AIG AMERICAN GENERAL

# Term Insurance Application
## Part A
## Pennsylvania Version

☐ **American General Life Insurance Company, Houston, TX**
*Member companies of American International Group, Inc.*

☐ **The United States Life Insurance Company in the City of New York, New York, NY**

The insurance company checked 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.

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**1. Proposed Insured** Name ____________________ Social Security # ____________
Sex ☐ M ☐ F Birthplace *(state, country)* ____________ Date of Birth ____________ Age ____
**Tobacco Use** Have you ever used any form of tobacco or nicotine products? ☐ yes ☐ no If yes, date of last use ____________

If yes, *type* and *quantity* of tobacco or nicotine products used ____________________

Driver's License No. ____________________ License State ____________

U.S. Citizen ☐ yes ☐ no If no, Date of Entry ____________ Type of Visa ____________

Address ____________________ City, State ____________ ZIP ____________

Home Phone (    ) ____________ Work Phone (    ) ____________ E-mail Address ____________

Employer ____________ Occupation ____________ Length of Employment ____________
Duties ____________________
Personal Income $ ____________ Household Income $ ____________ Net Worth $ ____________

**2. Owner** ☐ Proposed Insured ☐ Trust ☐ Someone other than Proposed Insured or Trust
**A. Complete if other than the proposed insured is owner** *(If contingent owner is required, use Remarks section.)*

Name ____________________ Social Security or Tax ID # ____________ Date of Birth ____________

Address ____________________ City, State ____________ ZIP ____________

Home Phone (    ) ____________ Relationship to Proposed Insured ____________
**B. Complete if owner is a trust** (*If trustee is premium payor also complete section 7 part D.)*

Exact Name of Trust ____________________ Trust Tax ID # ____________

Current Trustee(s) ____________________ Date of Trust ____________

**3. Plan of Insurance** Product Name ____________________ Amount Applied For $ ____________
Premium Class Quoted ____________ Reason for Insurance ____________
**Riders** ☐ Waiver of Premium ☐ Child $ ____________ **(Complete Child Rider Attachment)** ☐ No current children

**4. Primary Beneficiary**
Name ____________________ Relationship ____________ Share ______%
Name ____________________ Relationship ____________ Share ______%

**5. Contingent Beneficiary**
Name ____________________ Relationship ____________ Share ______%
Name ____________________ Relationship ____________ Share ______%

**6. Trust Information (if Beneficiary)** Exact Name of Trust ____________________

Trust Tax ID # ____________ Current Trustee(s) ____________ Date of Trust ____________

**7. Premium Payment** ☐ Modal $ ____________ ☐ Single $ ____________
**A. Frequency of modal premium:** ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (Bank Draft)
**B. Method:** ☐ Direct Billing ☐ Bank Draft (*Complete Bank Draft Authorization.)* ☐ List Bill: Number ____________
☐ Other *(Please explain.)* ____________________
**C. Amount submitted with application $** ____________
**D. Premium payor** *(Complete if other than owner.)*

Name ____________________ Social Security or Tax ID # ____________ Home Phone (    ) ____________

Address ____________________ City, State ____________ ZIP ____________

**8. Health and Age Questions** (*If the proposed insured answers yes to either question, temporary insurance is not available, the agreement will be void and any payment submitted will be refunded.)*
**A.** Has the proposed insured ever had a heart attack, stroke, cancer, diabetes, or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? ☐ yes ☐ no
**B.** Is the proposed insured age 71 or above? ☐ yes ☐ no

**9. Other Life Insurance or Annuities** *(Indicate life insurance policies or annuities in force or pending for the proposed insured(s).)*

Does any proposed insured have any existing or pending annuity or life insurance contracts? ☐ yes ☐ no

*(If yes, indicate life insurance policies or annuities in force or pending for the proposed insured(s).)*

**Type:** **i** = individual, **b** = business, **g** = group, **p** = pending life insurance or annuity

| Name of Proposed Insured | Policy Number | Insurance Company | Type(s) *(see above)* | Year of Issue | Face Amount | Replace* | 1035 Ex |
|---|---|---|---|---|---|---|---|
| | | | | | | ☐ yes | ☐ yes |
| | | | | | | ☐ yes | ☐ yes |
| | | | | | | ☐ yes | ☐ yes |

* **Replace** means that the insurance being applied for may replace, change or use any monetary value of any existing or pending life insurance policy or annuity. If replacement may be involved, complete and submit replacement-related forms. Please note: certain states require completion of replacement related forms even when other life insurance or annuities are not being replaced by the policy being applied for.

**10. Background Information**

**A.** Does the proposed insured intend to travel or reside outside of the United States or Canada within the next two years? ☐ yes ☐ no
*(If yes, list country, date, length of stay and purpose.)* ______

**B.** In the past five years, has the proposed insured participated in, or does he or she intend to participate in: any flights as a trainee, pilot or crew member; scuba diving; skydiving or parachuting; ultralight aviation; auto racing; cave exploration; hang gliding; boat racing; mountaineering; extreme sports or other hazardous activities? *(If yes, circle the applicable activities and complete the Aviation and/or Avocation Questionnaire.)* ☐ yes ☐ no

**C.** Has the proposed insured:

1) During the past 90 days submitted an application for life insurance to any other company or begun the process of filling out an application? *(If yes, list company name, amount applied for, purpose of insurance and if application will be placed.)* ☐ yes ☐ no
______

2) Ever had a life or disability insurance application modified, rated, declined, postponed, withdrawn, canceled or refused for renewal? *(If yes, list date and reason.)* ______ ☐ yes ☐ no

**D.** Has the proposed insured ever filed for bankruptcy? ☐ yes ☐ no
*(If yes, list chapter filed, date, reason and if discharged.)* ______

**E.** In the past five years, has the proposed insured been charged with or convicted of driving under the influence of alcohol or drugs or had any driving violations? ☐ yes ☐ no
*(If yes, list date, state, license no. and specific violation.)* ______

**F.** Has the proposed insured ever been convicted of or pled guilty or no contest to a felony or does he or she have any such charge pending against him or her? *(If yes, list date, state and felony.)* ______ ☐ yes ☐ no

## REMARKS

**11. Details and Explanations** ______

______

______

______

**Agent/Agency Information**

**Does the proposed insured have any existing or pending annuity or life insurance contracts?** ☐ yes ☐ no

**If yes, will the proposed insured replace, change, or use any monetary value of any existing or pending life insurance policy or annuity with any company in connection with the purchase of insurance?** ☐ yes ☐ no

*(If yes, please provide details in the Remarks section and attach all replacement-related forms. Certain states require completion of replacement-related forms even when life insurance or annuities are not being replaced by the policy being applied for.)*

I have ordered/obtained the following requirements: ☐ APS ☐ Blood Profile/Urinalysis ☐ EKG ☐ Inspection Report ☐ MD Exam ☐ Oral Fluids *(as state permits)* ☐ Paramedical Exam ☐ Treadmill ☐ Urinalysis Only *(If requirements are scheduled, please provide name of examiner, clinic and date ordered:)* ______

| Agent(s) to Receive Commission | Agency Number | Agent Number | % of Commission |
|---|---|---|---|
| | | | |
| | | | |

**I certify that the information supplied by the proposed insured/owner has been truthfully and accurately recorded on the Part A application.**

______
Writing Agent Name *(please print)*

______
State License #

X ______
Writing Agent Signature

X ______
Countersigned (Licensed resident agent if state required)

Phone # ( ) ______

E-mail Address ______

## AUTHORIZATION AND SIGNATURE

**American General Life Insurance Company, Houston, TX**

**The United States Life Insurance Company in the City of New York, New York, NY**

The above listed life insurance company as selected on page one of this application 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. In this application, "Company" refers to the insurance company which was selected on page one.

**Authorization to Obtain and Disclose Information and Declaration**

I give my consent to any of the entities listed below to give the Company, its legal representative, or American General Life Companies, an (affiliated service company), all information they have pertaining to medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; or any other information; for me or my minor children. Other information could include items such as: personal finances, habits, hazardous avocations, motor vehicle records from the Department of Motor Vehicles or court records, foreign travel, etc. The list of entities for which I give my consent to provide the information above is as follows: any physician or medical practitioner; any hospital, clinic or other health care facility; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the Medical Information Bureau (MIB).

I understand the information obtained will be used by the Company to determine eligibility for insurance and eligibility for benefits under an existing policy. The Company may disclose any information gathered during its evaluation of my application to: its reinsurers, the MIB, other persons or organizations performing business or legal services in connection with my application or claim, me, any physician designated by me, or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent from American General Life Companies. I understand this consent may be revoked at any time by sending a written request to American General Life Companies, ATTN: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931.

This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company to obtain an investigative consumer report on me. I understand that I may: request to be interviewed for the report; and receive, upon written request, a copy of such report. ☐ Check if you wish to be interviewed.

I have read the above statements or they have been read to me. They are true and complete to the best of my knowledge and belief. I understand that this application: (1) will consist of Part A, Part B, and if applicable, related forms; and (2) shall be the basis for any policy issued. I understand that any material misrepresentation made in this application and relied on by the insurer issuing the policy may be used to reduce or deny a claim or void the policy, if: (1) it is within its contestable period; and (2) such misrepresentation materially affects the acceptance of the risk. **Except as may be stated in a Limited Temporary Life Insurance Agreement (LTLIA) for which all requirements are met, I understand and agree that no insurance will be in effect under this application, or any new policy issued by the insurer, unless or until: the policy has been delivered and accepted; the full first modal premium for the policy has been paid; and there has been no change in the health of the proposed insured that would change the answers to any questions in the application.**

I understand and agree that no agent may: accept risks or pass upon insurability; make or modify contracts; or waive any of the insurers rights or requirements.

I have received a copy of the Notices to the Proposed Insured.

Limited Temporary Life Insurance Agreement– If eligible, I have received and accepted the LTLIA. This insurance is available only if; the full first modal premium is submitted with this application and "no" answers have been given by the proposed insured to the Health and Age questions in section 8.

**IRS Certification: Under penalties of perjury, I certify: (1) that the number shown on this application is my correct Social Security or Tax ID number; (2) that I am not subject to backup withholding under Section 3406(a)(1)(C) of the Internal Revenue Code; and (3) that I am a U.S. person (including a U.S. resident alien). The Internal Revenue Service does not require my consent to any provisions of this document other than the certifications required to avoid backup withholding. You must cross out item (2) if you are subject to backup withholding and cross out item (3) if you are not a U.S. person (including a U.S. resident alien).**

______________________________ ______________
Signature of Owner Date

**Proposed Insured/Owner Signature(s)**

Signed at (*City, State*) ______________________ On (*Date*) ______________________

X______________________ X ______________________
Primary Proposed Insured *(If under age 18, signature of parent or guardian)* Owner *(If other than proposed insured)*

## BANK DRAFT AUTHORIZATION

☐ **American General Life Insurance Company, Houston, TX** ☐ **The United States Life Insurance Company in the City of New York, New York, NY**

The company checked above will withdraw the premiums from the specified account. This insurance company will be referred to hereafter as "Company". "You", "your", "I", and "me" refer to the bank account owner whose name appears below.

**How Automatic Bank Draft Works:** Automatic bank draft is a debit service that offers a convenient way to pay life insurance premiums. The Company will collect the life insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

**Automatic Bank Draft Agreement**

I hereby authorize and request the Company to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the insurance policy, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s). I hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason or dishonor of any debit.

I understand that this authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable nonforfeiture provision. I acknowledge that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment.

I agree that this authorization may be terminated by me or the Company at any time and for any reason by providing written notice of such termination to the nonterminating party and may be terminated by the company immediately if any debit is not honored by the depository named for any reason.

This must be dated and signed by the bank account owner(s) as his/her name appears on bank records for the account provided on this authorization.

Financial Institution Name ______________________________

Financial Institution Address ____________________ City, State ____________________ ZIP __________

Routing Number |: ☐☐☐☐☐☐☐☐☐ :|

Account Number ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐ ||•

Type of Account: ☐ Checking ☐ Savings Credit Union: ☐ yes ☐ no

Name of Proposed Insured ______________________________ Premium Amount $ __________

Frequency: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly

Preferred Withdrawal Date (1st-28th) __________ ☐ **Please debit my account for all outstanding premiums due.**

Print Bank Account Owner(s) Name ______________________________

Signature(s) of Bank Account Owner(s) **X** ______________________________

**Please attach voided check or deposit slip.**

**Detach this page and leave it with the proposed insured**

## NOTICES TO THE PROPOSED INSURED

**American General Life Insurance Company, Houston, TX**

**The United States Life Insurance Company in the City of New York, New York, NY**

You have applied for life insurance with one of the insurance companies identified above. "Company" refers to the company with which you have applied for insurance. This notice is provided on behalf of that company and American General Life Companies, an affiliated service company.

## FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

American General Life Companies, P.O. Box 1931, Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

To make it easier to use its products and services, the Company may share information about you with the companies named above beyond the 24 month period described in Authorization to Obtain and Disclose Information and Declaration. You should notify the Company in writing at the address above if you do not want the Company to share this information with these affiliates.

## MEDICAL INFORMATION BUREAU

The designated insurer or its reinsurers may make a brief report regarding your insurability to the Medical Information Bureau (MIB), a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another MIB - member company for life or health insurance or a claim for benefits is submitted to such a company, the MIB will supply such company with the information they have about you.

At your request, the MIB will disclose any information it has in your file. If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address and phone number of the MIB's information office are:

P.O. Box 105, Essex Station, Boston, Massachusetts 02112, 617/426-3660

The designated insurer, or its reinsurer, may also release information in its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

## INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and correct this information, except information that relates to a claim or a civil or criminal proceeding.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access and correct information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at:

American General Life Companies, P.O. Box 1931, Houston, TX 77251-1931

## TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

### USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

*This form must be completed, signed and left with the applicant.*

Limited Temporary Life Insurance Agreement (Agreement)

**THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. PLEASE FOLLOW STEPS 1 - 4.**

1. **Check appropriate Company:**

☐ American General Life Insurance Company, Houston, TX

☐ The United States Life Insurance Company in the City of New York, New York, NY

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

2. **Complete the following:**

Primary Proposed Insured *(please print)* ____________________

Other Proposed Insured *(if applicable)* ____________________

Owner ____________________ Modal Premium Amount Received ____________________

Date of Policy Application ____________________

3. **Answer the following questions:**

| | YES | NO |
|---|---|---|
| a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? | | |
| b. Is any Proposed Insured age 71 or above? | | |

**STOP** If the answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

## TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

A. **Eligibility for Coverage:** If any Proposed Insured answers YES to either of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

B. **When Coverage Will Begin:** COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

***Coverage under this Agreement will not exist until all of the conditions listed above have been met.***

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application: (i) a check in the amount of the first modal premium; (ii) a completed and signed Automatic Bank Draft Agreement; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will automatically terminate if any form of payment submitted is not honored. All premium checks must be made payable to the Company checked above. Do not make check payable to the agent or leave payee blank. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

**C. When Coverage Will End:** COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner or his/her agent and all amendments and delivery requirements have been completed;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it was unable to approve the requested coverage at the premium amount quoted and a counter offer is made by the Company;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that it has declined or cancelled the application;
- The date the Company mails or otherwise provides notice to the Owner or his/her agent that a Proposed Insured is not eligible for coverage under this Agreement and the application will not be considered on a prepaid basis;
- The date the Company mails or otherwise provides a premium refund to the Owner or his/her agent; or
- 60 calendar days from the date coverage begins under this agreement.

**D. Coverage Amount:** Upon receiving proof of the death of the Primary Proposed Insured, and of the Other Proposed Insured if this is a joint life or survivorship policy, and if all eligibility requirements and conditions for coverage under this Agreement have been met, the total amount that will be paid by the Company pursuant to this and any other limited temporary life insurance agreements covering the Proposed Insured(s) will be ***the lesser of***:

- The plan amount the Proposed Insured applied for; or
- $500,000.00 plus the amount of any premium paid for coverage in excess of $500,000.00.

The Company will pay the death benefit to the beneficiary named in the application. If death is due to suicide, payment will be limited to the amount of premium paid.

**4. Complete and sign this section:**

Any misrepresentation contained in this Agreement and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement.

*I, the Owner, have received, read and understand this Agreement and agree to be bound by the terms and conditions stated herein.*

Signature of Owner ______________________ Date __________

Signature of Primary Proposed Insured ______________________ Date __________

Signature of Other Proposed Insured *(if applicable)* ______________________ Date __________

Writing Agent Name *(please print)* ______________________ Writing Agent # __________

*This form to be completed, detached and submitted with the signed application.*

## Limited Temporary Life Insurance Agreement Receipt

**Check appropriate Company:**

☐ American General Life Insurance Company, Houston, TX

☐ The United States Life Insurance Company in the City of New York, New York, NY

Primary Proposed Insured *(please print)* ______________________________

Other Proposed Insured *(if applicable)* ______________________________

Owner ______________________________

Modal Premium Amount Received ______________________________

| | YES | NO |
|---|---|---|
| a. Has any Proposed Insured ever had a heart attack, stroke, cancer, diabetes or disorder of the immune system, or during the last two years been confined in a hospital or other health care facility or been advised to have any diagnostic test or surgery not yet performed? | | |
| b. Is any Proposed Insured age 71 or above? | | |

**STOP** If the answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under the Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under the Agreement.

Upon receiving proof of the death of the Primary Proposed Insured, and of the Other Proposed Insured if this is a joint life or survivorship policy, and if all eligibility requirements and conditions for coverage under the Agreement have been met, the total amount that will be paid by the Company pursuant to the Agreement and any other limited temporary life insurance agreements covering the Proposed Insured(s) will be ***the lesser of***:

- The plan amount the Proposed Insured applied for; or
- $500,000.00 plus the amount of any premium paid for coverage in excess of $500,000.00.

**Any misrepresentation contained in the Agreement and relied on by the Company may be used to deny a claim or to void the Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of the Agreement.**

*I, the Owner, have received, read and understand the Agreement and agree to be bound by the terms and conditions stated therein.*

Signature of Owner ______________________________ Date ______________

Signature of Primary Proposed Insured ______________________________ Date ______________

Signature of Other Proposed Insured *(if applicable)* ______________________________ Date ______________

Writing Agent Name *(please print)* ______________________________ Writing Agent # __________