street *Phone Number*

____
City *State* *ZIP*

Occupation (Specialty) ______________ Annual Salary $ ______________

Description of Duties ______________

Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No

INSURANCE PLAN DESIRED

Waiting period (in days)
☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Monthly benefit desired
$ ______________
(in $100 increments)

The maximum benefit is $10,000 per month if under age 50; $6,000 per month if age 50-54; and $3,000 per month if age 55-59.

Maximum benefit period
To age 65

Premium to be paid
☐ Annually
☐ Semi-annually

$1,000 accidental death and dismemberment benefit
(included in plan)

____
Name of beneficiary

____
Relationship to you

Optional Riders
(Check all desired)
☑ Residual Benefits *(included)*
☐ Cost of Living Adjustment
☐ Guaranteed Purchase Option *(available if under age 40)*
☐ Recovery Benefit

INSURABILITY QUESTIONS

Name, address and telephone number of your physician: ______________

______________ Date last consulted: ______________

What treatment or medication was prescribed: ______________

Answer each question by checking the "Yes" or "No" box, as it applies.

1. DURING THE PAST FIVE YEARS, HAVE YOU EVER HAD OR BEEN TREATED FOR: (Circle specific disorders experienced)	Yes	No
a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	☐	☐
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	☐	☐
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	☐	☐
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	☐	☐
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	☐	☐
f. Diabetes or elevated glucose? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	☐	☐
g. Duodenal or stomach ulcer, or other disorder of stomach, liver (including hepatitis), gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	☐	☐
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	☐	☐
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	☐	☐
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	☐	☐
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	☐	☐
l. Mental or emotional problem requiring help of a physician or psychologist?	☐	☐
m. A surgical operation? A surgical operation advised but not performed?	☐	☐

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION →

Group Policy Number: G-300,017
Form ID - 06673611-1155 R04/06

Form S-10555 DI-RR-AGAC

"MIB" DISCLOSURE NOTICE

This Notice must be retained by the applicant. Detach before mailing.

Information regarding your insurability will be treated as confidential. American General Assurance Company or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

American General Assurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

APPLICATION FOR DISABILITY INCOME INSURANCE
CONTINUED FROM FRONT SIDE OF APPLICATION

Please print or type all information

2. Have you consulted any hospital, institution, physician or practitioner within the past five years for any disease, disorder, injury or other routine visit (including pregnancy) other than stated above? (This includes any self-diagnosis, treatment or medication) .... Yes ☐ No ☐

If "Yes" to any part of questions 1 a-m or 2, please explain fully in the chart below.
Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question Number	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted

What other Disability Insurance do you now carry or have an application pending for? (Give full details)

Insurance Company	Amount of Monthly Benefit	How long are benefits payable?	
		Accident	Sickness

3. Are you replacing any current Disability Income coverage you have? ☐ Yes ☐ No
(If "Yes", provide name of Insurance Company and Policy Number): ______________________

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to American General Assurance 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 transmission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by American General Assurance Company to collect and transmit such information.

I understand that this information will be used by American General Assurance Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which American General Assurance Company has taken in reliance upon this authorization. I understand that this authorization will not be valid after 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete.

I understand that my application for insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a policy is issued based on this application and the first premium is paid in full while there is no change in the insurability or health of such person from that stated in the application.

(Date Signed) _(Signature of Proposed Insured)_

SIGNATURE OF AGENT: ______________________

Form S-10555 DI-RR-AGAC AG4091 Group Policy Numbers: G-300,017 Form ID - 06673611-1155 R04/06

Just complete this application and return it today!

Mail your application to:

REYNOLDS & REYNOLDS INC
INSURANCE AGENTS & BROKERS
The Plaza - Suite 200 • 300 Walnut Street • Des Moines, IA 50309
(515) 243-1724 • FAX (515) 243-6664 • (800) 767-1724

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.