



### Name and Address Change

- American General Life Insurance Company
  - The United States Life Insurance Company in the City of New York
- A member of American International Group, Inc. (AIG)*

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Mailing Instructions: Send form(s) to: Standard Address • PO Box 818006 • Cleveland, OH 44181 • Fax: 1-844-930-0370

<b>A. POLICY IDENTIFICATION</b>	<p>Complete all policy information in this section. You may use this form for multiple policies that have the same policyowner and require the same signatures.</p> <p><b>POLICY No.:</b> _____</p> <p><b>INSURED/ANNUITANT NAME:</b> _____ <b>SSN/ITIN OR EIN:</b> _____  <small>(Required) (Required)</small></p> <p><input type="checkbox"/> Check here if this is a permanent address change</p> <p><b>OWNER NAME:</b> _____ <b>SSN/ITIN OR EIN:</b> _____  <small>(Required) (Required)</small></p> <p><b>ADDRESS:</b> _____ <b>PHONE No.:</b> _____          _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><input type="checkbox"/> Check here if this is a permanent address change</p> <p><b>CO-OWNER NAME:</b> _____ <b>SSN/ITIN OR EIN:</b> _____  <small>(if applicable) (if applicable)</small></p> <p><b>ADDRESS:</b> _____ <b>PHONE No.:</b> _____          _____</p> <p><b>EMAIL ADDRESS:</b> _____</p> <p><b>ASSIGNEE, IRREVOCABLE BENEFICIARY, OTHER NAME:</b> _____ <b>SSN/ITIN OR EIN:</b> _____  <small>(if applicable) (if applicable)</small></p>
<b>B. <input type="checkbox"/> NAME CHANGE</b>	<p>Check the box of the person whose name is to be changed. Check the reason for the name change.</p> <p><input type="checkbox"/> Insured/Annuitant   <input type="checkbox"/> Owner   <input type="checkbox"/> Co-Owner   Reason:   <input type="checkbox"/> Marriage   <input type="checkbox"/> Divorce</p> <p><input type="checkbox"/> Payor   <input type="checkbox"/> Beneficiary   <input type="checkbox"/> Correction   <input type="checkbox"/> Other (<i>Attach Certified Copy</i>)</p> <p><b>FROM:</b> (First, Middle, Last) _____ <b>TO:</b> (First, Middle, Last) _____</p> <p>_____</p> <p><b>NOTE: This form can not be used to change the ownership or beneficiary designations.</b></p>
<b>C. <input type="checkbox"/> ADDRESS CHANGE</b>	<p>Check the box of the person whose address is to be changed. Indicate the new address.</p> <p><input type="checkbox"/> Insured/Annuitant   <input type="checkbox"/> Owner   <input type="checkbox"/> Co-Owner   <input type="checkbox"/> Payor   <input type="checkbox"/> Assignee   <input type="checkbox"/> Beneficiary</p> <p><b>Name:</b> (First, Middle, Last) _____</p> <p><b>Address:</b> (Number and Street) _____</p> <p><b>City</b> _____ <b>State</b> _____ <b>Zip Code</b> _____ + _____</p> <p><b>Phone No.:</b> _____</p>

**D. SIGNATURE AND DATE**

This request must be dated and all required signatures must be written in ink, using full legal names by the person or persons who have rights of ownership under the terms of the contract. Acknowledgement of this change is not an admission that the policy/contract is in benefit or that the person(s) signing the change request is/are the owner(s). A recorded change, not signed by the owner(s), may not constitute a valid change.

**TAX CERTIFICATION (Substitute Form W-9) – Applicable to U.S. persons (including U.S. citizens and resident aliens). If you are not a U.S. person, you are required to submit the applicable IRS Form W-8 series (BEN, BEN-E, ECI, EXP or IMY).**

**Under penalties of perjury, I certify to the following:**

1. That the taxpayer identification number listed on this form is my correct SSN/TIN and I am a U.S. Citizen or other U.S. person (including resident aliens);
2. I further certify that I am exempt from and have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding. The Company is required to withhold income tax on any payments, which include interest and dividends when the owner is subject to backup withholding.; and
3. I am exempt from Foreign Account Tax Compliance Act ("FATCA") reporting.

**Certification Instructions:** You must cross out any statement in 1-3 that does not apply to you. For any instructions on how to complete this certification, please see the General Instructions for the IRS Form W-9 on [www.irs.gov](http://www.irs.gov). If you can complete a Form W-9 (Request for Taxpayer Identification Number) and you are a U.S. Citizen or U.S. resident alien, FATCA reporting may not apply to you. **Please consult your own tax advisor with any questions you may have regarding this certification.**

The Internal Revenue Service does not require your consent to any provision of this document other than the certification required to avoid backup withholding.

**Current/Existing Owner's Signature** (required)

X

**Date** \_\_\_\_\_

**Current/Existing Owner's Signature** (required)

X

**Date** \_\_\_\_\_

**Assignee, Irrevocable Beneficiary,  
Other Signature** (if required)

X

**Date** \_\_\_\_\_

**Complete this section if this Policy is owned by a trust or business.**

- Trust Owned: (Complete the Certification of Trust)  
 Business Owned: (Complete the Business Certification)

**Owner Signature**

Print full name of Company: \_\_\_\_\_

Print full name and title of authorized signer: \_\_\_\_\_

\_\_\_\_\_

**Authorized Signature** (required)

X

**Date** \_\_\_\_\_

**RETURN COMPLETED FORM TO THE ADDRESS OF THE COMPANY CHECKED ABOVE.**

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## INSTRUCTIONS AND CONDITIONS

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This page is for informational purposes only and does not need to be returned with the form.

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is solely responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

<b>POLICY INFORMATION</b>	Complete all policy information in this section. You may use this form for multiple policies that have the same policyowner and require the same signatures.
<b>NAME CHANGE</b>	Check the box of the person whose name is to be changed. Check the reason for the name change.
<b>ADDRESS CHANGE</b>	Check the box of the person whose address is to be changed. Indicate the new address.
<b>SIGNATURE AND DATE</b>	<p>Please elect ownership type and fill out all applicable information. All required signatures must be written in ink, using full legal names. The request must be signed by: the person or persons who have the rights of ownership under the terms of the Policy, by an assignee, or by any other party who may have an interest in the Policy by legal proceedings or statutes.</p> <ul style="list-style-type: none"><li>• If the owner is a trust, complete the Certification of Trust.</li><li>• If the owner is a business, complete the Business Certification.</li></ul>
<b>ADDITIONAL REQUIREMENTS</b>	<p><b>Guardianship/Conservatorship</b> - Signature of the current guardian is required along with the current Guardianship Papers or Letter of Conservatorship. The signature must be dated within one year of the request.</p> <p><b>Power of Attorney</b> - Request must be signed by the attorney-in-fact. A copy of the applicable Power of Attorney document is required. A completed, signed, dated, and notarized Power of Attorney Affidavit and Indemnity Agreement is required when the disbursement will be \$100,000 or over and/or the face amount of the policy is \$1,000,000 or over.</p>