Dear Employee,

As required by the group insurance policy, you must complete the attached Statement of Insurability Health Questionnaire, and your application must be approved by American General Life Insurance Company before the coverage you elected is effective. Please respond to all questions in the application.

After you have completed the application, please mail it to the plan administrator designated by your employer at the following address:

Western Insurance Specialties, Inc.
P.O. Box 12910
Reno, NV 89510

Thank you.

AIG
Group Benefits

American General Life Insurance Company*
Houston, Texas
*This company does not solicit business in New York

Statement of Insurability for Group Programs
Administrative Office
PO Box 1583, Neptune, NJ 07754-1583

Status: Please print or type all information requested. Please complete all sections of the application to avoid delays

Group Policy Number V256033 Job Title _____

1. Name of Employer Nevada System of Higher Education
2. Employee's/Member's First Name_____ Middle_____ Last _____
3. Home Address—Street_____ City_____ State_____ Zip_____
   Home Phone Number_____ Email Address _____
4. Complete the following for employee/member and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height FT' IN''	Weight LBS	Social Security #
EE								
SP/DP								

	EMPLOYEE/ MEMBER	**SPOUSE/DP**
5. Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver or lungs, cancer or other tumor, AIDS (Acquired Immune Deficiency Syndrome), AIDS related complex or other immune disorder, diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis or other musculoskeletal disease or disorder or are you currently taking any medication prescribed by a physician or other practitioner?	☐ Yes ☐ No	☐ Yes ☐ No
6. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?	☐ Yes ☐ No	☐ Yes ☐ No

If "yes" to any part of questions 5 through 6, give details on the following page. Use a separate sheet of paper if more space is needed for answers:

Question No.	**Does Question Apply to Employee, Spouse/DP**	**Condition**	**Date Occurred**	**Duration**	**Degree of Recovery**	**Names & Addresses of Physicians Hospitals/Clinics Consulted**

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AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB. Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. To facilitate the rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB, Inc. I understand that I may revoke this authorization at any time by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months, from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application. I authorize deductions from earnings for the costs of this insurance. I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.

_____ ➢ _____
(DATE SIGNED) (SIGNATURE OF EMPLOYEE/MEMBER)

_____ ➢ _____
(DATE SIGNED) (*SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)*

American General Life Insurance Company*
Houston, Texas
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These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

The Company, or its reinsurers, may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.