AMERICAN GENERAL FINANCIAL GROUP

The United States Life Insurance Company in the City of New York
Member American General Financial Group

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.

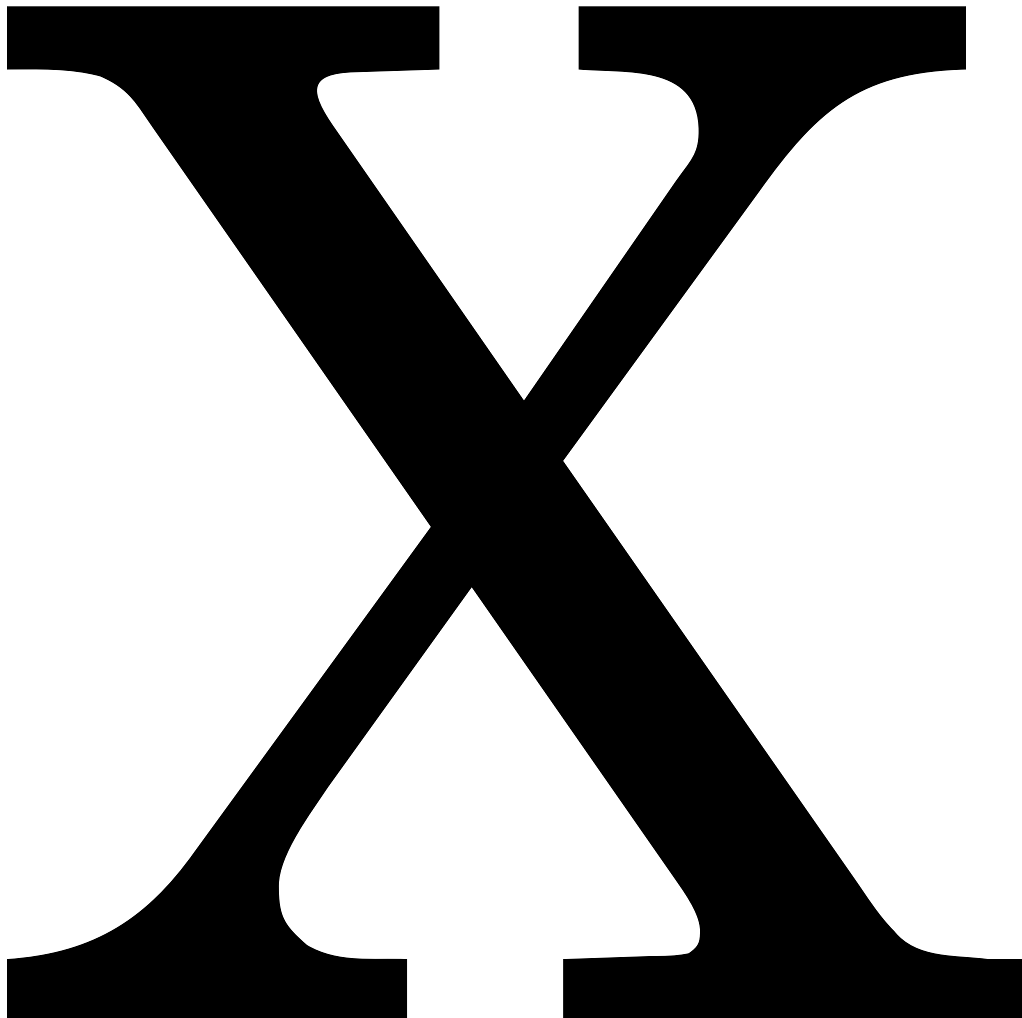
Information regarding your insurability will be treated as confidential except that The United States Life Insurance Company In the City of New York may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates 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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APPLICATION FOR GROUP VOLUNTARY PROGRAMS

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 have prior Dental coverage, please indicate your effective date. If no prior coverage, check "none".**

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
Employee	$ ❑ refused	$ ❑ refused	$ ❑ refused	$ ❑ refused	❑ None ★ Date / /	❑ None ★ Date / /
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	❑ ______ ❑ ______ ❑ ______ ❑ ______
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

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. Insurance shall 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 and health of all such persons from that stated in this application.

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 understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which The United States Life Insurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier.
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.
6. Employee authorizes deductions from earnings for the cost of the insurance.

(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 ______________

HOME OFFICE USE ONLY

		LIFE			AD&D			LTD			STD		
Underwriter/Date	Class	Amount	Units	Eff. Date	Amount	Units	Eff. Date	Amount	Units	Eff. Date	Amount	Units	Eff. Date
EE													
SP								/ / / / / / / / / /			/ / / / / / / / / /		
CH					/ / / / / / / / / /			/ / / / / / / / / /			/ / / / / / / / / /		
Dental		Prior Coverage ❑ Yes ❑ No			❑ Employee			❑ Employee & Spouse			❑ Employee & Child		❑ Full Family
Vision		Prior Coverage ❑ Yes ❑ No			❑ Employee			❑ Employee & Spouse			❑ Employee & Child		❑ Full Family

	Takeover	GI
Employee		
Spouse		
Child(ren)		

SELF ❑ HOME ❑