AIG AMERICAN GENERAL

Application for Group Voluntary Programs

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

New York, New York
Member of American International Group, Inc.
Administrative Office: 3600 Route 66, Client Services 3-C, P.O. Box 1588 Neptune, NJ 07754-1588

These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that The United States Life Insurance Company In the City of New York may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The United States Life Insurance Company In the City of New York 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.

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 investigation 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.

All applications missing information, will be returned

Group Policy Number V _____ **Division** _____

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.

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
Employee	$ _____ ☐ refused	$ _____ ☐ refused	$ _____ ☐ refused	$ _____ ☐ refused	☐ Prior Coverage ★ Date / /	☐ Refused
Spouse	$ _____ ☐ refused	$ _____ ☐ refused	(Must be in multiples of $100 Units – not to exceed max benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	☐ Employee ☐ Employee & Spouse ☐ Employee & Child ☐ Full Family	☐ Employee ☐ Employee & Spouse ☐ Employee & Child ☐ Full Family
Child(ren):	$ _____ ☐ refused	/ / / / / / /				

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

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

	EMPLOYEE/MEMBER	SPOUSE	CHILD
6. Have you ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in your urine, tuberculosis, diabetes, cancer, tumors or ulcers?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ 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?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If "yes" to any part of questions 6 and 7, 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 or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

8. Complete this item only if the plan description material offers smoker/non-smoker rates for life insurance. If not completed, you will be billed using smoker rates.

	EMPLOYEE	SPOUSE
Have you smoked cigarettes, pipes or cigars during the past 12 months.	☐ Yes ☐ No	☐ Yes ☐ No

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 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 that 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 30 months, 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. 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 insureds; 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 _____