

# American General

Life Companies

## Application for Group Insurance Programs

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

New York, New York

(Herein called the Company)

Administrative Office: 3600 Route 66, Mail Stop 3-C, Neptune, NJ 07753

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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](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.

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Please print or type all information requested.

**Group Policy Number** \_\_\_\_\_ **Division** \_\_\_\_\_

**Please complete all sections of the application to avoid delays.**

**Employee's annual salary** \$ \_\_\_\_\_ **Hire Date** \_\_\_\_\_

**Job Title** \_\_\_\_\_

1. Name of Employer/Association \_\_\_\_\_

2. Employee's/Member's full name \_\_\_\_\_  
FIRST MIDDLE LAST

3. Home Address \_\_\_\_\_  
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Select coverages with specific amounts for Life, AD&D, LTD and STD. If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter. \* If you had prior Dental coverage with the employer named above, please indicate by checking box and including your prior effective date.

**\*\*Wherever the term spouse appears can also read as domestic partner (DP) throughout the application.**

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
<b>Employee</b>	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	<input type="checkbox"/> Prior Coverage *Date / /	<input type="checkbox"/> Refused
<b>Spouse/DP**</b>	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	(not to exceed maximum benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family	<input type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family
<b>Child(ren):</b>	\$ _____ <input type="checkbox"/> refused	/ / / / / /				

4 (a) Do you have any disability insurance in force or pending (including group coverage)?  Yes  No  
If YES, please indicate companies and amounts \_\_\_\_\_

4 (b) Will this coverage applied for, replace any insurance in force now?  Yes  No  
If YES, please indicate companies and amounts \_\_\_\_\_

5. Complete the following for employee/member, spouse/domestic partner and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security #
<b>EE</b>						ft. in.	lbs.	
<b>SP/DP</b>						ft. in.	lbs.	
<b>CH</b>						ft. in.	lbs.	
<b>CH</b>						ft. in.	lbs.	

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**If you are eligible for Guaranteed Issue do not complete questions 6, 7, 8 and 9 unless you are applying for more than your group's Guaranteed Issue.**

- |  | <b>EMPLOYEE/MEMBER</b>                                   | <b>SPOUSE/DP</b>   | <b>CHILD</b>   |
|--|--|--|--|
| 6. (a) Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver; lungs or blood; chest pain; stroke or other neurological disorder; cancer or tumor; AIDS (Acquired Immune Deficiency Syndrome); AIDS related complex, or other immune disorder; diabetes or high blood pressure, mental or nervous disorder, arthritis or other musculoskeletal disease or disorder? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| (b) Have you, during the past 5 years, been diagnosed with or treated for alcohol or drug dependency?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 7. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution for any reason other than stated above?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 8. Are you presently taking any medications?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 9. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |

**If "yes" to any part of questions 6, 7, 8 and 9, give details below (not required for child(ren) if employee or spouse is also applying). Use a separate sheet of paper if more space is needed for answers:**

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

10. Have you used tobacco in any form during the past 12 months?	<b>EMPLOYEE/MEMBER</b> <input type="checkbox"/> Yes <input type="checkbox"/> No	<b>SPOUSE/DP</b> <input type="checkbox"/> Yes <input type="checkbox"/> No
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**If this question is not completed, you will be billed using smoker rates.**

**SIGNATURE IS REQUIRED ON THE FOLLOWING PAGE**

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**AUTHORIZATION**

1. I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to The United States Life Insurance Company in the City of New York (United States Life) or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes, information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information. 2. I understand that this information will be used by United States Life solely to determine eligibility for insurance. 3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months while insured under the contract, if not revoked earlier. 4. I know that I should retain a copy of this authorization for my records. 5. I agree that a photocopy of this authorization is as valid as the original. 6. To the best of my knowledge and belief, all statements made above are true and complete. All statements are representations and not warranties. 7. 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 insured's; and (b) while there is no change in the insurability or health of such person from that stated in the application. 8. I authorize deductions from earnings for the costs of this insurance. 9. 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)

➡ Witness to above Signature(s): \_\_\_\_\_

**BENEFICIARY DESIGNATION**

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and children insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Beneficiary of Employee  
and Relationship \_\_\_\_\_

Beneficiary of Spouse  
and Relationship \_\_\_\_\_