

American General Life Insurance Company of Delaware*
Wilmington, Delaware

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066
Phone: 1-877-672-1648 Fax: 1-877-672-1650

*This company does not solicit business in New York.

PLEASE PRINT OR TYPE ALL INFORMATION REQUESTED. COMPLETE IN FULL AND PROVIDE ALL NECESSARY SIGNATURES. SEE NEXT PAGE FOR COMPLETE INSTRUCTIONS.

1. Group Policy No. _____ 2. Issued To _____
NAME OF EMPLOYER

3. Employee's Full Name _____
FIRST MIDDLE LAST

Employee's Date of Birth _____
MO. DAY YR. SOCIAL SECURITY NUMBER

Name of Beneficiary _____ Relationship _____

4. Spouse's Full Name _____
FIRST MIDDLE LAST

Employee's Date of Birth _____
MO. DAY YR. SOCIAL SECURITY NUMBER

Name of Beneficiary _____ Relationship _____

5. Eligible Dependent Children To Be Continued? Yes No If yes, provide date of birth for the youngest covered dependent child _____

6. Employee's Billing Address _____
NUMBER STREET CITY STATE ZIP CODE

7. Date Employee's Employment Terminated _____
MO. DAY YR.

8. Reason For Termination Of Employment _____

9. Please check the group worksite product(s) you wish to continue: Accident Hospital Indemnity
 Critical Illness: Amount \$ _____ Cancer: Amount \$ _____

10. Select One Billing Mode: Annual Semiannual Quarterly

The applicable billing fees are:
Annual = \$20 per bill (\$20 per year)
Semiannual = \$15 per bill (\$30 per year)
Quarterly = \$10 per bill (\$40 per year)

11. Employee Premium \$ _____ Employee & Spouse or Emp. +1 Premium \$ _____
Employee & Child(ren) Premium \$ _____ Family Premium: \$ _____
Amount of Premium Check sent with this request \$ _____

YOUR CHECK TOTALLING THE FIRST FULL PREMIUM FOR EACH INSURED PLUS THE APPROPRIATE BILLING FEE MUST ACCOMPANY THIS REQUEST.

IMPORTANT NOTE: IF THE MASTER GROUP POLICY ENDS, YOUR COVERAGE UNDER THIS CONTINUATION OPTION WILL END.

Signature of Employee _____ Date Signed _____

Signature of Spouse _____ Date Signed _____

THIS SECTION MUST BE COMPLETED BY YOUR EMPLOYER

I verify the following:

Current amount of coverage for Employee \$ _____ Monthly premium \$ _____

Current amount of coverage for Employee & Spouse/Employee +1 \$ _____ Monthly premium \$ _____

Current amount of coverage for Employee & Child(ren) \$ _____ Monthly premium \$ _____

Current amount of coverage for Family \$ _____ Monthly premium \$ _____

Premium is paid through: _____
MO. DAY YR.

INSTRUCTIONS FOR COMPLETING THE REQUEST TO CONTINUE SUPPLEMENTAL MEDICAL PRODUCTS

1. You are eligible to continue your coverage after termination of employment if so stated in your certificate of insurance. Your lawful spouse and eligible dependent children, if insured, are also eligible to continue their coverage, but only if you continue your coverage. You must apply within 30 days of your termination date.
2. Be sure to fill this form out completely and obtain the appropriate signatures. You must obtain a signature from a representative of your employer.
3. Submit a check for the appropriate premium plus the billing fee. If you do not know your premium amount, call your employer and ask for the monthly premium figures. Multiply the total premium by the appropriate months for the mode you are selecting (x12 for annual, x6 for semiannual, x3 for quarterly) and add the billing fee. Your request will not be processed without the appropriate check.
4. You will receive a billing statement as soon as your request is processed.
5. Make your check payable to: **AI Life Insurance Company of New York**
6. Mail this request to: **American General Life Co.**
P.O. Box 30066
Tampa, FL 33630-3066