# HOW TO COMPLETE STATEMENT OF INSURABILITY FORM

Include Policy Number if known.

If more than four children are eligible, use an additional form(s). You must date and sign each form.

Provide details for "YES" answers to questions 6a-m or 7.

Employee's Name

Employee's Spouse

Circle Applicable Condition.

**3** Include full names and addresses of physicians, hospital, etc. Use a separate sheet of paper. (SIGNED & DATED by employee & spouse if applicable) if additional space is needed.

**4** Date & Sign (FULL SIGNATURE, NOT INITIALS) in all applicable spaces.

**4** Date & Sign (FULL SIGNATURE, NOT INITIALS) in all applicable spaces.

## Statement of Insurability for Group Insurance

The United States Life Insurance Company in The City of New York
Member of American International Group, Inc.
P.O. Box 1583
Neptune, NJ 07754-1583

**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: William Jones — Male ☒ Female ☐
2. Mailing Address: 423 Elm Street City: Springfield State: N.Y. Zip: 10014
3. Employed by: A.B.C. Manufacturing Company Date employed: 7/29/89
4. Are you now working at least 30 hours per week with your present employer? Yes ☒ No ☐

**PERSONAL DATA**

5. Give the following details about: Spouse's full name: Mary Jones

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 6/14/46 | N.Y.C., N.Y. | 6 Ft. 0 In. | 185 Lbs. | 3/24/51 Month/Day/Year | Brooklyn, N.Y. | 5 Ft. 3 In. | 128 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 |
|---|---|---|---|---|---|---|---|
| Michael | 10/17/84 | | | | | | |

**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? | ☒ | ☐ |
| b. | Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? | ☒ | ☐ |
| c. | Arthritis, gout, bursitis or rheumatism? | ☐ | ☒ |
| d. | Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? | ☐ | ☒ |
| e. | Disease or disorder of rectum or anus? Varicose veins or other vascular disorder? | ☐ | ☒ |
| f. | Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? | ☐ | ☒ |
| g. | Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? | ☐ | ☒ |
| h. | Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection? | ☐ | ☒ |
| i. | Menstrual, uterine or ovarian disorder? Disorder of the breast? | ☐ | ☒ |
| j. | Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose? | ☐ | ☒ |
| k. | Cancer or other tumor? Deformity or loss of limb? Congenital defect? | ☐ | ☒ |
| l. | Mental or emotional problem requiring help of a physician or psychologist? | ☐ | ☒ |
| m. | A surgical operation? A surgical operation advised but not performed? | ☐ | ☒ |

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 |
|---|---|---|---|---|---|---|
| 6a, 7 | Mary | Hypertension | 4/2/86 | on-going | under control | Paul Johnson, M.D. • 125 Park Avenue N.Y., N.Y. 10007 |
| 6b | William | Sprained Back | 8/11/81 | 3 weeks | 100% | James Dunn, D.C. • 4 Main Street Newark, N.J. 07412 |

**DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY**

1. To the best of my knowledge and belief, all the statements made above are true and complete.
2. I understand that my application for group insurance will be accepted or declined on the basis of these statements.

10/20/89 (DATE SIGNED) — *William Jones* (SIGNATURE OF EMPLOYEE/MEMBER)

10/20/89 (DATE SIGNED) — *Mary Jones* (SIGNATURE OF SPOUSE, IF GIVING A STATEMENT OF INSURABILITY)

(DATE SIGNED) — (SIGNATURE OF CHILD WHO IS NOT A MINOR, IF GIVING A STATEMENT OF INSURABILITY)

Witness to above Signature(s): *M.J. Rollins*

**AUTHORIZATION**

1. I authorize the sources stated below to give to United States Life, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any insurer; the Medical Information Bureau; any consumer reporting agency; any employer.
2. I understand that this information will be used by United States Life to determine eligibility for insurance.
3. I agree that this authorization is valid for 2 ½ years from the date signed.
4. I know that I have the right to receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.

10/20/89 (DATE SIGNED) — *William Jones* (SIGNATURE OF EMPLOYEE/MEMBER)

10/20/89 (DATE SIGNED) — *Mary Jones* (SIGNATURE OF SPOUSE, IF GIVING A STATEMENT OF INSURABILITY)

(DATE SIGNED) — (SIGNATURE OF CHILD WHO IS NOT A MINOR, IF GIVING A STATEMENT OF INSURABILITY)

FF - 99002000-1001-0102
Supply Ordering Number - 00305101-1013-0102

1. **Complete all items legibly. Missing information will cause delays.**
2. **If you need to make a correction, either:**
   a. **Make a legible correction on the same form. You (and your spouse, if applicable) should then sign (NOT INITIAL) and date the form next to the correction; OR**
   b. **Complete a new form**
3. **Include full names and address of physicians, hospital, etc. Use a separate sheet of paper (signed and dated by employee and spouse if applicable) if additional space is needed.**
4. **Date and sign (Full signature, not initials) in all applicable spaces.**
5. **For new enrollees, submit this form with a completed enrollment card.**
6. **Remove this instruction sheet prior to submission.**
7. **Mail to: The United States Life Insurance Company in the City of New York**
   **Attn.: Client Services 3-A**
   **P.O. Box 1583**
   **Neptune, NJ 07754-1583**

FF - 99002000-1001-0102
Supply Ordering Number - 00305101-1013-0102

# Statement of Insurability for Group Insurance

The United States Life Insurance Company in The City of New York
Member of American International Group, Inc.
P.O. Box 1583
Neptune, NJ 07754-1583

**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: ____________ 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 ☐

**PERSONAL DATA**

5. Give the following details about:
   a. yourself if you are giving a statement of insurability:

   Spouse's full name: ____________
   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.

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

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 |
|---|---|---|---|---|---|---|
| | | | | | | |

## DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

1. To the best of my knowledge and belief, all the statements made above are true and complete.
2. I understand that my application for group insurance will be accepted or declined on the basis of these statements.

*(DATE SIGNED)* *(SIGNATURE OF EMPLOYEE/MEMBER)*

*(DATE SIGNED)* *(SIGNATURE OF SPOUSE, IF GIVING A STATEMENT OF INSURABILITY)*

*(DATE SIGNED)* *(SIGNATURE OF CHILD WHO IS NOT A MINOR, IF GIVING A STATEMENT OF INSURABILITY)*

Witness to above Signature(s): ____________

## AUTHORIZATION

1. I authorize the sources stated below to give to United States Life, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any insurer; the Medical Information Bureau; any consumer reporting agency; any employer.
2. I understand that this information will be used by United States Life to determine eligibility for insurance.
3. I agree that this authorization is valid for 2 ½ years from the date signed.
4. I know that I have the right to receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.

*(DATE SIGNED)* *(SIGNATURE OF EMPLOYEE/MEMBER)*

*(DATE SIGNED)* *(SIGNATURE OF SPOUSE, IF GIVING A STATEMENT OF INSURABILITY)*

*(DATE SIGNED)* *(SIGNATURE OF CHILD WHO IS NOT A MINOR, IF GIVING A STATEMENT OF INSURABILITY)*

**(These notices should be detached and retained by the applicant)**

## 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.