

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

New York, New York

Administrative Office: 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583

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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, Massachusetts 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](http://www.mib.com).

**NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)**

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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

Subsidiary of American International Group, Inc.

New York, New York

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**GROUP POLICY NO.:** \_\_\_\_\_ **SOCIAL SECURITY NO.:** \_\_\_\_\_

Use this form to give a statement for any combination of: yourself, your spouse and/or your eligible children. In all cases you must complete the EMPLOYEE/MEMBER DATA section. *Please print or type all information requested.*

**EMPLOYEE/MEMBER DATA**

1. Your full name: \_\_\_\_\_ Salary: \_\_\_\_\_ Male  Female
2. Mailing Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_
3. Employed by: \_\_\_\_\_ Date employed: \_\_\_\_\_
4. Are you now working at least 30 hours per week with your present employer? Yes  No  Job Title \_\_\_\_\_

**PERSONAL DATA**

5. Give the following details about: \_\_\_\_\_ Spouse's full name: \_\_\_\_\_
- a. yourself if you are giving a statement of insurability: \_\_\_\_\_
- b. your spouse if she or he is giving a statement of insurability: \_\_\_\_\_

Date of Birth	Place of Birth	Height	Weight	Date of Birth	Place of Birth	Height	Weight
Month/Day/Year		Ft. In.	Lbs.	Month/Day/Year		Ft. In.	Lbs.

- c. your eligible children if they are giving a statement of insurability:

Child's name	Date of Birth	Child's name	Date of Birth	Child's name	Date of Birth	Child's name	Date of Birth

**INSURABILITY QUESTIONS**

In the following questions, "person" refers to each person (you only, your spouse and/or each eligible child) who is giving a statement of insurability. Answer each question by checking the "Yes" or "No" box, as it applies.

6. WITHIN THE PAST 7 YEARS, HAVE YOU HAD AND BEEN TREATED FOR: (Circle specific disorders experienced.)	YES	NO
a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	<input type="checkbox"/>	<input type="checkbox"/>
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis, gout, bursitis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	<input type="checkbox"/>	<input type="checkbox"/>
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	<input type="checkbox"/>	<input type="checkbox"/>
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	<input type="checkbox"/>	<input type="checkbox"/>
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	<input type="checkbox"/>	<input type="checkbox"/>
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental or emotional problem requiring help of a physician or psychologist?	<input type="checkbox"/>	<input type="checkbox"/>
m. A surgical operation? A surgical operation advised but not performed?	<input type="checkbox"/>	<input type="checkbox"/>

7. Have you had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 7 years?  Yes  No

GIVE DETAILS BELOW IF: (A) "Yes" to any part of question 6, or (B) "Yes" to question 7 for a condition not specified in question 6.

Question No.	Name of Person	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals or Clinics Consulted

