

Credit Card Authorization Form

Form to be used only for the collection of
initial insurance premium on Term, Whole
Life, and Accident & Health Products Only

American General Life Insurance Company

Please read this authorization carefully and complete all requested items.

Type of Insurance/Contract Applied For: _____

Policy Number: _____

Name of Proposed Insured: _____

Proposed Policy Owner: _____

Cardholder Name: (exactly as it appears on the card) _____

Cardholder Email Address: _____

Cardholder Billing Address: _____

Credit Card Number: _____ Expiration Date: _____

Card Type: ☐ American Express® ☐ MasterCard® ☐ Visa®

Quoted Initial Premium Amount: _____

I authorize and request the Company and/or its representative to charge the credit card listed above for the Quoted Initial Premium Amount. I understand and agree that:

- 1) If there are no changes to the policy as applied for, the charge to the account for the Quoted Initial Premium Amount will be processed when the Company places the policy in force.
- 2) In the event of changes to the policy as applied for, any new Initial Premium Amount will be communicated to me. If I accept that change, the charge to the account for the new amount will be processed when the Company places the policy in force.

Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I understand and agree that this transaction is subject to the acceptance by, and the terms and conditions of, the credit card company indicated above. I understand and agree that this Authorization Form is not a part of the application or policy of insurance applied for and does not modify any terms or conditions contained therein. I understand and agree that the Company shall incur no liability if the credit card company dishonors any amount charged under this Authorization and may terminate this Authorization immediately if any charges are not paid. I agree to hold the Company harmless from any and all costs, claims, or causes of actions arising from or related to this authorization. I authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. I understand and agree that payment of the initial premium is one of the conditions required for coverage to be placed into effect. If the charge is declined for any reason, I understand and agree that coverage will not be placed into effect.

Name of Authorized Person (printed): _____ Date _____

For Internal Use Only

#: _____ Date: _____

Signature of Authorized Person on Account

X

Signed on (date) _____

Please return this copy with the application.



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Signature of Authorized Person on Account

X

Signed on (date) _____

Applicant: Please retain this copy for your records.

