

SERFF Tracking Number: AMGN-126098186 State: Arkansas
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
 City of New York
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Life & Health
 Project Name/Number: G-19027-L/G-19027-L

Filing at a Glance

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

Product Name: Life & Health	SERFF Tr Num: AMGN-126098186	State: ArkansasLH
TOI: H21 Health - Other	SERFF Status: Closed	State Tr Num: 42054
Sub-TOI: H21.000 Health - Other	Co Tr Num:	State Status: Approved-Closed
Filing Type: Form	Co Status:	Reviewer(s): Rosalind Minor
	Author: Cheryl Sileno	Disposition Date: 04/08/2009
	Date Submitted: 04/06/2009	Disposition Status: Approved-Closed
		Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: G-19027-L	Status of Filing in Domicile: Pending
Project Number: G-19027-L	Date Approved in Domicile:
Requested Filing Mode: Review & Approval	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, Trust, Other
	Explanation for Other Group Market Type: all other statutory eligible groups.
Filing Status Changed: 04/08/2009	State Status Changed: 04/08/2009
Deemer Date:	Corresponding Filing Tracking Number:
Filing Description:	

RE: Application for Group [Voluntary] Insurance Programs

Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs G-19027-L

SERFF Tracking Number: AMGN-126098186 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Life & Health
Project Name/Number: G-19027-L/G-19027-L

The United States Life Insurance Company in the City of New York wishes to submit the above referenced filing for your review and approval. This form is a new form and is not intended to replace any existing forms previously filed and approved.

The enclosed application, G-19027-L, will be used for our employer and association group programs. The Application for Group [Voluntary] Insurance Programs; Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs (G-19027-L) will be used to allow employees/members to apply for group life &/or health coverages under their employer's or association's insurance programs. This would be done through any distribution channel including but not limited to direct mail marketing and on-line enrollment. The TOI selected is for "Health - Other", but since it is a combined application for both life and health coverages, we ask that the form be reviewed for both coverages under this submission.

Although this form will primarily be used by employer/employee and association groups, we are requesting approval for use by all other statutory eligible groups as well.

The form has been completed in John Doe fashion and is in final printed format subject only to changes in font style, margins, page numbers and paper stock. The bracketed areas are filed as variable to allow for changes but would only be changed if such changes are within the allowable parameters or requirements in the state statutes.

The application will be implemented for use upon approval by your Department.

Please let me know if you have any questions.

Your review of this filing is appreciated.

Company and Contact

Filing Contact Information

Cheryl Sileno, Senior Analyst
3600 Route 66

cheryl_sileno@aigag.com
(732) 922-7771 [Phone]

SERFF Tracking Number: AMGN-126098186 State: Arkansas

Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York

Company Tracking Number:

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Life & Health

Project Name/Number: G-19027-L/G-19027-L

Neptune, NJ 07754 (732) 922-5593[FAX]

Filing Company Information

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

SERFF Tracking Number: AMGN-126098186 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Life & Health
Project Name/Number: G-19027-L/G-19027-L

Filing Fees

Fee Required? Yes
Fee Amount: \$20.00
Retaliatory? No
Fee Explanation: 1 form x \$20.00 = \$20.00
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$20.00	04/06/2009	26988014

SERFF Tracking Number: AMGN-126098186 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Life & Health
Project Name/Number: G-19027-L/G-19027-L

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	04/08/2009	04/08/2009

SERFF Tracking Number: AMGN-126098186 State: Arkansas

Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York

Company Tracking Number:

TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other

Product Name: Life & Health

Project Name/Number: G-19027-L/G-19027-L

Item Type	Item Name	Item Status	Public Access
Supporting Document	Flesch Certification	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	Yes
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	AR Guaranty Notice and Consumer Notice	Approved-Closed	Yes
Supporting Document	AR Certificate of Compliance	Approved-Closed	Yes
Form	Application for Group [Voluntary] Insurance Programs; Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs	Approved-Closed	Yes

SERFF Tracking Number: AMGN-126098186 State: Arkansas
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
 City of New York
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Life & Health
 Project Name/Number: G-19027-L/G-19027-L

Form Schedule

Lead Form Number: G-19027-L

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G-19027-L	Application/Enrollment Form	Application for Group [Voluntary] Insurance Programs; Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs	Initial		50	G-19027-L_FINAL_John Doe Version_.pdf

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

[These Notices must be detached and retained by the applicant]

[MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is [50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.]

The Company, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.]

[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.]

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

Please print or type all information requested.

Group Policy Number G-123456 Division Eastern

Please complete all sections of the application to avoid delays.

Employee's annual salary \$ 35,000 Hire Date 01/15/2005

Job Title Clerk]E

1. Name of [Employer/Association] ABC Company

2. [Employee's/Member's full name] John A. Doe
FIRST MIDDLE LAST

3. Home Address 123 Main Street Any Town Any State 01234 (123) 435-7890
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

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

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

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental	Vision
Employee	\$ <u>35,000</u> <input type="checkbox"/> refused	\$ <u>35,000</u> <input type="checkbox"/> refused	\$ <u>35,000</u> <input type="checkbox"/> refused	\$ <u>35,000</u> <input type="checkbox"/> refused	<input type="checkbox"/> Prior Coverage * Date / /	<input type="checkbox"/> Refused
Spouse/DP**	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	(not to exceed maximum benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family	<input checked="" type="checkbox"/> Employee <input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family
Child(ren):	\$ _____ <input type="checkbox"/> refused	/ / / / / /				

]F

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

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

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

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	[Social Security #]
EE	<u>John A. Doe</u>	<u>35</u>	<u>02/01/74</u>	<u>M</u>	<u>Any Town, Any State</u>	<u>6ft. in.</u>	<u>190 lbs.</u>	<u>123-45-6789</u>
[SP/DP]						ft. in.	lbs.	
[CH]						ft. in.	lbs.	
[CH]						ft. in.	lbs.	

]I

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

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

- | | | | |
|--|---|--|--|
| | EMPLOYEE/MEMBER | [SPOUSE/DP] | [CHILD] |
| | <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
- [6. **Version 1:** 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?
Version 2: Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver ; lungs or blood; chest pain; stroke or other neurological disorder; cancer or tumor; AIDS (Acquired Immune Deficiency Syndrome); AIDS related complex, or other immune disorder; diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency; arthritis or other musculoskeletal disease or disorder?] **J**
- [7. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution for any reason other than stated above?] **K**
- [8. Are you presently taking any medications?] **L**
- [9. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?] **M**

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

SIGNATURE IS REQUIRED [ON THE FOLLOWING PAGE]

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

10. Have you used tobacco in any form during the past [12-36] months?	EMPLOYEE/MEMBER <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	[SPOUSE/DP] <input type="checkbox"/> Yes <input type="checkbox"/> No
---	---	--

If this question is not completed, you will be billed using smoker rates.

JO

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

[AUTHORIZATION

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

4/01/09
(DATE SIGNED)

➤ John A. Doe
(SIGNATURE OF EMPLOYEE/MEMBER)

[
(DATE SIGNED)

➤ _____]S
(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 _____]T

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

[Important Notice

For residents of Arkansas, Louisiana, Maryland 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, Virginia 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 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.

The following statement does not apply to an application for life insurance in New York:

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.

[LOGO]A

[Application for Group [Voluntary] Insurance Programs]

[Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs]B

[Employee/Spouse/Domestic Partner]C

[Program Name]D

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

New York, New York
(Herein called the Company)

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

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.]U

SERFF Tracking Number: AMGN-126098186 State: Arkansas
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
 City of New York
 Company Tracking Number:
 TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
 Product Name: Life & Health
 Project Name/Number: G-19027-L/G-19027-L

Supporting Document Schedules

Satisfied -Name: Flesch Certification **Review Status:** Approved-Closed 04/08/2009
Comments:
Attachment:
 Flesch Score Certif. (KC).pdf

Bypassed -Name: Application **Review Status:** Approved-Closed 04/08/2009
Bypass Reason: Th e purpose of this filing is to file an application. Please refer to the Form Schedule page for a
 acopy of the application.

Comments:

Bypassed -Name: Health - Actuarial Justification **Review Status:** Approved-Closed 04/08/2009
Bypass Reason: N/A. This is a filing for a application for certain group life and health products.

Comments:

Bypassed -Name: Outline of Coverage **Review Status:** Approved-Closed 04/08/2009
Bypass Reason: N/A. This is a filing for a application for certain group life and health products.

Comments:

Satisfied -Name: AR Guaranty Notice and Consumer Notice **Review Status:** Approved-Closed 04/08/2009

Comments:

Attachments:

AR Guaranty Notice.pdf
 CN-AR (USL)(Neptune).pdf

Review Status:

SERFF Tracking Number: AMGN-126098186 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 42054
City of New York
Company Tracking Number:
TOI: H21 Health - Other Sub-TOI: H21.000 Health - Other
Product Name: Life & Health
Project Name/Number: G-19027-L/G-19027-L
Satisfied -Name: AR Certificate of Compliance Approved-Closed 04/08/2009
Comments:
Attachment:
AR Certificate of Compliance.pdf

READABILITY CERTIFICATION

I, Keith Coleman, Compliance Officer and Assistant Secretary 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 Score is as follows:

Application for Group [Voluntary] Insurance Programs
Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs G- 19027-L 50.2

Keith W. Coleman

4/06/09

Date: _____

Keith Coleman
Compliance Officer and Assistant Secretary

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.

IMPORTANT POLICYHOLDER SERVICE INFORMATION REGARDING YOUR INSURANCE

In the event you need to contact someone about this insurance for any reason please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact the insurance company issuing this insurance at the following address and telephone number:

**United States Life Insurance Company
Customer Service
3600 Route 66
Neptune, NJ 07754-1580
800-346-7692**

If you have been unable to contact or obtain satisfaction from the company or the agent, you may contact the Arkansas Insurance Department at:

**Arkansas Insurance Department
Consumer Services Division
1200 West Third Street
Little Rock, Arkansas 72201-1904
Phone: 501-371-2640, 800-852-5494**

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, company or the Arkansas Insurance Department, have your policy number available.

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-19027-L Application for Group [Voluntary] Insurance Programs
Evidence/Statement of Insurability for Group [Voluntary] Insurance Programs

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

Keith W. Coleman

Signature of Company Officer

Keith Coleman

Name

Assistant Secretary & Compliance Officer

Title

4/6/09

Date