

AMERICAN GENERAL ASSURANCE COMPANY
SCHAUMBURG, ILLINOIS (HEREIN CALLED "WE/US/OUR")

LOAN NUMBER	MONTHLY MORTGAGE PAYMENT	LOAN OFFICER I.D.	IF YOU ARE AGE	MONTHLY PREMIUM	TOTAL INSURED MO. PAYMENT	RATE PER \$10
			18—30			
LENDER			31—40			
NAME AND ADDRESS OF APPLICANT (HEREIN CALLED "YOU"). PLEASE PRINT OR TYPE.			41—50			
			51—55			
			MORTGAGE DISABILITY INSURANCE APPLICATION			

DATE OF BIRTH	STATE OF BIRTH	HEIGHT	WEIGHT	SOCIAL SECURITY NUMBER	TELEPHONE NUMBER ()
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OCCUPATION	EMPLOYER
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FULL NAME AND ADDRESS OF YOUR PHYSICIAN OR MEDICAL FACILITY:

TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

	Yes	No
(1) ARE YOU GAINFULLY EMPLOYED ON A FULL—TIME BASIS (30 HOURS PER WEEK) AND PRESENTLY WORKING?	<input type="checkbox"/>	<input type="checkbox"/>
(2) HAVE YOU:		
(A) IN THE PAST FIVE YEARS RECEIVED ANY MEDICAL ADVICE OR ATTENTION OR BEEN A PATIENT IN A HOSPITAL OR SANITORIUM?	<input type="checkbox"/>	<input type="checkbox"/>
(B) EVER BEEN TREATED FOR, OR BEEN ACTUALLY DIAGNOSED AS HAVING ANY OF THE FOLLOWING (PLEASE CIRCLE): HEART DISEASE; HIGH BLOOD PRESSURE; RHEUMATIC FEVER; CANCER; DIABETES; LUNG DISEASE; NERVOUS DISORDER; STROKE; EPILEPSY; DISEASE OF THE DIGESTIVE OR URINARY TRACT.	<input type="checkbox"/>	<input type="checkbox"/>
(C) IN THE LAST THREE YEARS BEEN TREATED FOR A HERNIA; ANY DISORDER OF THE EYES OR EARS, ARMS OR LEGS, BACK OR JOINTS?	<input type="checkbox"/>	<input type="checkbox"/>
(D) IN THE LAST THREE YEARS BEEN ABSENT FROM WORK FOR A PERIOD OF MORE THAN FIVE CONSECUTIVE DAYS DUE TO INJURY OR ILLNESS?	<input type="checkbox"/>	<input type="checkbox"/>
(E) EVER BEEN MEDICALLY DIAGNOSED AS HAVING ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS) OR ANY AIDS RELATED COMPLEX, CONDITION OR DISORDER (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>

PLEASE EXPLAIN FULLY ANY "YES" ANSWERS TO QUESTION (2) (A) THROUGH (E) ABOVE. INCLUDE DATES, REASONS, DOCTORS' NAMES AND ADDRESSES:

BY SIGNING BELOW: (1) YOU HEREBY AUTHORIZE: (A) ANY LICENSED PHYSICIAN, MEDICAL PRACTITIONER, HOSPITAL CLINIC, VETERANS ADMINISTRATION OR OTHER MEDICAL OR MEDICALLY RELATED FACILITY; (B) INSURANCE COMPANY; (C) THE MEDICAL INFORMATION BUREAU; OR, (D) OTHER ORGANIZATION, INSTITUTION OR PERSON THAT HAS ANY RECORDS OR KNOWLEDGE OF YOU OR YOUR HEALTH, TO GIVE ANY SUCH INFORMATION TO US OR OUR REINSURERS; (2) YOU AGREE THIS AUTHORIZATION IS VALID FOR TWO AND ONE-HALF YEARS FROM THE DATE SIGNED. A COPY IS AS VALID AS THE ORIGINAL; AND, (3) YOU HAVE READ THE REVERSE SIDE CONTAINING THE "CONSUMER PRIVACY NOTICE".

APPLICANTS SIGNATURE DATE

REFUSAL: I DO NOT WANT THIS INSURANCE. SIGNED _____	COMPANY USE ONLY: EFFECTIVE DATE OF INSURANCE _____
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NOTICE: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO FRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE: By signing the reverse side: (1) You acknowledge having read the “CONSUMER PRIVACY NOTICE” and understand you can have copies. A copy is as valid as the original; (2) You authorize your mortgagee to add the monthly insurance premium to your mortgage payment; (3) You understand that this information will be used by us to determine eligibility for insurance; and, (4) You realize any false statements made on this application could result in loss of coverage.

THE INSURANCE APPLIED FOR WILL BECOME EFFECTIVE ON THE FIRST DAY OF THE MONTH FOLLOWING APPROVAL OF THE APPLICATION IF APPROVED BY THE 20TH OF THE MONTH. IF APPROVED AFTER THE 20TH OF THE MONTH, INSURANCE WILL BECOME EFFECTIVE ON THE FIRST DAY OF THE SECOND MONTH FOLLOWING APPROVAL. WE RESERVE THE RIGHT TO REQUIRE MEDICAL EXAMS.

CONSUMER PRIVACY NOTICE

Information you provide will be treated as confidential. However, we or our reinsurers may make a brief report thereon to the Medical Information Bureau. The Bureau is a non-profit organization of life insurance companies. It operates an information exchange for its members. If a member company to which you have applied for life or health insurance or filed a claim requests, the Bureau will give the company the information in its files.

If you make a request, the Bureau will disclose the information in your file to you. (Medical information will be disclosed only to your attending physician.) If you think the file information is in error, you may contact the Bureau and seek a correction. Correction procedures are set forth in the Federal Fair Credit Reporting Act. The address of the Bureau’s information office is:

Medical Information Bureau
P. O. Box 105
Essex Station
Boston, Massachusetts 02212
Phone: 617—426—3660

We or our reinsurers may also release certain information in our files to other insurers. We may do so if you apply for life or health insurance or file a claim with such other insurers.

In processing your application, and only with your permission, we may cause an investigative consumer report to be prepared. We obtain this information from your neighbors, friends or others with whom you are acquainted. We inquire as to your character, general reputation and mode of living. If an investigative consumer report is prepared in connection with this application, you may request to be interviewed in connection with the preparation of this report. If you would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope, including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon your written request to our Home Office at the below address. You may receive a copy of such report by contacting the reporting agency.

You have the right to obtain access to certain items of information we have collected about you. You further have the right to request correction of information if you feel it is inaccurate, and to know the specific reasons why coverage is not issued.

If you wish to have a more detailed description of our information practices, we will be pleased to furnish this information upon your written request to our Home Office at the below address.

AMERICAN GENERAL ASSURANCE COMPANY
Mortgage Division
1000 Woodfield Road
Schaumburg, Illinois 60173—4793

Additional space for “Yes” answers to medical questions from reverse side.