

SERFF Tracking Number: AMGN-125828983 State: Arkansas  
Filing Company: The United States Life Insurance Company in the State Tracking Number: 40325  
City of New York  
Company Tracking Number: G-19462; G-19463; G-19464  
TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
Product Name: Group Disability Insurance  
Project Name/Number: Application for Group Disability Insurance/G-19462; G-19463; G-19464

## Filing at a Glance

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

Product Name: Group Disability Insurance SERFF Tr Num: AMGN-125828983 State: ArkansasLH  
TOI: H11G Group Health - Disability Income SERFF Status: Closed State Tr Num: 40325  
Sub-TOI: H11G.005 Combined Short Term and Co Tr Num: G-19462; G-19463; G- State Status: Approved-Closed  
Long Term 19464  
Filing Type: Form Co Status: Reviewer(s): Rosalind Minor  
Author: Maggie Sheehan Disposition Date: 09/24/2008  
Date Submitted: 09/23/2008 Disposition Status: Approved-Closed  
Implementation Date Requested: On Approval Implementation Date:  
State Filing Description:

## General Information

Project Name: Application for Group Disability Insurance Status of Filing in Domicile: Authorized  
Project Number: G-19462; G-19463; G-19464 Date Approved in Domicile: 09/02/2008  
Requested Filing Mode: Domicile Status Comments:  
Explanation for Combination/Other: Market Type: Group  
Submission Type: New Submission Group Market Size: Small and Large  
Overall Rate Impact: Group Market Type: Employer, Association  
Filing Status Changed: 09/24/2008 Deemer Date:  
State Status Changed: 09/24/2008  
Corresponding Filing Tracking Number:  
Filing Description:  
To Whom It May Concern:

The United States Life Insurance Company in the City of New York (USL) wishes to submit the above referenced filing for your review and approval.

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The individual applications, G-19462, G-19463, G-19464 will be used to enroll any eligible participants from associations and employer/employee groups for Group Disability Income Insurance coverage through any distribution channel including but not limited to direct mail marketing, and telemarketing. This individual application will be used with the G-19000 policy series of forms previously approved by your department. This individual application is a new form and is not intended to replace any existing forms previously filed and approved.

Although the application will primarily be used by associations and employer/employee groups, we are requesting approval for use by all other statutory eligible groups.

Any bracketed information is being filed as variable and is illustrative. An Explanation of Variability (EOV) for each form is enclosed. Unless otherwise informed, we reserve the right on a case by case basis to alter the layout of the enclosed form, including color, type face and font, and to go outside the range of variables set forth in the application if we are requested to do so by the policyholder, but will only do so if such changes are within the allowable parameters or requirements in the state statutes.

We certify that the type size will always remain as the state required size and all statutory/regulatory requirements will not be changed.

Sincerely,  
Maggie Sheehan  
Analyst, Product Management  
Maggie\_sheehan@aigag.com

## Company and Contact

### Filing Contact Information

Maggie Sheehan, Analyst maggie\_sheehan@aigag.com  
3600 Route 66 (732) 922-7688 [Phone]  
Neptune, NJ 07754 (732) 922-5593[FAX]

### Filing Company Information

The United States Life Insurance Company in CoCode: 70106 State of Domicile: New York

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the City of New York  
830 Third Avenue Group Code: 12 Company Type:  
7th Floor  
New York, NY 10022 Group Name: AIG State ID Number:  
(713) 831-3508 ext. [Phone] FEIN Number: 13-5459480  
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## Filing Fees

Fee Required? Yes  
Fee Amount: \$50.00  
Retaliatory? No  
Fee Explanation: Filing fee of \$50.00 per submission (not per form) for policies, endorsements, advertisements  
etc.  
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$50.00	09/23/2008	22665052

SERFF Tracking Number: AMGN-125828983 State: Arkansas  
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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	09/24/2008	09/24/2008



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<b>Item Type</b>	<b>Item Name</b>	<b>Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Certification/Notice	Approved-Closed	Yes
<b>Supporting Document</b>	Application	Approved-Closed	Yes
<b>Supporting Document</b>	Explanations of Variability	Approved-Closed	Yes
<b>Form</b>	Application for Group Disability Insurance	Approved-Closed	Yes
<b>Form</b>	Application for Group Disability Insurance	Approved-Closed	Yes
<b>Form</b>	Application for Business Overhead Insurance	Approved-Closed	Yes

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## Form Schedule

Lead Form Number: G-19462; G-19463; G-19464

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G-19462	Application/Enrollment Form	Application for Group Disability Insurance	Initial		46	Generic DI Application Short form_G-19462_.pdf
Approved-Closed	G-19463	Application/Enrollment Form	Application for Group Disability Insurance	Initial		46	Generic DI Application USL long form_G-19463_.pdf
Approved-Closed	G-19464	Application/Enrollment Form	Application for Business Overhead Insurance	Initial		46	Generic BOE Application USL _G-19464_.pdf



Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; arthritis or other musculoskeletal disease or disorder; [ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV]?  Yes  No
2. **Other than stated above**, 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?  Yes  No
3. Are you now taking prescription medication or receiving medical attention?  Yes  No

For "Yes" answers to questions [1-3] above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes"  Yes  No

Question #	Condition	Date Occurred	Duration	Name and Address of Physicians, Hospitals or Clinics Consulted

**EXISTING AND PENDING INSURANCE SECTION**

5. Do you have any disability insurance in force or pending? (including group Coverage) . . . . .  Yes  No  
 (If "Yes", please indicate companies and amounts) \_\_\_\_\_
6. Will this coverage applied for replace any insurance now in force? . . . . .  Yes  No  
 (If "Yes", please indicate which insurance and the amount being replaced)  
 \_\_\_\_\_

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

**[ Important Notice:** Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state specific variations refer to page [xx] of this application) ]

A copy of this application will be attached to and made a part of your certificate.

Date \_\_\_\_\_ Member/Applicant's Signature \_\_\_\_\_

**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 Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., 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, Inc., 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 (866) 692-6901 [TTY (866) 346-3642].

The Company 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 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.

**[Important Notice**

***For residents of Arkansas, Louisiana and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

***For residents of Maine, Tennessee and Washington:***

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

***For residents of Maryland:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

***For residents of Oklahoma:*** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

***For residents of Virginia:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]





Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disease or disorder of the rectum? Vascular or blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	m. A surgical operation? Or a surgical operation advised but not performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? <input type="checkbox"/> Yes <input type="checkbox"/> No	n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No
	o. Alcohol or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. 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 those stated above?  Yes  No

[3. Are you now taking prescription medication or receiving medical attention?]  Yes  No

For "Yes" answers to questions [1-3] above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes"  Yes  No

Question #	Condition	Date Occurred	Duration	Name and Address of Physicians, Hospitals or Clinics Consulted

**EXISTING AND PENDING INSURANCE SECTION**

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

6. Will this coverage applied for replace any insurance now in force? .....  Yes  No  
 (If "Yes", please indicate which insurance and the amount being replaced)  
 \_\_\_\_\_

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

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Date \_\_\_\_\_ Member/Applicant's Signature \_\_\_\_\_

G-19463

Group Policy No. [ G-XXXXXX] [A] [date]

Pg. [ ]

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MIB-19431

**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.

FCRA-19432

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***For residents of Maryland:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

***For residents of Oklahoma:*** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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**Please answer these brief questions.**

**To the best of your knowledge and belief:**

1. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disease or disorder of the rectum? Vascular or blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	m. A surgical operation? Or a surgical operation advised but not performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? <input type="checkbox"/> Yes <input type="checkbox"/> No	n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? <input type="checkbox"/> Yes <input type="checkbox"/> No
	o. Alcohol or drug abuse? <input type="checkbox"/> Yes <input type="checkbox"/> No

2. 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 those stated above?  Yes  No

[3. Are you now taking prescription medication or receiving medical attention?]  Yes  No

For "Yes" answers to questions [1-3] above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes"  Yes  No

Question #	Condition	Date Occurred	Duration	Name and Address of Physicians, Hospitals or Clinics Consulted

**EXISTING AND PENDING INSURANCE SECTION**

5. Do you have any Business Overhead Insurance in force or pending? (including group coverage). . . . .  Yes  No  
(If "Yes", please indicate companies and amounts) \_\_\_\_\_

6. Will this coverage applied for replace any insurance now in force? . . . . .  Yes  No  
(If "Yes", please indicate which insurance and the amount being replaced)

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

[ **Important Notice:** Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state specific variations refer to page [xx] of this application) ]

A copy of this application will be attached to and made a part of your certificate.

Date \_\_\_\_\_ Member/Applicant's Signature \_\_\_\_\_

**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 Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., 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, Inc., 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 (866) 692-6901 [TTY (866) 346-3642].

The Company 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.

MIB-19431

**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.

FCRA-19432

**[ Important Notice**

***For residents of Arkansas, Louisiana and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

***For residents of Florida:*** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

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***For residents of Maryland:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

***For residents of Oklahoma:*** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

***For residents of Virginia:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]





SERFF Tracking Number: AMGN-125828983 State: Arkansas  
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 40325  
 City of New York  
 Company Tracking Number: G-19462; G-19463; G-19464  
 TOI: H11G Group Health - Disability Income Sub-TOI: H11G.005 Combined Short Term and Long Term  
 Product Name: Group Disability Insurance  
 Project Name/Number: Application for Group Disability Insurance/G-19462; G-19463; G-19464

## Supporting Document Schedules

**Satisfied -Name:** Certification/Notice **Review Status:** Approved-Closed 09/24/2008  
**Comments:**  
**Attachments:**  
 AR LH214AR\_112805.pdf  
 Readability Certification.pdf  
 AR Guaranty Notice.pdf

**Satisfied -Name:** Application **Review Status:** Approved-Closed 09/24/2008  
**Comments:**  
**Attachments:**  
 Generic BOE Application USL \_G-19464\_.pdf  
 Generic DI Application USL long form\_G-19463\_.pdf  
 Generic DI Application Short form\_G-19462\_.pdf

**Satisfied -Name:** Explanations of Variability **Review Status:** Approved-Closed 09/24/2008  
**Comments:**  
**Attachments:**  
 Generic DI App Short Form EOV.pdf  
 Generic BOE App EOV.pdf  
 Generic DI App Long Form EOV.pdf

## Certificate of Compliance with Arkansas Rule and Regulation 19

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

Form Number(s): G-19462 Application for Group Disability Insurance  
G-19463 Application for Group Disability Insurance  
G-19464 Application for Business Overhead Insurance

I hereby certify that the filing above meets all applicable Arkansas requirements including the requirements of Rule and Regulation 19.



\_\_\_\_\_  
Signature of Company Officer

Keith Coleman  
\_\_\_\_\_  
Name

Compliance Officer  
\_\_\_\_\_  
Title

9/23/2008  
\_\_\_\_\_  
Date

.READABILITY CERTIFICATION

I, Keith Coleman, Compliance Officer of The United States Life Insurance Company in the City of New York, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Scores are as follows:

Application for Group Disability Insurance	G- 19462	46.3
Application for Group Disability Insurance	G-19463	46.1
Application for Business Overhead Insurance	G-19464	46.1



Date: 9/23/2008

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Keith Coleman  
Compliance Officer

## LIMITATIONS AND EXCLUSIONS UNDER THE ARKANSAS LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION ACT

Residents of this state who purchase life insurance, annuities or health and accident insurance should know that the insurance companies licensed in this state to write these types of insurance are members of the Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association"). The purpose of the Guaranty Association is to assure that policy and contract owners will be protected, within certain limits, in the unlikely event that a member insurer becomes financially unable to meet its obligations. If this should happen, the Guaranty Association will assess its other member insurance companies for the money to pay the claims of policy owners who live in this state and, in some cases, to keep coverage in force. The valuable extra protection provided by the member insurers through the Guaranty Association is not unlimited, however. And, as noted in the box below, this protection is not a substitute for consumers' care in selecting insurance companies that are well managed and financially stable.

### DISCLAIMER

The Arkansas Life and Health Insurance Guaranty Association ("Guaranty Association") may not provide coverage for this policy. If coverage is provided, it may be subject to substantial limitations or exclusions and require continued residency in this state. You should not rely on coverage by the Guaranty Association in purchasing an insurance policy or contract.

Coverage is NOT provided for your policy or contract or any portion of it that is not guaranteed by the insurer or for which you have assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract.

Insurance companies or their agents are required by law to provide you with this notice. However, insurance companies and their agents are prohibited by law from using the existence of the Guaranty Association to induce you to purchase any kind of insurance policy.

The Arkansas Life and Health  
Insurance Guaranty Association  
c/o The Liquidation Division  
1023 West Capitol  
Little Rock, Arkansas 72201

Arkansas Insurance Department  
1200 West Third Street  
Little Rock, Arkansas 72201-1904

The state law that provides for this safety-net is called the Arkansas Life and Health Insurance Guaranty Association Act ("Act"). Below is a brief summary of the Act's coverages, exclusions and limits. This summary does not cover all provisions of the Act; nor does it in any way change anyone's rights or obligations under the Act or the rights or obligations of the Guaranty Association.

### COVERAGE

Generally, individuals will be protected by the Guaranty Association if they live in this state and hold a life, annuity or accident and health insurance contract or policy, or if they are insured under a group insurance contract issued by a member insurer. The beneficiaries, payees or assignees of policy or contract owners are protected as well, even if they live in another state.

## EXCLUSIONS FROM COVERAGE

However, persons owning such policies are NOT protected by the Guaranty Association if:

- They are eligible for protection under the laws of another state (this may occur when the insolvent insurer was incorporated in another state whose guaranty association protects insureds who live outside that state);
- The insurer was not authorized to do business in this state;
- Their policy or contract was issued by a nonprofit hospital or medical service organization, an HMO, a fraternal benefit society, a mandatory state pooling plan, a mutual assessment company or similar plan in which the policy or contract owner is subject to future assessments, or by an insurance exchange.

The Guaranty Association also does NOT provide coverage for:

- Any policy or contract or portion thereof which is not guaranteed by the insurer or for which the owner has assumed the risk, such as non-guaranteed amounts held in a separate account under a variable life or variable annuity contract;
- Any policy of reinsurance (unless an assumption certificate was issued);
- Interest rate yields that exceed an average rate;
- Dividends and voting rights and experience rating credits;
- Credits given in connection with the administration of a policy by a group contract holder;
- Employers' plans to the extent they are self-funded (that is, not insured by an insurance company, even if an insurance company administers them);
- Unallocated annuity contracts (which give rights to group contractholders, not individuals);
- Unallocated annuity contracts issued to/in connection with benefit plans protected under Federal Pension Benefit Corporation ("FPBC") (whether the FPBC is yet liable or not);
- Portions of an unallocated annuity contract not owned by a benefit plan or a government lottery (unless the owner is a resident) or issued to a collective investment trust or similar pooled fund offered by a bank or other financial institution);
- Portions of a policy or contract to the extent assessments required by law for the Guaranty Association are preempted by State or Federal law;
- Obligations that do not arise under the policy or contract, including claims based on marketing materials or side letters, riders, or other documents which do not meet filing requirements, or claims for policy misrepresentations, or extra-contractual or penalty claims;
- Contractual agreements establishing the member insurer's obligations to provide book value accounting guarantees for defined contribution benefit plan participants (by reference to a portfolio of assets owned by a nonaffiliate benefit plan or its trustees).

## **LIMITS ON AMOUNT OF COVERAGE**

The Act also limits the amount the Guaranty Association is obligated to cover: The Guaranty Association cannot pay more than what the insurance company would owe under a policy or contract. Also, for any one insured life, the Guaranty Association will pay a maximum of \$300,000 -- no matter how many policies and contracts there were with the same company, even if they provided different types of coverages. Within this overall \$300,000 limit, the Association will not pay more than \$300,000 in health insurance benefits, \$300,000 in present value of annuity benefits, or \$300,000 in life insurance death benefits or net cash surrender values -- again, no matter how many policies and contracts there were with the same company, and no matter how many different types of coverages. There is a \$1,000,000 limit with respect to any contract holder for unallocated annuity benefits, irrespective of the number of contracts held by the contract holder. These are limitations for which the Guaranty Association is obligated before taking into account either its subrogation and assignment rights or the extent to which those benefits could be provided out of the assets of the impaired or insolvent insurer.



**Please answer these brief questions.**

**To the best of your knowledge and belief:**

1. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? <input type="checkbox"/> Yes <input type="checkbox"/> No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disease or disorder of the rectum? Vascular or blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	m. A surgical operation? Or a surgical operation advised but not performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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2. 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 those stated above?  Yes  No

[3. Are you now taking prescription medication or receiving medical attention?]  Yes  No

For "Yes" answers to questions [1-3] above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes"  Yes  No

Question #	Condition	Date Occurred	Duration	Name and Address of Physicians, Hospitals or Clinics Consulted

**EXISTING AND PENDING INSURANCE SECTION**

5. Do you have any Business Overhead Insurance in force or pending? (including group coverage). . . . .  Yes  No  
(If "Yes", please indicate companies and amounts) \_\_\_\_\_

6. Will this coverage applied for replace any insurance now in force? . . . . .  Yes  No  
(If "Yes", please indicate which insurance and the amount being replaced)  
\_\_\_\_\_

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

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MIB-19431

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FCRA-19432

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***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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***For residents of Oklahoma:*** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

***For residents of Virginia:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]





Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? <input type="checkbox"/> Yes <input type="checkbox"/> No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? <input type="checkbox"/> Yes <input type="checkbox"/> No
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d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? <input type="checkbox"/> Yes <input type="checkbox"/> No
e. Disease or disorder of the rectum? Vascular or blood disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? <input type="checkbox"/> Yes <input type="checkbox"/> No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No	m. A surgical operation? Or a surgical operation advised but not performed? <input type="checkbox"/> Yes <input type="checkbox"/> No
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**EXISTING AND PENDING INSURANCE SECTION**

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

6. Will this coverage applied for replace any insurance now in force? .....  Yes  No  
 (If "Yes", please indicate which insurance and the amount being replaced)  
 \_\_\_\_\_

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

[ Important Notice: Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state specific variations refer to page [xx] of this application ) ]

A copy of this application will be attached to and made a part of your certificate.

Date \_\_\_\_\_ Member/Applicant's Signature \_\_\_\_\_

G-19463

Group Policy No. [ G-XXXXXX] [A] [date]

Pg. [ ]

**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 Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., 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, Inc., 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 (866) 692-6901 [TTY (866) 346-3642].

The Company 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.

MIB-19431

**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.

FCRA-19432

**[Important Notice**

**For residents of Arkansas, Louisiana and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

**For residents of the District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

**For residents of Maine, Tennessee and Washington:**

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

**For residents of Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

**For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

**For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

**For residents of Oklahoma:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

**For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

**For residents of Virginia:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]



Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; arthritis or other musculoskeletal disease or disorder; [ Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV]?  Yes  No
2. **Other than stated above**, 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?  Yes  No
3. Are you now taking prescription medication or receiving medical attention?  Yes  No

For “Yes” answers to questions [1-3] above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check “Yes”  Yes  No

Question #	Condition	Date Occurred	Duration	Name and Address of Physicians, Hospitals or Clinics Consulted

**EXISTING AND PENDING INSURANCE SECTION**

5. Do you have any disability insurance in force or pending? (including group Coverage) . . . . .  Yes  No  
(If “Yes”, please indicate companies and amounts) \_\_\_\_\_
6. Will this coverage applied for replace any insurance now in force? . . . . .  Yes  No  
(If “Yes”, please indicate which insurance and the amount being replaced)  
\_\_\_\_\_

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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 Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and 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 the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. 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.

**[ Important Notice:** Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state specific variations refer to page [xx] of this application) ]

A copy of this application will be attached to and made a part of your certificate.

Date \_\_\_\_\_ Member/Applicant’s Signature \_\_\_\_\_

**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 Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., 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, Inc., 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 (866) 692-6901 [TTY (866) 346-3642].

The Company 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 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.

**[Important Notice**

***For residents of Arkansas, Louisiana and West Virginia:*** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of Colorado:*** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

***For residents of the District of Columbia:*** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

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***For residents of Kentucky:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime.

***For residents of Maine, Tennessee and Washington:***

It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

***For residents of Maryland:*** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

***For residents of New Jersey:*** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

***For residents of New Mexico:*** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES.

***For residents of New York:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

***For residents of Ohio:*** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

***For residents of Oklahoma:*** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

***For residents of Pennsylvania:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

***For residents of Virginia:*** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. ]



# APPLICATION FOR GROUP DISABILITY INSURANCE

## Explanation of Variability for Form No. G-19462

### GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case.
- The Association Logo, if inserted, will vary on a case-by-case basis.

*Please note: The above variables will not be explained everywhere they appear. Items which are considered illustrative are not explained.*

### APPLICATION FORM G-G-19462 SECTION

### EXPLANATION OF VARIABLE AREA

#### Heading

A space has been left for Association logos to be included if a particular client requests it as well as a place for instructions for completing the form which may be included or omitted.

#### Information Section

Formatting of this information and some content may also vary depending upon solicitation method.

In certain instances some of the applicant information such as name and address may be pre-filled and format may vary based upon solicitation method.

#### Question 9 (page 1)

90 days may be changed to be 30, 60 or 90 days during which the applicant performed their regular occupation.

30 hours per week may be changed to be either 20, 25, or 30 hours per week.

#### Insurance Requested (Question 14)

The waiting period options will be included as shown or one or more of the waiting period options available may be omitted.

In addition, in certain instances the waiting period may be pre-filled and no options will appear or it may simply be a blank space to be completed by the applicant, rather than options.

Specific monthly benefit amounts may also be shown or omitted in place of the blank space currently shown.

Monthly benefit amounts may range from \$500 up to \$20,000 per month, not to exceed \$40,000. (Minimums and maximums may vary depending upon whether the coverage is for short term or long term disability) These amounts will never exceed the state allowable maximums, if any.

The monthly benefit will never exceed 75% of the insured's basic monthly pay and may range from 20-75%.

## **APPLICATION FOR GROUP DISABILITY INSURANCE**

### **Explanation of Variability for Form No. G-19462**

#### **Billing/Payment Options (Question 15)**

The options listed will be included as shown or one or more of the options available may be omitted.

#### **Health Questions**

Question 1- The AIDS / HIV section will be included as shown or omitted.

Question 3 will be included as shown or omitted.

#### **Important Notice**

The language will be included as shown, or may be replaced with the appropriate state specific language appearing on the attached page of the Application.

# APPLICATION FOR BUSINESS OVERHEAD INSURANCE

## Explanation of Variability for Form No. G-19464

### GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case.
- The Association Logo, if inserted, will vary on a case-by-case basis.

*Please note: The above variables will not be explained everywhere they appear. Items which are considered illustrative are not explained.*

### APPLICATION FORM G-19464 SECTION

### EXPLANATION OF VARIABLE AREA

#### Heading

A space has been left for Association logos to be included if a particular client requests it as well as a place for instructions for completing the form which may be included or omitted

#### Information Section

Formatting of this information and some content may also vary depending upon solicitation method.

In certain instances some of the applicant information such as name and address may be pre-filled and format may vary based upon solicitation method.

#### Question 9 (page 1)

90 days may be changed to be 30, 60 or 90 days during which the applicant performed their regular occupation.

30 hours per week may be changed to be either 20, 25, or 30 hours per week.

#### Insurance Requested (Question 14)

The waiting period options will be included as shown or one or more of the waiting period options available may be omitted.

In addition, in certain instances the waiting period may be pre-filled and no options will appear or it may simply be a blank space to be completed by the applicant, rather than options.

Specific monthly benefit amounts may also be shown or omitted in place of the blank space currently shown.

Monthly benefit amounts may range from \$500 up to \$20,000 per month, not to exceed \$40,000. (Minimums and maximums may vary depending upon whether the coverage is for short term or long term disability) These amounts will never exceed the state allowable maximums, if any.

The monthly benefit will never exceed 75% of the insured's basic monthly pay and may range from 20-75%.

## APPLICATION FOR BUSINESS OVERHEAD INSURANCE

### Explanation of Variability for Form No. G-19464

**Billing/Payment Options  
(Question 15)**

The options listed will be included as shown or one or more of the options available may be omitted.

**Health Questions**

Question 3 will be included as shown or omitted.

**Important Notice**

The language will be included as shown, or may be replaced with the appropriate state specific language appearing on the attached page of the Application.

# APPLICATION FOR GROUP DISABILITY INSURANCE

## Explanation of Variability for Form No. G-19463

### GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case.
- The Association Logo, if inserted, will vary on a case-by-case basis.

*Please note: The above variables will not be explained everywhere they appear. Items which are considered illustrative are not explained.*

### APPLICATION FORM G-19463 SECTION

### EXPLANATION OF VARIABLE AREA

#### Heading

A space has been left for Association logos to be included if a particular client requests it as well as a place for instructions for completing the form which may be included or omitted.

#### Information Section

Formatting of this information and some content may also vary depending upon solicitation method.

In certain instances some of the applicant information such as name and address may be pre-filled and format may vary based upon solicitation method.

#### Question 9 (page 1)

90 days may be changed to be 30, 60 or 90 days during which the applicant performed their regular occupation.

30 hours per week may be changed to be either 20, 25, or 30 hours per week.

#### Insurance Requested (Question 14)

The waiting period options will be included as shown or one or more of the waiting period options available may be omitted.

In addition, in certain instances the waiting period may be pre-filled and no options will appear or it may simply be a blank space to be completed by the applicant, rather than options.

Specific monthly benefit amounts may also be shown or omitted in place of the blank space currently shown.

Monthly benefit amounts may range from \$500 up to \$20,000 per month, not to exceed \$40,000. (Minimums and maximums may vary depending upon whether the coverage is for short term or long term disability)

These amounts will never exceed the state allowable maximums, if any.

The monthly benefit will never exceed 75% of the insured's basic monthly pay and may range from 20-75%.

## APPLICATION FOR GROUP DISABILITY INSURANCE

### Explanation of Variability for Form No. G-19463

**Optional Insurance  
(Question 15)**

The options listed will be included as shown or one or more of the options available may be omitted

**Billing/Payment Options  
(Question 16)**

The options listed will be included as shown or one or more of the options available may be omitted.

**Health Questions**

Question 3 will be included as shown or omitted.

**Important Notice**

The language will be included as shown, or may be replaced with the appropriate state specific language appearing on the attached page of the Application.