

SERFF Tracking Number: AMGN-126553197 State: Arkansas
Filing Company: The United States Life Insurance Company in the State Tracking Number: 45229
City of New York
Company Tracking Number: G-19560
TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
Product Name: Group Term Life / Disability
Project Name/Number: Combination Application G-19560/G-19560

Filing at a Glance

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

Product Name: Group Term Life / Disability SERFF Tr Num: AMGN-126553197 State: Arkansas
TOI: L04G Group Life - Term SERFF Status: Closed-Approved- State Tr Num: 45229
Closed

Sub-TOI: L04G.500 Other Co Tr Num: G-19560 State Status: Approved-Closed
Filing Type: Form Reviewer(s): Linda Bird
Author: Bernadette Pham Disposition Date: 05/12/2010
Date Submitted: 03/22/2010 Disposition Status: Approved-Closed

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: Combination Application G-19560
Project Number: G-19560
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:
Filing Status Changed: 05/12/2010

Status of Filing in Domicile: Pending
Date Approved in Domicile:
Domicile Status Comments:
Market Type: Group
Group Market Size: Large
Group Market Type: Association, Trust, Other
Explanation for Other Group Market Type: all
statutory eligible groups
State Status Changed: 03/23/2010
Created By: Bernadette Pham
Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Bernadette Pham

Filing Description:

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-19560, will be used for our association group programs. The application will be used to allow members to apply for group life & health coverages under their association's insurance programs (Life, Long Term Disability). This would be done through any distribution channel including but not limited to direct mail marketing and on-

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 line enrollment.

Although this form will primarily be used by association groups, we are requesting approval for use by other statutory eligible groups as well (for example, Trust groups). In addition, the TOI selected is " L04G Group Life - Term". However, this is a combined application for both life and disability coverages. We ask that the application be reviewed for both coverages under this submission.

The form is 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.

Thank you.

Company and Contact

Filing Contact Information

Bernadette Pham, Analyst bernadette.pham@aglife.com
 3600 Route 66 732-922-7225 [Phone]
 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 Group Name: AIG State ID Number:
 New York, NY 10022 FEIN Number: 13-5459480
 (713) 831-3508 ext. [Phone]

Filing Fees

Fee Required? No
 Retaliatory? No
 Fee Explanation:
 Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
The United States Life Insurance Company in the City of New York	\$50.00	03/22/2010	35066179

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	05/12/2010	05/12/2010
Approved-Closed	Linda Bird	03/23/2010	03/23/2010

Amendments

Schedule	Schedule Item Name	Created By	Created On	Date Submitted
Form	Application for Term Life Insurance and Disability Income	Bernadette Pham	05/11/2010	05/11/2010
Supporting Document	EOV for G-19560	Bernadette Pham	05/11/2010	05/11/2010

Filing Notes

Subject	Note Type	Created By	Created On	Date Submitted
An oversight	Note To Filer	Linda Bird	05/10/2010	05/10/2010
An oversight	Note To Reviewer	Bernadette Pham	05/06/2010	05/06/2010

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 Product Name: Group Term Life / Disability
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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	EOV for G-19560		Yes
Form (<i>revised</i>)	Application for Term Life Insurance and Disability Income		Yes
Form	Application for Term Life Insurance and Disability Income	Replaced	Yes

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	EOV for G-19560		Yes
Form (<i>revised</i>)	Application for Term Life Insurance and Disability Income		Yes
Form	Application for Term Life Insurance and Disability Income	Replaced	Yes

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 Product Name: Group Term Life / Disability
 Project Name/Number: Combination Application G-19560/G-19560

Amendment Letter

Submitted Date: 05/11/2010

Comments:

Thank you so much for "re-opening" this filing. We have included the MIB/FCRA disclosure notices. These notices are at the end of the application. In addition, we have included the EOV document as well. Please advise should you have any questions. Thank you again.

Changed Items:

Form Schedule Item Changes:

Form Schedule Item Changes:

Form Number	Form Type	Form Name	Action	Form Action Other	Previous Filing #	Replaced Form #	Readability Score	Attachments
G-19560	Application/EApplication nrollment Form	Application for Term Life Insurance and Disability Income	Initial				50.200	G-19560 Final 2.pdf

Supporting Document Schedule Item Changes:

User Added -Name: EOV for G-19560

Comment:

EOV for G-19560 Final 2.pdf

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Product Name: Group Term Life / Disability
Project Name/Number: Combination Application G-19560/G-19560

Note To Reviewer

Created By:

Bernadette Pham on 05/06/2010 03:58 PM

Last Edited By:

Bernadette Pham

Submitted On:

05/06/2010 03:59 PM

Subject:

An oversight

Comments:

Thank you for the approval of G-19560! However, we have just realized that we erroneously left out the MIB and FCRA disclosure notices from the medical application. Please advise if we need to re-submit the application under a new filing or if at all possible, could you re-open this filing? We would like to add the disclosure notices information and update the EOv. We apologize for any inconvenience this may have caused. Any assistance will be much appreciated. Thank you so much!

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Form Schedule

Lead Form Number: G-19560

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	G-19560	Application/ Enrollment Form Application for Term Life Insurance and Disability Income	Initial		50.200	G-19560 Final 2.pdf

[OWNER INFORMATION (The Proposed Insured will be the Owner if no designation below.)

Owner's Full Name (If Trust Owner – Trustee's Legal Name and Date of Trust) ___ Relationship _____ Date of Birth ___/___/___

Address _____ City _____ State _____ ZIP _____ Social Security No. _____ **19**

Term Life BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT **10**

[Send Bills to: Home Office] **11**

PART 3

COVERAGE OPTIONS FOR DISABILITY INCOME INSURANCE

[(Eligible classes are Resident Physicians and Practicing Physicians)] **12**

1. Amount of disability income requested: \$ _____ monthly benefit (up to **[\$12,500] 13**. Cannot exceed **[66⅔%] 13** of your monthly earned income or **[\$20,000]13** when added to any other disability insurance inforce or applied for.)

2. Waiting period desired: 2 months 3 months 6 months 9 month 12 months **14**

3. Add new catastrophic disability rider? Yes No **15**

Disability Income BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT **10**

[Send Bills to: Home Office] **11**

PART 4

INSURABILITY QUESTIONS

Answer each question by checking the “Yes” or “No” box, as it applies. Circle specific disorders experienced.

CHECK ONE

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation for **[30] 16** or more hours per week at your usual place of business? Yes No
If no, give details here: _____

2. 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? Yes 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? Yes No
 - c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? Yes No
 - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? Yes No
 - e. Disease or disorder of the rectum? Vascular or blood disorder? Yes No
 - f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? Yes No
 - g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? Yes No
 - h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? Yes No
 - i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? Yes No
 - j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? Yes No
 - k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? Yes No
 - l. Mental or emotional problem requiring help of a physician, psychologist or counselor? Yes No

- m. A surgical operation? Or a surgical operation advised but not performed? Yes No
- n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? Yes No
- o. Alcohol or drug abuse? Yes No
- p. Have you used tobacco products within the past 12 months? Yes No
3. 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
4. Are you now taking prescription medication or receiving medical attention? Yes No

For "Yes" answers to questions (1-4) 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	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

PART 5

[FAMILY HISTORY

Age if Age at
Living? Death? Cause of Death?

Father _____

Mother _____] 17

[FINANCIAL SECTION

Proposed Insured's Annual Income: Earned Income \$ _____ Other Income \$ _____
(Bonuses, Investments, Rental Income, etc.)

Occupation: Physician Other: _____ Specialty: _____

Total Assets: \$ _____ Total Liabilities: \$ _____ Net Worth: \$ _____

Indicate Income of Proposed Insured's, if applicable: \$ _____] 18

EXISTING AND PENDING INSURANCE SECTION

Life and/or Disability Income Insurance inforce and/or Pending on Proposed Insured's Life, including Business and Group Insurance:
(If none, check "None.") None

Name of Company	Disability Income Amount	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?	
					Yes	No

[OTHER INFORMATION

Has Proposed Insured: (If any "Yes" answers to (c), (d) and (e), give name, date and details in Detail Section below.)

- (a) Flown as a , Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? Yes No
- (b) Engaged in, within the past two years, or contemplates engaging in ballooning, parachuting, hang gliding, vehicle racing, skin or scuba diving, mountain climbing, or any similar sport or avocation? Yes No
- (c) Plans to travel or reside outside the United States or Canada within the next year? Yes No
- (d) Had a DUI within the past five years, three or more moving/reckless driving violations within three years, or had driver's license suspended or revoked within three years? Yes No
- (e) Ever been convicted of a felony? Yes No
- (f) Ever filed for Bankruptcy? If "Yes," Year _____ Yes No

Details: _____

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I (We) affirm that the Proposed Insured is an eligible [member] 20 and that the Proposed Insured [[and any dependents (if enrolled)] meet[s]] 8 the eligibility requirements for coverage described in the brochure which I (we) received.

To the best of my (our) knowledge and belief, the above answers are true and complete. I (We) understand that the coverage now being applied for shall not be in force unless a Certificate is issued and, if issued, that such coverage will be in force as of the effective date shown on the Certificate in accordance with its terms, providing the full initial premium is received by The United States Life Insurance Company in the City of New York during the Proposed Insured's lifetime and within 31 days of such proposed effective date.

I (We) understand that should the Proposed Insured be confined to a hospital on the date his or her insurance would otherwise become effective, the effective date will be the date after the Proposed Insured is discharged from the hospital.

AUTHORIZATION TO OBTAIN INFORMATION *(A photocopy of this authorization shall be as valid as the original.)*

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, [AMA Insurance Agency, Inc.,] 21 MIB, Inc., formerly known as 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 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 MIB, to give such records or knowledge to any agency employed by the United States Life Insurance Company in the City of New York to collect and transmit such information. I understand that this information will be used by the United States Life Insurance Company in the City of New York solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the United States Life Insurance Company in the City of New York. 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 understand that I or my authorized representative is entitled to receive a copy of this authorization. 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(s) refer to page [xx] of this application.)*]**22**

X _____ X _____
Signature of Proposed Insured Date

X _____ X _____
Signature of Owner is required if other than Proposed Insured Date] 9

[Return this completed form to XXXXXX, Address XXXXX, XXXXX, XXXXX

For further information, call toll-free XXXXX. Hours are from XXXX a.m. to XXXX p.m. Central Time, Monday through Friday.
Visit our website at: XXXXX] 23

[Important Notice

For residents of Arkansas, Louisiana, Rhode Island 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 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.

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.

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.] 22

[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.]

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Supporting Document Schedules

	Item Status:	Status Date:
Satisfied - Item: Flesch Certification Comments: Attachments: Final Readability Certification (KC).pdf AR LH214AR_112805.pdf		
Satisfied - Item: Application Comments: Attachment: G-19560 Final 1.pdf		
Satisfied - Item: EOV for G-19560 Comments: Attachment: EOV for G-19560 Final 2.pdf		

READABILITY CERTIFICATION

I, Keith Coleman, Compliance Officer & Assistant Secretary, do hereby certify that the enclosed form has been tested and meets the minimum reading score.

The Flesch Score is as follows:

Application for [XXXX][Level]Term Life Insurance and Disability Income
G-19560 50.2

Date: 03/22/2010



Keith Coleman
Compliance Officer &
Assistant Secretary

**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-19560

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 & Assistant Secretary

Title

March 22, 2010

Date

[OWNER INFORMATION (The Proposed Insured will be the Owner if no designation below.)

Owner's Full Name (If Trust Owner – Trustee's Legal Name and Date of Trust) ___ Relationship _____ Date of Birth ___/___/___

Address _____ City _____ State _____ ZIP _____ Social Security No. _____]9

Term Life BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT]10

[Send Bills to: Home Office]] 11

PART 3

COVERAGE OPTIONS FOR DISABILITY INCOME INSURANCE

[(Eligible classes are Resident Physicians and Practicing Physicians)] 12

1. Amount of disability income requested: \$ _____ monthly benefit (up to [\$12,500] 13. Cannot exceed [66⅔%] 13 of your monthly earned income or [\$20,000]13 when added to any other disability insurance inforce or applied for.)

2. Waiting period desired: 2 months] 3 months] 6 months] 9 month] 12 months] 14

[3. Add new catastrophic disability rider? Yes No] 15

Disability Income BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT] 10

[Send Bills to: Home Office]] 11

PART 4

INSURABILITY QUESTIONS

Answer each question by checking the “Yes” or “No” box, as it applies. Circle specific disorders experienced.

CHECK ONE

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation for [30] 16 or more hours per week at your usual place of business? Yes No
If no, give details here: _____

2. 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? Yes 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? Yes No
 - c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? Yes No
 - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? Yes No
 - e. Disease or disorder of the rectum? Vascular or blood disorder? Yes No
 - f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? Yes No
 - g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? Yes No
 - h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? Yes No
 - i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? Yes No
 - j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? Yes No
 - k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? Yes No
 - l. Mental or emotional problem requiring help of a physician, psychologist or counselor? Yes No

- m. A surgical operation? Or a surgical operation advised but not performed? Yes No
- n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? Yes No
- o. Alcohol or drug abuse? Yes No
- p. Have you used tobacco products within the past 12 months? Yes No
3. 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
4. Are you now taking prescription medication or receiving medical attention? Yes No

For "Yes" answers to questions (1-4) 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	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

PART 5

[FAMILY HISTORY

Age if Age at
Living? Death? Cause of Death?

Father _____

Mother _____] 17

[FINANCIAL SECTION

Proposed Insured's Annual Income: Earned Income \$ _____ Other Income \$ _____
(Bonuses, Investments, Rental Income, etc.)

Occupation: Physician Other: _____ Specialty: _____

Total Assets: \$ _____ Total Liabilities: \$ _____ Net Worth: \$ _____

Indicate Income of Proposed Insured's, if applicable: \$ _____] 18

EXISTING AND PENDING INSURANCE SECTION

Life and/or Disability Income Insurance inforce and/or Pending on Proposed Insured's Life, including Business and Group Insurance:
(If none, check "None.") None

Name of Company	Disability Income Amount	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?	
					Yes	No

[OTHER INFORMATION

Has Proposed Insured: (If any "Yes" answers to (c), (d) and (e), give name, date and details in Detail Section below.)

- (a) Flown as a , Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? Yes No
- (b) Engaged in, within the past two years, or contemplates engaging in ballooning, parachuting, hang gliding, vehicle racing, skin or scuba diving, mountain climbing, or any similar sport or avocation? Yes No
- (c) Plans to travel or reside outside the United States or Canada within the next year? Yes No
- (d) Had a DUI within the past five years, three or more moving/reckless driving violations within three years, or had driver's license suspended or revoked within three years? Yes No
- (e) Ever been convicted of a felony? Yes No
- (f) Ever filed for Bankruptcy? If "Yes," Year _____ Yes No

Details: _____

] 19

I (We) affirm that the Proposed Insured is an eligible [member] 20 and that the Proposed Insured [[and any dependents (if enrolled)] meet[s]] 8 the eligibility requirements for coverage described in the brochure which I (we) received.

To the best of my (our) knowledge and belief, the above answers are true and complete. I (We) understand that the coverage now being applied for shall not be in force unless a Certificate is issued and, if issued, that such coverage will be in force as of the effective date shown on the Certificate in accordance with its terms, providing the full initial premium is received by The United States Life Insurance Company in the City of New York during the Proposed Insured's lifetime and within 31 days of such proposed effective date.

I (We) understand that should the Proposed Insured be confined to a hospital on the date his or her insurance would otherwise become effective, the effective date will be the date after the Proposed Insured is discharged from the hospital.

AUTHORIZATION TO OBTAIN INFORMATION (A photocopy of this authorization shall be as valid as the original.)

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, [AMA Insurance Agency, Inc.,] 21 MIB, Inc., formerly known as 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 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 MIB, to give such records or knowledge to any agency employed by the United States Life Insurance Company in the City of New York to collect and transmit such information. I understand that this information will be used by the United States Life Insurance Company in the City of New York solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the United States Life Insurance Company in the City of New York. 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 understand that I or my authorized representative is entitled to receive a copy of this authorization. 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(s) refer to page [xx] of this application.)]22

X _____ X _____
Signature of Proposed Insured Date

X _____ X _____
Signature of Owner is required if other than Proposed Insured Date] 9

[Return this completed form to XXXXXX, Address XXXXX, XXXXX, XXXXX

For further information, call toll-free XXXXX. Hours are from XXXX a.m. to XXXX p.m. Central Time, Monday through Friday.
Visit our website at: XXXXX] 23

[Important Notice

For residents of Arkansas, Louisiana, Rhode Island 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 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.

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.

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.] 22

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

APPLICATION FOR GROUP LEVEL TERM OR TERM LIFE INSURANCE AND DISABILITY INCOME

Memorandum of Variable Material FORM No. G-19560

GENERAL COMMENTS

- Any bracketed or handwritten information is being filed as variable. This data will vary from case to case. Variable data will never exclude or limit provisions required by the jurisdiction in which the group policy is issued. The appropriate required language will always appear, but the arrangement or formatting may vary. Since the use of the enrollment may vary from electronic, to face-to-face, to direct mail, to telemarketing, etc... we need flexibility to conform the layout of the items found in the application to the layout in the marketing materials, etc... We certify that the type size will always remain as the State required size and all statutory/regulatory provisions and requirements will not be changed.
- Brackets around numbers or alphas in a listing and punctuation or words such as, "and"/"or" in a listing will be included or deleted as needed in order to make the statement read correctly. Numeric variables within the application will reflect the policy provisions and will always comply with the minimum statutory requirements of the jurisdiction in which the group policy is issued.
- The format may vary; however, the relative prominence of the provisions will not change.
- The Association, Administrator or Plan Logo, if inserted, will vary on a case-by-case basis.
- Member must apply for both life and disability income insurance in all cases.

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

SECTION

EXPLANATION OF VARIABLE AREA

1. Heading

A space has been left in the heading of the Application. It may contain a program name specific to a particular association or it may be omitted.

The reference to the product name on the Application may vary. Although it will always be used for our Group Term Life and Group Disability, it may sometimes also be used for Level Term Life and Group Disability.

In addition, in certain instances the application heading may contain a program name specific to a particular association.

2. Logo

A space has been left for Association, Administrator or Plan logos to be included if a particular client requests it. Formatting of this information

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

APPLICATION FOR GROUP LEVEL TERM OR TERM LIFE INSURANCE AND DISABILITY INCOME

Memorandum of Variable Material FORM No. G-19560

and some content may also vary depending upon group and solicitation method.

3. Instructions

The instructions can be modified, replaced or shown for any client who wishes to include any type of instructional information regarding the completion of the form.

4. Proposed Insured Name and Address

The proposed insured name and address will appear as shown or may be prefilled as part of the solicitation.

In certain instances Full Name may be replaced by any of the following terms:

Applicant Name
Individual Name
Member Name

Business Address may be included as shown or omitted.

5. Personal Information

Any of the items may be included as shown or omitted.

The question "May we e-mail you regarding our products and services...." will appear as shown or may be modified to reference the name of the administrator.

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

6. Life Insurance Amount

The increments may vary from \$500 to \$1,000. The maximum amount of Term Life coverage will not exceed \$3,000,000.

7. Level Term Options

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

8. Optional Benefits

The optional benefits may appear as shown or one or more of the options available may be omitted

In certain instances, at the request of a client an additional plan option(s) may be added to allow for different benefits and to allow multiple plan choices.

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

APPLICATION FOR GROUP LEVEL TERM OR TERM LIFE INSURANCE AND DISABILITY INCOME

Memorandum of Variable Material FORM No. G-19560

If shown, the accidental death and dismemberment benefit amount may vary from \$500 to \$3,000,000.

If shown, the child coverage life insurance amount may vary from \$1,000 to \$50,000. Rates may vary but this amount will never exceed the state approved rate for this program.

The words "Primary" and "Contingent" may appear as shown or may be replaced with just the word "Beneficiary" and if so, only one line will be needed.

The beneficiary for child coverage disclosure will be included as shown only if the child coverage option appears on the application.

At the end of the medical questions, just above the Authorization section, "and any dependents (if enrolled) meet" will appear as shown if the dependent child rider option appears on the application; the word "meet" will be either singular, "meets", or plural "meet" to coincide with the subject

- 9. Owner Information** This will appear as shown or may be omitted.
- 10. Billing Modes** The options listed will be included as shown or one or more of the options available may be omitted.
- 11. Billing Options** The options listed will be included as shown or omitted.
- 12. Eligible members** Eligibility description will be included as shown, omitted, or modified according to plan design.
- 13. Disability Insurance Amount** The maximum amount of disability income will not exceed \$20,000.
The percentage of monthly earned income may vary from 50% to 80%.
The maximum when added to any other disability insurance in force of applied for may vary from \$10,000 to \$30,000.
- 14. Waiting Period** The waiting period options will appear as shown or one or more of the options available may be omitted.
- 15. Optional Benefit** The catastrophic disability rider will be included as shown or may be omitted.

In certain instances, at the request of a client an additional plan option(s) may be added to allow for different benefits and to allow multiple plan choices.

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

APPLICATION FOR GROUP LEVEL TERM OR TERM LIFE INSURANCE AND DISABILITY INCOME

Memorandum of Variable Material FORM No. G-19560

- 16. Health Questions** In Question 1, 30 hours per week may be changed to be either 20, 25, or 30 hours per week.
- 17. Family History** This will appear as shown or may be omitted.
- 18. Financial Section** This will appear as shown or may be omitted.
- 19. Other Information Section** This will appear as shown or may be omitted.
- 20. Declaration Statement** The word “member” may appear as shown or replaced by the word “physician”.
- 21. Authorization to Obtain Information** The reference to the AMA Insurance Agency, Inc., will appear as shown only if the plan’s policyholder is the American Medical Association, or it may be omitted.
- 22. 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.
- 23. Mailing Instructions** This section is a placeholder for the administrator’s mailing instructions and/or contact information.
- Disclosure Notices** These notices will always be provided to the customer, when applicable. They may appear as an attachment beneath the application, as separate notices with the application or as an attachment in a brochure. For this reason, the language related to the notices being retained by the applicant may vary based upon the manner in which it is provided.
- They are also being bracketed as variables as they may be omitted in instances (for example, where no MIB is required.) In addition, these disclosure notices may be modified to update contact information or to conform with changes in regulations.

SERFF Tracking Number: AMGN-126553197 State: Arkansas
 Filing Company: The United States Life Insurance Company in the State Tracking Number: 45229
 City of New York
 Company Tracking Number: G-19560
 TOI: L04G Group Life - Term Sub-TOI: L04G.500 Other
 Product Name: Group Term Life / Disability
 Project Name/Number: Combination Application G-19560/G-19560

Superseded Schedule Items

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Creation Date:	Schedule	Schedule Item Name	Replacement Creation Date	Attached Document(s)
03/22/2010	Form	Application for Term Life Insurance and Disability Income	05/11/2010	G-19560 Final 1.pdf (Superseded)

[OWNER INFORMATION (The Proposed Insured will be the Owner if no designation below.)

Owner's Full Name (If Trust Owner – Trustee's Legal Name and Date of Trust) ___ Relationship _____ Date of Birth ___/___/___

Address _____ City _____ State _____ ZIP _____ Social Security No. _____]9

Term Life BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT]10

[Send Bills to: Home Office]] 11

PART 3

COVERAGE OPTIONS FOR DISABILITY INCOME INSURANCE

[(Eligible classes are Resident Physicians and Practicing Physicians)] 12

1. Amount of disability income requested: \$ _____ monthly benefit (up to [\$12,500] 13. Cannot exceed [66⅔%] 13 of your monthly earned income or [\$20,000]13 when added to any other disability insurance inforce or applied for.)

2. Waiting period desired: 2 months] 3 months] 6 months] 9 month] 12 months] 14

[3. Add new catastrophic disability rider? Yes No] 15

Disability Income BILLING OPTIONS

How do you wish to be billed? Annually Semi-annually Quarterly Monthly EFT] 10

[Send Bills to: Home Office]] 11

PART 4

INSURABILITY QUESTIONS

Answer each question by checking the “Yes” or “No” box, as it applies. Circle specific disorders experienced.

CHECK ONE

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation for [30] 16 or more hours per week at your usual place of business? Yes No
If no, give details here: _____

2. 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? Yes 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? Yes No
 - c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? Yes No
 - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? Yes No
 - e. Disease or disorder of the rectum? Vascular or blood disorder? Yes No
 - f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? Yes No
 - g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? Yes No
 - h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? Yes No
 - i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? Yes No
 - j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? Yes No
 - k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? Yes No
 - l. Mental or emotional problem requiring help of a physician, psychologist or counselor? Yes No

- m. A surgical operation? Or a surgical operation advised but not performed? Yes No
- n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? Yes No
- o. Alcohol or drug abuse? Yes No
- p. Have you used tobacco products within the past 12 months? Yes No
3. 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
4. Are you now taking prescription medication or receiving medical attention? Yes No

For "Yes" answers to questions (1-4) 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	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

PART 5

[FAMILY HISTORY

Age if Age at
Living? Death? Cause of Death?

Father _____

Mother _____] 17

[FINANCIAL SECTION

Proposed Insured's Annual Income: Earned Income \$ _____ Other Income \$ _____
(Bonuses, Investments, Rental Income, etc.)

Occupation: Physician Other: _____ Specialty: _____

Total Assets: \$ _____ Total Liabilities: \$ _____ Net Worth: \$ _____

Indicate Income of Proposed Insured's, if applicable: \$ _____] 18

EXISTING AND PENDING INSURANCE SECTION

Life and/or Disability Income Insurance inforce and/or Pending on Proposed Insured's Life, including Business and Group Insurance:
(If none, check "None.") None

Name of Company	Disability Income Amount	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?	
					Yes	No

[OTHER INFORMATION

Has Proposed Insured: (If any "Yes" answers to (c), (d) and (e), give name, date and details in Detail Section below.)

- (a) Flown as a , Private, Commercial or Military pilot in the past two years, or are any such flights planned in the future? Yes No
- (b) Engaged in, within the past two years, or contemplates engaging in ballooning, parachuting, hang gliding, vehicle racing, skin or scuba diving, mountain climbing, or any similar sport or avocation? Yes No
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Details: _____

] 19

I (We) affirm that the Proposed Insured is an eligible [member] 20 and that the Proposed Insured [[and any dependents (if enrolled)] meet[s]] 8 the eligibility requirements for coverage described in the brochure which I (we) received.

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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, [AMA Insurance Agency, Inc.,] 21 MIB, Inc., formerly known as 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 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 MIB, to give such records or knowledge to any agency employed by the United States Life Insurance Company in the City of New York to collect and transmit such information. I understand that this information will be used by the United States Life Insurance Company in the City of New York solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the United States Life Insurance Company in the City of New York. 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 understand that I or my authorized representative is entitled to receive a copy of this authorization. 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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X _____ X _____
Signature of Proposed Insured Date

X _____ X _____
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[Return this completed form to XXXXXX, Address XXXXX, XXXXX, XXXXX

For further information, call toll-free XXXXX. Hours are from XXXX a.m. to XXXX p.m. Central Time, Monday through Friday.
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