



American General Assurance Company

A member company of American International Group, Inc.

For Office Use Only-Policy No.

APPLICATION FOR GROUP BUSINESS OVERHEAD EXPENSE INSURANCE

For members of the Pennsylvania Veterinary Medical Association

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. (Fraud provisions vary by state.)

PERSONAL INFORMATION

Name: _____

Social Security Number: _____

Practice Name: _____

Home Telephone No.: _____

Billing Address: _____

Business Telephone No.: _____

Fax Number: _____

E-mail: _____

Please fill in your Daytime Phone Number to assist us in contacting you should the need arise in processing your application: (_____) _____

Occupation: _____

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

I WOULD LIKE TO APPLY FOR BUSINESS OVERHEAD EXPENSE INSURANCE

Average monthly amount of eligible overhead expenses in the preceding six months? \$ _____ per month

Type of Organization:

Proprietorship Corporation Partnership

If Corporation or Partnership, my share of eligible expenses are: _____ %

Indicate the monthly benefit desired (in \$100 increments):

\$ _____

(The maximum benefit is \$15,000 per month if under age 55; and \$10,000 per month if age 55-59.)

I wish to pay premiums: Annually Semi-Annually

Waiting Period: 15 Day 30 Day

Benefit Period: **24 Months**

Optional Benefit Rider (check if desired):

Optional Guaranteed Purchase Rider

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Height _____ ft. _____ in. Weight _____ lbs. Sex M F Date of Birth ____/____/____ Place of Birth _____

1. Have you ever had or been treated for: (Circle specific disorders experienced)

- a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? Yes No
- b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes No
- c. Arthritis, gout, bursitis or rheumatism? Yes No
- d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? Yes No
- e. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder? Yes No
- f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? Yes No
- g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Yes No
Colitis, diverticulitis, or other disorder of small or large intestine? Yes No
- h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? Yes No
- i. Menstrual, uterine, or ovarian disorder, disorder of the breast? Yes No
- j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? Yes No
- k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes No
- l. Mental or emotional problem requiring help of a physician or psychologist? Yes No
- m. A surgical operation? A surgical operation advised but not performed? Yes No

2. Have you consulted any hospital, institution, physician, or practitioner within the past five years for any disease, disorder or injury other than stated above? Yes No

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION →

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE (Retain for your records)

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.

