

AIG Life Insurance Company*

Wilmington, Delaware
 A member company of American International Group, Inc.
 Administrative Office P.O. Box 667, Wilmington, DE 19899-9853
 Phone: (302) 594-2000

*This company does not solicit business in New York

Please print or type all information requested. Group Policy Number _____ Hire Date _____

Group Policyholder: _____

Applicant's Name: _____
 (First, Middle, Last)

Applicant's Address: _____
 (Number) (Street) (City) (State) (Zip) (Daytime Phone Number)

Social Security Number: _____ Date of Birth: _____ Gender M/F _____ Height _____ Weight _____
 (mm/dd/yy)

Premium: _____

Benefits Requested Employee Face Amount Spouse Face Amount

<input type="checkbox"/>	AIG Group CriticalCare Basic Plan	\$	\$
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Coverage Options: (Applicant Only) (Applicant & Spouse)

(Write spouse's name below if you are applying for Applicant and Spouse coverage; if no spouse or if spouse is not to be covered, put N/A or "None" in space below.)

NAME	AGE	DATE OF BIRTH MM/DD/YY	SEX	HEIGHT	WEIGHT	SOCIAL SECURITY #
SP						

- Has any proposed insured used any form of tobacco or nicotine product, including a nicotine patch, in the last 12 months?

Employee		Spouse	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- Has any proposed insured ever been diagnosed with or treated by a member of the medical profession for any of the following:

Employee		Spouse	
Yes	No	Yes	No

 - stroke, transient ischemia attacks (TIA),
 - kidney failure, polycystic kidneys, abnormal kidney function;
 - glaucoma, macular degeneration, optic neuritis;
 - familial adenomatous polyposis (Gardener's Syndrome);
 - cancer, malignant tumor or growth;
 - diabetes; heart disease, multiple sclerosis
 - need an organ transplant?
- Has any proposed insured tested positive for the human immuno-deficiency virus (HIV) or its antibodies, or been diagnosed with or received treatment for acquired immune deficiency syndrome (AIDS) or AIDS – related complex (ARC), or other immune disorders?

Employee		Spouse	
Yes	No	Yes	No
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Beneficiary * (Please print full name and relationship):

First Name	Initial	Last Name	Relationship
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*** The applicant will be the beneficiary for his or her spouse and/or dependent children if dependent coverage is selected unless designated otherwise.**

AUTHORIZATION: I authorize the premium for this insurance to be deducted from my salary and forwarded to the Company.

Applicant's Signature

Date

Applicant's Spouse's Signature
(if Spouse coverage is elected)

Date

FRAUD NOTICE: 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.

NOTICE: In accordance with LRS 22:213.7, The Company does not discriminate on the basis of genetic information, request or receipt of genetic services, or genetic testing or results concerning an proposed insured or a proposed insured's family member.