

The following Notices must be detached and retained by the applicant.

NOTICE OF INFORMATION PRACTICES

The Company wishes to notify you that in processing your application for insurance, a Consumer Investigative Report may be prepared as to the character, general reputation, personal characteristics and/or mode of living of any person to be insured. The information for this report will be obtained through personal interviews with your friends, neighbors and acquaintances.

You have the right to make a written request within a reasonable time period to receive additional information about the nature and scope of this investigation.

(Printed in compliance with Public Law 91-508 and certain privacy protection statutes.)

MIB PRE-NOTICE

Information regarding your insurability will be treated as confidential. The Company, or its reinsurer(s) may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number 866 692 6901 [TTY 866 346 3642]. The Company, or its reinsurer(s), may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

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	\$	\$	
<input type="checkbox"/>	AIG Group CriticalCare Enhanced Plan	\$	\$	Child Face Amount
<input type="checkbox"/>	AIG Group CancerCare Basic Plan	\$	\$	\$
<input type="checkbox"/>	AIG Group CancerCare Enhanced Plan	\$	\$	\$

Coverage Options: (Applicant Only) (Applicant & Spouse) (Applicant & Child(ren)) (Applicant & Family)

(Write spouse's name below if you are applying for Applicant and Spouse or Applicant and Family 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						
CH						
CH						
CH						
CH						

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

Yes	No
<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:

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

 - 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?

3. 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? Yes No
4. If any question answered "YES", please give proposed insured person's name and explain. Please specify condition, date occurred, duration, degree of recovery and name/address of doctor/hospital/clinic. Use a separate sheet if necessary:

Name of Person	Question Number	Date	Duration	Details	Name of Physician or Hospital

Beneficiary * (Please print full name and relationship):

First Name	Initial	Last Name	Relationship

* 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.

ACKNOWLEDGEMENT – AGREEMENT – AUTHORIZE – UNDERSTAND

I, the Primary Proposed Insured (or Spouse signing below), by my signature set forth thereafter: agree to the following: (a) All statements and Answers in this application are complete and true to the best of my knowledge and belief. (b) Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (1) during the lifetime of all proposed insureds; and (2) while there is no change in the insurability and health of such person from that stated in the application (c) No agent has authority to waive any answer or otherwise modify this application or to bind the Company in any way by making any promise or representation which is not set out in writing in this application. **AUTHORIZE:** (a) the Company to obtain an investigative consumer report on me; (b) any consumer reporting agency, employer, Medical Information Bureau("MIB"), or any governmental or other entity possessing non-health-related information concerning me to disclose such information to the Company, its reinsurers, and its legal representative. Any data obtained will be used by the Company to determine eligibility for insurance and will not be released by the persons or organizations who perform business or legal services in connection with my application, and any entity to which release of such data is required by law. I know that I or my authorized representative may request to receive a copy of this Authorization. I agree that a facsimile of this Authorization shall be as valid as the original and that this Authorization shall be valid for the purpose of collecting information in connection with a claim for: (1) two and one-half years from the date shown below for the purpose of collecting information in connection with an application for insurance, (2) the term of coverage of the applied-for-insurance policy, and (3) the duration of a claim for benefits. **ACKNOWLEDGE** receipt of the following notices: (a) "Notice of Information Practices" required by Public Law 91-508 and other information practices statutes; (b) MIB Pre-Notice; (c) Investigative Consumer Report; and (d) Outline of Coverage, if applicable. **UNDERSTAND** that" (a) I am applying for a critical illness policy and not a major medical insurance policy; and (b) If I am a Medicaid recipient, any policy benefits paid may reduce any Medicaid benefits otherwise payable

PRIMARY PROPOSED INSURED – If an investigative consumer report is prepared in connection with this Application:

- I elect to be interviewed. I elect NOT to be interviewed.

SPOUSE– If an investigative consumer report is prepared in connection with this application:

- I elect to be interviewed. I elect NOT to be interviewed.

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.