# American General Life Insurance Company

2727-Allen Parkway, Houston, Texas 77019
(A STOCK COMPANY)
1-800-811-2696

**GUARANTEED RENEWABLE TO THE POLICY EXPIRY DATE, SUBJECT TO: CHANGE IN PREMIUMS BY CLASS; THE POLICY'S TERMINATION PROVISION; AND PAYMENT OF THE MAXIMUM BENEFIT AMOUNT - BENEFITS FOR DIAGNOSIS OF A CRITICAL ILLNESS, AS DEFINED AND LIMITED IN THIS POLICY NONPARTICIPATING**

**THE COMPANY AGREES TO PAY** the benefits described in this Policy, subject to its provisions, exclusions and limitations.

**WE, OUR, COMPANY or US** refers to American General Life Insurance Company.

**YOU** or **YOUR** refers to the Owner of this Policy, which means the Insured unless otherwise stated in the application or later changed.

**LEGAL CONTRACT.** This Policy is a legal contract between You and Us. You should READ THIS CONTRACT CAREFULLY. Refer to DEFINITIONS to understand the meaning of defined words.

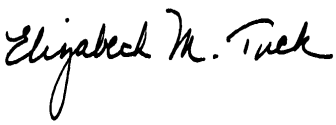
**GUARANTEED RENEWABLE TO THE POLICY EXPIRY DATE, AS SHOWN IN THE POLICY DATA, SUBJECT TO CHANGE IN PREMIUMS BY CLASS.** You may continue the coverage provided by this Policy on each Insured Person by paying all premiums when they are due, until the Policy anniversary on or following the Expiry Date, subject to the Policy's Termination provision and the payment of the Maximum Amount. We will not add any restrictive riders or endorsements while this Policy is in force. We reserve the right to change the premium charged for this Policy. Any change in premium will be made on a class basis only, as We determine, and will be based on the Insured Person's Age on the Date of Issue. No change in premium will become effective until 40 days after We deliver to You, or mail to Your last known address, on Our Home Office records a written notice of premium change.

**TEN DAYS TO EXAMINE POLICY.** You may return this Policy within ten (10) days after delivery, either to Us or to Our authorized agent, if You are not satisfied with it for any reason. The return of this Policy will void it from the Effective Date and any premium paid will be refunded.

**THIS IS A LIMITED BENEFIT POLICY…PLEASE READ IT CAREFULLY**

**Insured** – [John Doe] **Policy Number** – [123456]

**Signed for American General Life Insurance Company at Houston, Texas.**



Secretary

President

**THIS IS A LIMITED BENEFIT POLICY FOR DIAGNOSIS OF DEFINED CRITICAL ILLNESS ONLY AND IT DOES NOT PAY BENEFITS FOR LOSS FROM ANY OTHER CAUSE. PLEASE READ IT CAREFULLY - IT CONTAINS WAITING PERIODS, EXCLUSIONS AND A PREEXISTING CONDITION LIMITATION.**

## CONTENTS OF POLICY



A copy of the application, and any supplemental applications, are included after Page 24.

## POLICY PROVISIONS IN ALPHABETICAL ORDER

**POLICY DATA**

**Insured Person** - [Insured]

| | | | |
|---|---|---|---|
| Insured | [John Doe] | Policy Number | [126T03007] |
| Gender | [Male] | Date of Issue | [January 1, 2005] |
| Premium Class | [Standard-Tobacco] | Age at Issue | [35] |
| Premium Period | [Annual] | Expiry Date* | [January 1, 2015] |

**SCHEDULE OF BENEFITS AND PREMIUMS**

| **Benefits** | **Benefit Amounts** | **Annual Premium** |
|---|---|---|
| Base Policy | [$10,000-$500,000] | [$00.00] |
| Benefit Extension Rider | [$00.00] | [$00.00] |
| Accidental Death & Dismemberment Rider | [$25,000-$150,000] | [$00.00] |
| Medical Personnel HIV Benefit Rider | [$00.00] | [$00.00] |
| Total Annual Premium | | [$00.00] |

Premiums payable other than annually are equal to a percentage of the annual premium and include additional premium charges. You will save money by paying the premium on an annual basis. The first [ANNUAL] premium is [$00.00].

THIS IS A [ANYSTATE] POLICY.

*Coverage may expire prior to the Expiry Date; see the Termination Provision for more details.

**POLICY SCHEDULE**

**CRITICAL ILLNESS DIAGNOSIS BENEFITS**

**CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT***

| | |
|---|---|
| **INSURED** | **[$10,000-$100,000]** |
| **[INSURED SPOUSE]** | **[$10,000-$500,000]** |
| **[INSURED CHILD]** | **[$10,000-$50,000, not to exceed Insured's Amount]** |

**There is NO coverage for a Critical Illness that is initially Incurred, Manifested and/or Diagnosed before the end of the Waiting Period. There is NO coverage for Loss Of Independent Living, if an Insured Person initially Incurred and/or was Diagnosed with permanent loss of two or more Activities of Daily Living before the end of the Waiting Period.**

**The Waiting Period begins on the Effective Date and continues for the number of days stated below:**

| | |
|---|---|
| **Waiting Period** | **30 days for all Critical Illness, except for Invasive Cancer and In Situ Cancer.**<br>**90 days for Invasive Cancer and In Situ Cancer.** |

| **CRITICAL ILLNESS DIAGNOSIS** | **CRITICAL ILLNESS MAXIMUM BENEFIT PERCENTAGE** |
|---|---|
| [Invasive Cancer | 100%] |
| [Heart Attack | 100%] |
| [Kidney (Renal) Failure | 100%] |
| [Stroke | 100%] |
| [Coma | 100%] |
| [Coronary Artery Bypass | 25% of the Maximum Benefit Amount, or $50,000 whichever is less] |

***Any Benefits for Coronary Artery Bypass are payable only once per lifetime, per Insured Person.***

| | |
|---|---|
| [Major Organ Transplant | 100%] |

[Paralysis/Paralyzed

***Any Benefits for the following types of Paralysis/Paralyzed are payable only once per lifetime, per Insured Person.***

| | |
|---|---|
| Quadriplegia | 100% |
| Paraplegia | 50% |
| Hemiplegia | 50%] |
| [Severe Burn | 100%] |
| [Loss of Sight, Speech or Hearing | 100%] |
| [In Situ Cancer | 25% of the Maximum Benefit Amount, or $25,000 whichever is less] |

***Any Benefits for In Situ Cancer are payable only once per lifetime, per Insured Person.***

| | |
|---|---|
| **Loss of Independent Living** | [100%] |

**Elimination Period – [180 days]**

**PREVENTATIVE CARE BENEFITS**

| | |
|---|---|
| Health Screening Tests | **NOT** to exceed a total of $50.00, per Insured Person, Per Calendar Year. There is no Waiting Period for this Benefit. |
| **RETURN OF PREMIUM UPON THE DEATH OF THE INSURED** | **Total Premium Paid – less any benefits previously paid under policy** |

* Coverage may expire prior to the Expiry Date; see the TERMINATION provision for more details.

## DEFINITIONS

**ACTIVITIES OF DAILY LIVING** mean the following self-care functions: (1) bathing: washing in either a tub or shower, including the task of getting into or out of the tub or shower without the assistance of another person; (2) dressing: putting on or taking off all items of clothing and any necessary braces, fasteners or artificial limbs without the assistance of another person; (3) toileting: getting on and off the toilet and performing associated personal hygiene without the assistance of other person; (4) transferring: moving onto or out of a bed, chair, or wheelchair without the assistance of another person; (5) continence: the ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel or bladder functions, the ability to perform the associated personal hygiene (including caring for catheter or colostomy bag) without the assistance of another person; or (6) eating: feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table) or a feeding tube, or intravenously without the assistance of another person.

**AGE** means the attained age as of the last birthday.

**CALENDAR YEAR** means the period from January 1 through December 31.

**CRITICAL ILLNESS** means only the illnesses listed in the Policy Schedule. See the Critical Illness Diagnosis Benefits Provision for definitions, exclusions and limitations.

**DIAGNOSED/DIAGNOSIS/DIAGNOSTIC** means a definitive diagnosis made by a Physician (where applicable, specializing in a particular area of medicine):

(a) based upon the use of diagnostic evaluations, clinical and/or laboratory investigations, tests and observations; and the results must be documented in and supported by the Insured Person's medical records; and

(b) meeting any Diagnostic Requirements stated in this Policy for the particular Critical Illness being Diagnosed.

**ELIMINATION PERIOD** means the number of consecutive days shown on the Policy Schedule during which the Insured Person must be prevented from performing two or more Activities of Daily Living. The Elimination Period begins after the end of the Waiting Period.

**EXPIRY DATE** means the period of time the Insured elects for coverage, as shown in the Application, subject to the Termination provision.

**IMMEDIATE FAMILY MEMBER** means a person who is related to the Insured in any of the following ways: spouse; child (including a legally adopted child, or stepchild-providing a biological parent is also covered; son-in-law; and daughter-in-law); parents, (includes stepparent, mother-in-law, and father-in-law); and brother or sister (including stepbrother, or stepsister, brother-in-law, and sister-in-law).

**INCURS/INCURRED** means an event or incident that:

(a) initially occurs on or after the date coverage on an Insured Person becomes effective under this Policy; and

(b) initially occurs while coverage on an Insured Person under this Policy is in force; and

(c) is not excluded by any specific description or exclusion stated in this Policy.

**INSURED** means the person named as "Insured" in the Policy Data.

**INSURED PERSON** means the Insured and any Insured Spouse or Insured Child indicated as an Insured Person in the Policy Data. An Insured Spouse will become the Insured upon the death or termination of coverage on the person otherwise named as Insured in the Policy Data.

**LOSS OF INDEPENDENT LIVING** means an Insured Person is permanently unable to perform two or more of the six activities of Daily Living.

**MANIFESTS/MANIFESTED/MANIFESTATION** means a condition or symptom that would initially cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment:

(a) on or after the date coverage on an Insured Person becomes effective under this Policy; and

(b) while coverage on an Insured Person under this Policy is in force; and

(c) that is not excluded by any specific description or exclusion stated in this Policy.

**MEDICALLY RELATED** means a successive Critical Illness stated in the Policy Schedule that: (a) results from the same or related organic, pathological, or physiological causes, conditions, or symptoms as a previous Critical Illness; and (b) is Incurred or Manifests more than 180 days after the previous Critical Illness ended. A successive Critical Illness that is NOT Medically Related to previous Critical Illness must be Diagnosed by a Physician.

**MONTH** means calendar month.

**PHYSICIAN** means a person who:

(a) is a legally qualified practitioner of the healing arts licensed in the United States or its territories; by a federal, state, or territorial licensing authority for such practitioners; and

(b) practices within the scope of his or her license in the United States or its territories; and

(c) is not the Insured Person; and

(d) is not the Insured Person's Immediate Family Member; and

(e) does not customarily reside in the same household as the Insured Person.

**PREEXISTING CONDITION** means:

(a) the existence of a condition or symptom that would cause an ordinary prudent person to seek Diagnosis, medical advice, care, attention or treatment within the two (2) year period before the date coverage on the Insured Person becomes effective under this Policy; or

(b) a condition or symptom for which medical advice, care, attention or treatment was recommended by a Physician or received from a Physician within the two (2) year period before the date coverage on the Insured Person becomes effective under this Policy.

**TRANSIENT ISCHEMIC ATTACK (TIA):** A neurological condition or event with the signs and symptoms of a stroke, but which disappear clinically within a twenty-four hour period no residual signs, symptoms, deficits, or abnormalities that are revealed or shown on neuroimaging studies.

**YEAR** means a consecutive 365-day period.

## CRITICAL ILLNESS DIAGNOSIS

We will pay the Critical Illness Maximum Benefit Percentage stated in the Policy Schedule (subject to all applicable Policy provisions), if a Critical Illness is both initially Incurred (or Manifests, as stated in the Policy), and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective, or for Invasive and In Situ Cancer, 90 days after the date coverage on the Insured Person becomes effective.

## BENEFITS

### CRITICAL ILLNESS MAXIMUM BENEFIT AMOUNT

The Critical Illness Maximum Benefit Amount for all Critical Illnesses for each Insured Person is as stated in the Policy Schedule.

### BENEFIT PAYMENT CONDITIONS

The payment of benefits for a Critical Illness stated in the Policy Schedule is subject to the following conditions:

(a) the Critical Illness initially Incurs and/or Manifests as stated in the Policy; and

(b) the Critical Illness is initially Diagnosed while the coverage on an Insured Person is effective under this Policy; and

(c) the Critical Illness is Diagnosed within the United States or its territories; and

(d) the benefit payment is not excluded by any general or specific exclusion or limitation.

## CRITICAL ILLNESS DIAGNOSIS BENEFITS

### INVASIVE CANCER

**INVASIVE CANCER. If the words "Invasive Cancer" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO Benefits for this illness.**

**INVASIVE CANCER** means the presence of a malignant tumor characterized by the uncontrolled growth and spread of malignant cells and the invasion of tumor.

*For the purpose of this definition, Invasive Cancer does NOT include:*

(a) any carcinoma in situ lesion regardless of origin, classified as $TisN_0M_0$;

(b) any $T_1N_0M_0$ lesion treated by endoscopic procedures;

(c) Melanoma, $T_1N_0M_0$ with maximum Breslow thickness of less or equal to 1.0mm; or Prostate cancer $T_1bN_0M_0$.

**INVASIVE CANCER BENEFIT**

If Invasive Cancer initially both Manifests and is Diagnosed more than 90 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Maximum Benefit Percentage.

This Critical Illness must not have Manifested itself and/or been Diagnosed within the first 90 days after the date coverage on the Insured Person becomes effective under this Policy.

**DIAGNOSTIC REQUIREMENTS FOR INVASIVE CANCER**

Invasive Cancer must be Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on a microscopic examination of fixed tissues or preparations from the hemic system. Such Diagnosis shall be based solely on the accepted criteria of malignancy after a study of the histocytologic architecture or pattern of the suspected tumor, tissue, and/or specimen. Clinical diagnosis of Invasive Cancer will be accepted as evidence that Invasive Cancer exists when a pathological diagnosis cannot be made, provided the medical evidence substantially documents the clinical diagnosis of Invasive Cancer and the Insured Person receives treatment for Invasive Cancer.

## HEART ATTACK

**HEART ATTACK. If the words "Heart Attack" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**HEART ATTACK** means the death of a portion of the heart muscle because of inadequate cardiac blood supply to the relevant area.

**HEART ATTACK BENEFIT**

If a Heart Attack initially both Incurs and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the applicable Critical Illness Maximum Benefit Percentage.

This Critical Illness must not have Manifested itself and/or been Diagnosed within the first 30 days following the date coverage on the Insured Person becomes effective under this Policy.

**DIAGNOSTIC REQUIREMENTS FOR HEART ATTACK**

This Diagnosis must be supported by three or more of the following five criteria which are consistent with a new Heart Attack:

(a) typical clinical presentation; and

(b) new electrocardiographic (EKG) changes consistent with acute myocardial infarction; and

(c) serial measurements of cardiac biomarkers showing a pattern and a level consistent with a heart attack.

## KIDNEY (RENAL) FAILURE

**KIDNEY FAILURE. If the words "Kidney (Renal) Failure" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**KIDNEY (RENAL) FAILURE** means the end stage failure which:

(a) presents a chronic irreversible failure of both kidneys as described below; and

(b) requires treatment by renal dialysis or kidney transplant.

**KIDNEY (RENAL) FAILURE BENEFIT**

If Kidney (Renal) Failure initially both Manifests and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage.

This Critical Illness must not have Manifested itself and/or been Diagnosed within the first 30 days following the date coverage on the Insured Person becomes effective under this Policy.

**DIAGNOSTIC REQUIREMENTS FOR KIDNEY (RENAL) FAILURE**

The Diagnosis of Kidney (Renal) Failure must be based on the chronic irreversible failure of the function of both kidneys, requiring regular dialysis or kidney transplant.

## STROKE

**STROKE. If the word "Stroke" is NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**STROKE** means a cerebrovascular incident caused by infarction of brain tissue, cerebral or subarachnoid hemorrhage, cerebral embolism or cerebral thrombosis. This diagnosis must be supported by all of the following conditions:

(a) evidence of permanent neurological damage at least 6 weeks after the event; and

(b) findings on Magnetic Resonance Imaging, Computerized Tomography, or other reliable imaging techniques consistent with the diagnosis of a new stroke.

*For the purpose of this definition, Stroke does **NOT** mean:*

(a) Transient Ischemic Attacks (TIAs); or

(b) Brain damage due to accident or injury, infection, vasculities, and inflammatory disease, a demylenating process; or

(c) Vascular disease affecting the eye or optic nerve; or

(d) Ischemic disorders of the vestibular system.

**STROKE BENEFIT**

If a Stroke is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage.

**DIAGNOSTIC REQUIREMENTS FOR STROKE**

The Diagnosis of Stroke must be made by a neurologist based on documented neurological deficits and confirmatory neuroimaging studies.

## COMA

**COMA. If the word "Coma" is NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**COMA/COMATOSE** means a profound state of unconsciousness from which the Insured Person cannot be aroused to consciousness, and in which stimulation will produce no more than primitive avoidance reflexes, which lasts for a period of at least 96 hours.

**COMA BENEFIT**

If a Coma is both initially Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage.

**DIAGNOSTIC REQUIREMENTS FOR COMA**

The Diagnosis of Coma must be documented by evidence of a neurological deficit that is expected to last for a continuous 12-month period or longer from the date of the Diagnosis to determine Coma.

## CORONARY ARTERY BYPASS

**CORONARY ARTERY BYPASS**. **If the words "Coronary Artery Bypass" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**CORONARY ARTERY BYPASS** means the use of a non-coronary blood vessel or blood vessels (either artery or vein) to surgically bypass obstructions in a native coronary artery or arteries.

**CORONARY ARTERY BYPASS BENEFIT**

We will pay the Critical Illness Benefit if more than 30 days after the date coverage on the Insured Person becomes effective under this Policy both:

(a) the need for a Coronary Artery Bypass is first Diagnosed; and

(b) the Insured Person undergoes a Coronary Artery Bypass.

***We will pay this benefit once per lifetime per Insured Person.***

An illness that does not require surgery but requires a medical procedure such as balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedures is NOT covered.

**DIAGNOSTIC REQUIREMENTS FOR CORONARY ARTERY BYPASS**

The Diagnosis of the need for a Coronary Artery Bypass must be made by a cardiologist based on angiographic evidence of the underlying disease.

## MAJOR ORGAN TRANSPLANT

**MAJOR ORGAN TRANSPLANT. If the words "Major Organ Transplant" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**MAJOR ORGAN TRANSPLANT** means having undergone surgery as a recipient of a transplant as follows:

(a) human bone marrow using haematopoietic stem cells preceded by total bone marrow ablation; or

(b) whole human organs limited to: heart, lung, liver, or pancreas because of the irreversible end stage failure of such organ.

*For the purpose of this definition, Major Organ Transplant does **NOT** mean:*

(a) other stem cell transplant; or

(b) part of an organ transplant or any other whole organ not listed above.

**MAJOR ORGAN TRANSPLANT BENEFIT**

We will pay the Critical Illness Maximum Benefit Percentage, if more than 30 days after the date coverage on the Insured Person becomes effective under this Policy both:

(a) the need for a Major Organ Transplant is first Diagnosed; and

(b) the Insured Person undergoes a Major Organ Transplant.

## PARALYSIS/PARALYZED

**PARALYSIS/PARALYZED. If the words "Paralysis/Paralyzed" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**PARALYSIS/PARALYZED** means quadriplegia, paraplegia, or hemiplegia that is expected to last for a continuous 12-month period or longer from the date of the Diagnosis to determine if Paralysis is permanent. "Quadriplegia" means the complete and irreversible Paralysis of both upper and lower limbs. "Paraplegia" means the complete and irreversible Paralysis of both lower limbs. "Hemiplegia" means the complete and irreversible Paralysis of the upper and lower limbs of the same side of the body. "Limb" means entire arm or an entire leg.

**PARALYSIS BENEFIT**

If Paralysis is both initially Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage. ***We will pay this benefit once per lifetime per Insured Person.***

If an Insured Person is Diagnosed with more than one type of Paralysis, only the largest benefit amount for the separate types of Paralysis will be paid.

***We will NOT pay any benefit for a Paralysis that results from psychiatric related causes.***

**DIAGNOSTIC REQUIREMENTS FOR PARALYSIS**

The Diagnosis of Paralysis must be based on documented evidence of the illness or injury that caused the Paralysis.

## SEVERE BURN

**SEVERE BURN. If the words "Severe Burn" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**SEVERE BURN** means the cosmetic disfigurement of body surface or area that is a full-thickness or third-degree burn covering at least 20% of the body surface.

**SEVERE BURN BENEFIT**

If a Severe Burn is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage.

## LOSS of SIGHT, SPEECH, or HEARING

**LOSS OF SIGHT, SPEECH, OR HEARING. If the words "Loss of Sight, Speech or Hearing" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits for this illness.**

**LOSS OF SIGHT, SPEECH, OR HEARING** means the irreversible loss of sight in both eyes as described below, the irreversible loss of the ability to speak as described below, or the irreversible loss of hearing for all sounds in both ears as described below.

**LOSS OF SIGHT, SPEECH, OR HEARING BENEFIT**

If a Loss of Sight, Speech, or Hearing is initially both Incurred and is Diagnosed more than 30 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage.

***We will NOT pay any benefit for a Loss of Sight, Speech, or Hearing that results from psychiatric related causes.***

**DIAGNOSTIC REQUIREMENTS FOR LOSS OF SIGHT, SPEECH, OR HEARING**

The Diagnosis of Loss of Sight, Speech, or Hearing must be made by a licensed professional or specialist in the applicable field of medicine. The Diagnosis of Loss of Sight must indicate that corrective visual acuity is greater than 20/200 in both eyes or the field of vision is less than 20 degrees in both eyes. The Diagnosis of Loss of Speech must include documented evidence of the illness, which results in the loss of the ability to communicate orally for the continuous 12-month period prior to the Diagnosis. The Diagnosis of Loss of Hearing must be established by an audiometric and auditory threshold test. The auditory threshold cannot be more than 90 decibels while utilizing a hearing aid.

**IN SITU CANCER BENEFIT**

If In Situ Cancer initially both Manifests and is Diagnosed more than 90 days after the date coverage on the Insured Person becomes effective under this Policy, We will pay the Critical Illness Maximum Benefit Percentage not to exceed $25,000. ***We will pay this benefit once per lifetime per Insured Person.***

**DIAGNOSTIC REQUIREMENTS FOR IN SITU CANCER**

In Situ Cancer must be Diagnosed by a Physician certified to practice pathological anatomy or osteopathic pathology and must be based on a microscopic examination of fixed tissues or preparations from the hemic system. ***A clinical diagnosis alone does not meet the requirements of this provision.***

## LOSS OF INDEPENDENT LIVING

**LOSS OF INDEPENDENT LIVING. If the words "Loss Of Independent Living" are NOT listed under "Critical Illness Diagnosis" in the Policy Schedule, this provision does not apply and We will pay NO benefits.**

**LOSS OF INDEPENDENT LIVING BENEFIT**

If an Insured Person both initially Incurred and was Diagnosed with permanent loss of two or more Activities of Daily Living after the Waiting Period, We will pay any remaining amount of the Critical Illness Maximum Benefit Percentage, if we receive proof that such permanent loss continues after the end of the Elimination Period.

There is NO coverage for Loss of Independent Living, if the Insured Person initially Incurred or was Diagnosed with permanent loss of two or more Activities of Daily Living before the end of the Waiting Period.

Loss of two or more Activities of Daily Living must be diagnosed by a Physician and expected by such Physician to be permanent. An Insured Person must also be under the regular and appropriate care of a Physician.

## DIAGNOSTIC REQUIREMENTS

**ALL CRITICAL ILLNESSES**

We reserve the right to require that a physical examination of the Insured Person and/or the review of any Critical Illness Diagnosis by a Physician of Our choice in the United States at Our expense. Such Physician must:

(a) have specialty training and board certification in the field of Medicine specific to the Critical Illness being Diagnosed; and

(b) must follow all standardly accepted procedures and protocols in the Diagnosis of the Critical Illness.

We will not pay for any travel or other expenses of the Insured Person related to any such examination. We reserve the right to select an independent and acknowledged expert in the applicable field of medicine to review the evidence used in making any disputed Critical Illness Diagnosis. Such expert's opinion regarding the disputed Critical Illness Diagnosis shall be binding on both You and the Company.

## PREVENTIVE CARE BENEFIT

If an Insured Person undergoes any of the health screening tests listed below while covered by this Policy, We will pay up to the Preventive Care Benefit stated in the Policy Schedule.

***Payment of this benefit does not reduce the Critical Illness Maximum Benefit Amount provided by this Policy for any covered Critical Illness.***

### HEALTH SCREENING TESTS

*Tests are limited to:*

(a) Blood test for triglycerides;

(b) Breast ultrasound;

(c) Chest X-ray;

(d) Colonoscopy;

(e) Electrocardiogram;

(f) Fasting blood glucose test;

(g) Flexible sigmoidoscopy;

(h) Hemocult stool analysis;

(i) Mammography;

(j) Pap test;

(k) PSA (blood test for prostate cancer);

(l) Serum cholesterol test to determine level of HDL and LDL;

(m) Serum Protein Electrophoresis (blood test for myeloma); and

(n) Stress test on a bicycle or treadmill.

## RETURN OF PREMIUM UPON DEATH OF THE INSURED

If the Insured dies while this Policy is in force, We will return to the Owner, or to the Owner's Beneficiary if the Owner is deceased or to the Owner's estate if there is no surviving Beneficiary, 100% of all premiums paid for this Policy and any attached Riders, less any benefits paid under this Policy and any attached Riders. The premiums to be returned will be calculated without interest and after all pending claims have been settled. If the sum of all Benefits paid under this Policy and applicable Riders is equal to or greater than the sum of the Premiums paid, there will be no return of premiums.

## EXCLUSIONS

### EXCLUSIONS

For any Insured Person:

(a) We will pay NO benefits for any Critical Illness that is Incurred or Manifests, whichever is applicable as stated in this Policy, and/or Diagnosed before the first 30 days after the date coverage on the Insured Person becomes effective under this Policy, or for Invasive or In Situ Cancer, before the end of the first 90 days after the date coverage on the Insured Person becomes effective under this Policy. However, an Insured Child born after the Effective Date of this Policy or any subsequent reinstatement will be covered from birth for the Critical Illnesses stated in the Policy Schedule.

(b) There is a 180-day waiting period between Diagnosed Critical Illnesses that are Medically Related. During this period, We will pay NO benefits under this Policy if Diagnosed Critical Illnesses are Medically Related.

(c) We will pay NO benefits for any Critical Illness or any loss caused in whole or in part by, or resulting in whole or in part from the following:

(i) the Insured Person's attempt at suicide, or intentional self-inflicted injury or sickness, while sane or insane; or

(ii) the Insured Person being under the influence of an excitant, depressant, hallucinogen, narcotic; or any other drug or intoxicant including those prescribed by a Physician that are misused by the Insured Person; or

(iii) the Insured Person's commission of or attempt to commit an assault or a felony; or

(iv) the Insured Person engaging in an illegal activity or occupation; or

(v) the Insured Person's voluntary participation in any riot or civil insurrection; or

(vi) any illness, loss, or condition specifically excluded from the definition of any Critical Illness; or

(vii) war, or any act of war, whether declared or not; or

(viii) balloon angioplasty, laser relief of an obstruction, and/or other intra-arterial procedure; or

(ix) the Insured Person practicing for or participating in any semi-professional or professional competitive athletic contest for which compensation or remuneration is paid or received.

**PREEXISTING CONDITION LIMITATION**

We will pay **NO** benefits for Critical Illness that are caused by a Preexisting Condition unless the Critical Illness commences after this Policy has been in force for two (2) years from the Effective Date or most recent reinstatement date. Preexisting Conditions are subject to the Incontestable Provision.

## PREMIUMS

This Policy is effective for an initial term of one Premium Period as stated in the Policy Data. It may be renewed by the timely payment of the renewal premium. The first premium is due on or before the Effective Date. Each renewal premium is due at the expiration of the period for which the preceding premium was paid. Each renewal premium must be paid on or before its due date, or within the Grace Period. You may pay premiums at Our Home Office. You may, by written request to Us, change the Premium Period, subject to Our rules at the time of Your request.

**GRACE PERIOD**

If a premium, other than the first, is not paid on its due date, Your Policy will remain in force for a period of 31 days from the premium due date.

**LAPSE**

If any premium is not paid before the end of the Grace Period, Your Policy will lapse. The date of lapse will be the date on which the unpaid premium was due. ***Your Policy will terminate upon lapse and provide NO further benefits*****.**

**REINSTATEMENT**

If Your Policy lapses, You may request to reinstate it by:

(a) submitting a written request for reinstatement within 60 days after the end of the Grace Period;

(b) providing evidence of insurability as We may require; and

(c) paying any required premium.

If We approve Your request for reinstatement, coverage will become effective on the same date of the month on which this Policy was issued, but in the Month that follows Our approval of Your request for reinstatement.

We will pay **NO** benefits for any Critical Illness that Incurs or Manifests, whichever is applicable as stated in this Policy, and/or is Diagnosed:

(a) before the end of 30 days after the date coverage on the Insured Person becomes effective under this Policy due to reinstatement; or

(b) for Invasive and In Situ Cancer, before the end of 90 days after the date coverage on the Insured Person becomes effective under this Policy due to reinstatement.

However, an Insured Child born after the Effective Date of this Policy or any subsequent reinstatement will be covered from birth for the Critical Illnesses stated in the Policy Schedule.

Subject to the Reinstatement and Incontestable provisions, Your rights and Our obligations under this Policy will be the same as before the Policy lapsed.

If You do not request a reinstatement within 60 days from the date any unpaid premium was due, no further benefits will be provided by Your Policy, and after the stated time, You may be required to apply for a new Policy.

**UNEARNED PREMIUM REFUND**

If the Insured or the Insured Spouse, if covered under this Policy, dies before the end of a Premium Period for which premium has been paid, We will refund the portion of premium that was applied to coverage for the decedent for the time period beyond the end of the Month in which death occurred.

## CLAIMS

**NOTICE OF CLAIM**

You must provide to Us written notice of loss within 60 days from the date of loss or as soon as reasonably possible, but in no event more than 180 days thereafter. You may provide notice of loss at Our Home Office. Your notice should include Your name and Policy Number as shown in the Policy Data.

**CLAIM FORMS**

When We receive Your notice of loss, We will send You the forms required to file a claim. If the forms are not sent within 15 days, You will have met the time frame for filing proof of loss if You have provided to Us a written statement of the nature and extent of Your loss within the time allowed for filing a proof of loss.

**PROOF OF LOSS**

You must provide to Us, at Your expense, a written proof of loss determined to be satisfactory to Us within 90 days from the date of loss. If it is not reasonably possible for You to provide such written proof of loss within the stated time, Your claim will not be affected if You provide such written proof of loss as soon as reasonably possible. However, unless You are legally incapacitated, You must file a written proof of loss no later than 15 months from the date of loss.

You must provide to Us any authorizations necessary to obtain medical or other records to verify Critical Illness.

**TIME OF PAYMENT OF CLAIMS**

We will pay benefits, upon receipt of written proof of loss determined to be satisfactory by Us.

**PAYMENT OF CLAIMS**

Except as described in the Medicaid Eligibility provision, all benefits becoming payable will be paid to You or to Your designated beneficiary in the event of Your death, unless You have assigned the benefits. If We have recorded, at Our Home Office, Your written assignment of benefits, either before or with Your written proof of loss, We can pay all or part of any benefit to a hospital or person that provided medical care or treatment.

If any Benefits are payable to Your estate or to a person who is without legal capacity, We can pay up to $1,000 of Benefits to any relative by blood or connection by marriage whom We determine is entitled to payment. Such payment will discharge Our liability for that payment.

**ASSIGNMENT**

You may assign the benefits payable under this Policy. Your rights and those of any other person referred to in this Policy will be subject to the assignment. We are not bound by an assignment unless it is in writing and until a duplicate of the original assignment has been filed at Our Home Office. We assume no responsibility regarding the validity of any assignment.

**UNPAID PREMIUMS**

We will deduct any premium due from any benefits that becomes payable under this Policy.

**PHYSICAL EXAMINATION AND AUTOPSY**

At Our expense We can require:

(a) a physical examination on an Insured Person by a Physician of Our choice in the United States, as often as We deem necessary while a claim is pending. We will not pay for any travel or other expenses of the Insured Person related to such examination; or

(b) an autopsy to be performed after an Insured Person's death, if allowed by law or if this Policy was not issued for delivery in the State of Mississippi.

No benefit under this Policy will be paid until such examination, or autopsy as allowed by law, is conducted from which We receive written proof of loss determined to be satisfactory by Us.

**LEGAL ACTIONS**

No legal action may be brought to recover any benefits provided by this Policy until 60 days after the date We receive written proof of loss. No action may be brought after three (3) years from the date written proof must have been provided.

## GENERAL PROVISIONS

**ENTIRE CONTRACT**

This Policy, riders, endorsements and the attached application and any application for reinstatement are the entire contract. This contract is made in consideration of the application and the payment of premiums as required. We rely on all statements in the application and any application for reinstatement as being and true to the best of the knowledge and belief of the person signing the application.

**AGENT'S AUTHORITY**

No change to this Policy will be valid unless it is in writing and signed by one of Our officers at Our Home Office. No agent or other representative has authority to change or waive any Policy provision or extend the time for paying a premium.

**AGE AND GENDER**

If an Insured Person's Age or Gender is not correct as shown in this Policy, all benefits payable under this Policy will be such as the premium paid would have purchased at the correct Age or Gender. If the correct Age is such that We would not have issued this Policy or an Insured Person's coverage under this Policy would have terminated, We will only be liable for a refund of any premiums paid for the period for which there was no coverage.

**INCONTESTABLE**

After this Policy has been in force for a period of two years during the lifetime of the Insured Person, it shall become incontestable as to the statements contained in the application, except for any fraudulent misrepresentation. After this Policy has been in force for a period of two years during the lifetime of the Insured Person following any reinstatement, it shall become incontestable as to the statements contained in any application for reinstatement, except for any fraudulent misrepresentation. After this Policy has been in force for a period of two years during the lifetime of the Insured Person following any additional coverage for an Insured Spouse or Insured Child added by rider after this Policy is issued, it shall become incontestable as to the statements contained in any such supplemental application, except for any fraudulent misrepresentation.

**EFFECTIVE DATE**

This Policy's Effective Date is the Date of Issue shown on the Policy Data. This Policy will take effect at 12:01 AM (Central Time) on the Effective Date and will terminate at 11:59 PM (Central Time) on the date provided for termination. If this Policy lapses and is reinstated, the Effective Date is as described in the Reinstatement Provision. The Effective Date for any rider adding coverage for an Insured Spouse or Insured Child after this Policy is issued will be as described in that rider.

**TERMINATION**

Coverage for each Insured Person will terminate on the earlier of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that 100% of the Critical Illness Maximum Benefit Amount is paid for that Insured Person; or

(c) the next policy anniversary date following the attainment of age 70, for all benefits, except the Loss of Independent Living; or

(d) the maximum age for an Insured Child, as shown in the Insured Child provision; or

(e) the Expiry Date.

This Policy can be continued for any remaining Insured Persons, after coverage has been terminated for an Insured Person. Subsequent premiums will be recalculated to reflect the remaining Insured Persons' current coverage and their original age on the Date of Issue of this Policy. The termination of coverage on an Insured Person will not reduce Our liability for any claim originating prior to the termination.

This Policy will terminate on the earliest of:

(a) the date on which this Policy lapses or terminates; or

(b) the date that 100% of the Critical Illness Maximum Benefit Amount is paid for the Insured and any Insured Spouse; or

(c) any premium due date requested by You in writing to terminate this Policy; or

(d) the end of the Grace Period following the due date for which a premium was not paid; or

(e) the death of the Insured, unless the Insured Spouse, if any, elects to continue this Policy; or

(f) the death of the Insured Spouse who continued this Policy after the death of the Insured; or

(g) the date the Insured Person becomes covered by a separate Critical Illness policy issued by Us; or

(h) the Expiry Date.

**OWNER**

The Insured is the Owner of this Policy unless later changed.

As Owner, You may exercise all rights in this Policy while the Insured Person is living. If You are without legal capacity, We will allow Your rights to be exercised by:

(a) a legally appointed Guardian responsible for Your property; or

(b) a person who We determine is responsible for Your welfare and support.

To exercise Your rights, You must follow the procedures stated in this Policy. All elections, designations, changes and requests must be made in writing and in a form acceptable to Us.

If You change Your beneficiary, address, or request any other action by Us, You should do so on the form prepared for each purpose. You may obtain such forms from Our Home Office.

**BENEFICIARY**

The beneficiary designated by You in the application or later changed on Our records will receive any benefits unpaid at Your death. Each beneficiary is classified as a Primary or Contingent Beneficiary. All surviving beneficiaries of the same class will share equally in any payments to that class, unless otherwise designated by You.

If no stated beneficiary is living at the time of Your Death, We will pay:

(a) the executor or administrator of Your estate; or

(b) Your spouse, child, or parent who We determine is entitled to payment.

**CHANGE OF OWNER OR BENEFICIARY**

While the Insured Person is living, You may change:

(a) the Owner; or

(b) a Beneficiary designation, if it is not restricted by a previous designation.

We can require that any change be endorsed on Your Policy. Any change will be effective as of the date Your change request was signed, except that it will not apply to any payment We make or any action We take before We record or acknowledge Your request in Our Home Office.

**MEDICAID ELIGIBILITY**

The Insured Person's current or future eligibility for Medicaid may affect the payment of benefits provided by this Policy. When Medicaid is involved it is possible that the benefits will not be paid directly to You, because of state regulations and/or federal regulations that may require payments to the Medicaid organization or to the medical provider.

**CONFORMITY WITH STATE STATUTES**

Any provision that conflicts with any laws of the state where You lived, when this Policy was issued, is amended to conform with that law.

**NONPARTICIPATION**

This Policy does not participate in surplus, and its premiums does not include a charge for participation in surplus.

**TAX CONSEQUENCES**

Benefits paid under this Policy may be taxable. If so, You or Your Beneficiary may incur tax obligation. As with all tax matters, You should consult Your personal tax advisor for more information about how this may affect You.

## FAMILY COVERAGE

**INSURED SPOUSE**

**If the words "Insured Spouse" are NOT shown as an "Insured Person" in the Policy Data and the Policy Schedule, this provision does not apply and We will pay NO benefits for Your spouse.**

An **Insured Spouse** means only the Insured's spouse named in the application for this Policy.

Any coverage on an Insured Spouse will terminate according to the "Termination" provision. The termination of coverage on the Insured Spouse will not reduce any liability We may have under this Policy for any claim originating prior to the termination of such coverage.

If this Policy is in force and the Insured dies, the Insured Spouse may continue this Policy by payment of the required premiums when they are due. The following conditions will apply:

(a) the Insured Spouse will become the Insured under this Policy; and

(b) subsequent premiums will be based on the Insured Spouse's Age on the Date of Issue of this Policy.

If this Policy is in force and the Insured Spouse dies, We will reduce the subsequent premium.

If this Policy is in force and the Insured's marriage to the Insured Spouse is terminated by a divorce decree, the Insured Spouse may obtain a separate Critical Illness policy, subject to the Conversion Privilege provision below.

Coverage provided on any Insured Person by this Policy cannot be continued if the Insured Person is subsequently covered by a separate Critical Illness policy issued by Us. Coverage on any Insured Person provided by this Policy ceases when coverage on such Insured Person becomes effective under a separate Critical Illness policy issued by Us.

**INSURED CHILD**

**If the words "Insured Child" are NOT shown as an "Insured Person" in the Policy Data, and the Policy Schedule, this provision does not apply and We will pay NO benefits for Your child.**

An **Insured Child** under this Policy is the Insured's child (biological child, legally adopted child, or stepchild) who is unmarried and dependent on the Insured, and is:

(a) named in the application and is less than 18 years of Age on the date of application; or

(b) born after the Effective Date of this Policy, and the Insured is named as parent on the child's birth certificate; or

(c) legally adopted by the Insured after the Effective Date of this Policy and before the child's 18th birthday.

Coverage on any Insured Child will terminate on the earlier of:

(a) the date this Policy lapses or terminates; or

(b) the premium due date following the Insured Child's 18th birthday unless:

  (i) the Insured Child remains an unmarried dependent on the Insured; and

  (ii) the Insured Child is either enrolled as a fulltime student in high school or in an institution of higher learning beyond high school, or has been so enrolled for at least five months of each year since his or her 18th birthday, or is eligible to enroll in such an institution but is prevented from enrolling due to illness or injury; or

(c) the premium due date after the Insured Child's 25th birthday if coverage on an Insured Person is continued past the Insured Child's 18th birthday under this provision; or

(d) the Date of Issue of a separate policy, which is issued to the Insured Spouse and provides coverage on the Insured Child; or

(e) Expiry Date.

The termination of an Insured Child's coverage will not reduce any liability We have under this Policy for any claim originating prior to the termination.

If this Policy is in force when an Insured Child's coverage terminates, such Insured Child may obtain a separate Critical Illness policy, subject to the Conversion Privilege provision below.

The coverage provided on an Insured Child by this Policy may be continued, so long as the Insured Child is:

(a) legally incapable of self-sustained employment due to mental or physical incapacity; and

(b) dependent upon the Insured for support and maintenance.

You must submit satisfactory proof of incapacity and dependency to Us within 31 days of the date on which the coverage on the Insured Child would terminate if he or she were not incapacitated and dependent, and subsequently as We may require, but not more frequently than annually after the two (2) year period following the date coverage on the Insured Child would otherwise have terminated. We may charge an additional premium for continuing the coverage on any Insured Child. We will determine the premium on the basis of the Age, Sex, and premium rate and class in effect for the Insured Child on the date proof of incapacity and dependency is provided.

## CONVERSION PRIVILEGE

We will issue a separate Critical Illness Policy to an Insured Spouse or Insured Child as described in this Policy.

Written application with payment of the first premium for such separate policy must be made:

(a) by the Insured Spouse within 31 days following termination of marriage by a divorce decree and prior to the policy anniversary on or following the Insured Spouse's 64th birthday; or

(b) by the Insured Child within 31 days following the termination of his or her coverage under this Policy.

*If Critical Illness coverage is still being issued by Us in Your state of residence, a separate policy will be issued:*

(a) without evidence of insurability; and

(b) with the same Exclusion and Preexisting Condition Limitation provisions applicable to such Insured Person, if any, provided by this Policy; and

(c) with a current Date of Issue; and

(d) at the premium rate and class in effect for the Insured Person's Age and Sex on the date of application for the separate policy; and

(e) with the same benefits payable, if any, reduced by any benefits previously paid for the Critical Illnesses stated in the Policy Schedule; and

(f) with the same Incontestable provision applicable to such Insured Person provided by this Policy, commencing on the date coverage on the Insured Person becomes effective under this Policy.

# American General Life Insurance Company

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(A STOCK COMPANY)
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