

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

Member of American International Group, Inc.

**IMPORTANT NOTICE**

Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

United States Life's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust.

**ALL QUESTIONS MUST BE COMPLETED**

**SUPPLEMENTAL GENERAL INFORMATION**

1. Full name of Applicant: \_\_\_\_\_

2. Street address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing address (if different): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

3. Full name and address of recipient for all future correspondence: \_\_\_\_\_

Telephone: ( ) \_\_\_\_\_ Fax: ( ) \_\_\_\_\_

4. Applicant is a  Proprietorship  Partnership  Corporation  Union  
 Association  Other: \_\_\_\_\_

5. Nature of business: \_\_\_\_\_ SIC code: \_\_\_\_\_

Years in business: \_\_\_\_\_ (Please note, business must be in force at least 2 years for LTD, 1 year for STD.)

6. Number of payroll deductions per year: \_\_\_\_\_

7. Are the employees of any other locations, affiliates or subsidiary companies to be covered?

Yes  No If yes, give

| Name of Company | Nature of Business | Full Address | # of Full-time Employees | Contact Person |
|-----------------|--------------------|--------------|--------------------------|----------------|
|                 |                    |              |                          |                |
|                 |                    |              |                          |                |

8. Is this new coverage?  Yes  No

9. Is this replacing an inforce benefit?  Yes  No If yes, complete the following:

- Name of current carrier: \_\_\_\_\_
- Date of cancellation: \_\_\_\_\_ (Effective date of this policy will follow date of cancellation once approved.)
- Please submit a current listing and billing statement (for each coverage) which includes: name (employee or spouse), date of birth, social security #, smoking status, and amount of coverage. For LTD or STD takeover, census should include salary and occupation.
- Please submit a Certificate of Insurance for each coverage.

10. Are you applying for other coverages with The United States Life Insurance Company?  Yes  No

If yes, please explain: \_\_\_\_\_

11. Do you currently have any other coverages in force with The United States Life Insurance Company?

Yes  No

If yes, please list type of coverage and policy numbers: \_\_\_\_\_

The United States Life Insurance Company in the City of New York  
Member of American International Group, Inc.  
(Called United States Life)

**APPLICATION FOR GROUP INSURANCE**

ALL QUESTIONS MUST BE COMPLETED

**SUPPLEMENTAL GENERAL INFORMATION (Continued)**

12. Do you participate in Social Security and Workers Compensation?  Yes  No  
If no, please explain: \_\_\_\_\_
13. Initial Enrollment/Solicitation dates (60 days max.): \_\_\_\_\_ to \_\_\_\_\_
14. Eligibility date for future employees will be:  
 1st of the month following \_\_\_\_\_ months  1st of the month following date of hire.
15. When would you like age bracket changes and increases in amounts of insurance to take effect?  
 Plan Anniversary  Immediate
16. Total number of eligible employees: \_\_\_\_\_
17. Definition of "full-time":  
"Full-time" means active work on the participating employer's regular work schedule for the class of employees to which you belong. The work schedule must be at least 20 hours per week for life insurance/accidental death and dismemberment, and at least 30 hours per week for long-term and short-term disability. If this definition is not satisfactory, please re-define:  
\_\_\_\_\_  
\_\_\_\_\_
18. Do you want to exclude any classes of full-time employees from coverage?  Yes  No  
If yes, list each class by salary, job title, union membership or other condition pertaining to employment:  
\_\_\_\_\_  
\_\_\_\_\_

**COVERAGE DATA**

- |  |   |
|--|---|
| <p>1. <b>LIFE INSURANCE:</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/><b>2-199 LIVES</b></p> <p>A. Premium rate schedule:<br/><input type="checkbox"/> Unismoke <input type="checkbox"/> Smoker/Non-smoker</p> <p>B. Waiver of premium: standard</p> <p>C. Requested benefit schedule: standard<br/>Employee: \$10,000 to \$200,000* available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.<br/>Spouse: \$10,000 to \$200,000*, available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.<br/>Children: \$5,000</p> | <p><b>200+ LIVES</b></p> <p>A. Premium rate schedule:<br/><input type="checkbox"/> Unismoke <input type="checkbox"/> Smoker/Non-smoker</p> <p>B. Waiver of premium (if proposed) <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>C. Requested benefit schedule:<br/>Employee: _____<br/>Spouse: _____<br/>Children: _____<br/>Please advise if any of the above are excluded.</p> |
|--|---|

\*\$300,000 maximum available to groups of 50-199 eligible lives.

**Please note: For groups domiciled in Florida and Texas, spouse amounts limited to 50% of employee's amount. New York spouses limited to employee's amount.**

- |  |  |
|--|--|
| <p>2. <b>ACCIDENTAL DEATH AND DISMEMBERMENT (AD&amp;D):</b> <input type="checkbox"/> Yes <input type="checkbox"/> No<br/><b>2-199 LIVES</b></p> <p>A. Requested benefit schedule: standard<br/>Employee: \$10,000 to \$200,000*, available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.<br/>Spouse: \$10,000 to \$200,000*, available in \$10,000 increments, not to exceed 5X the employee's basic annual salary.</p> | <p><b>200+ LIVES</b></p> <p>A. Requested benefit schedule:<br/>Employee: _____<br/>Spouse: _____</p> |
|--|--|

\*\$300,000 maximum available to groups of 50-199 eligible lives.

**Please note: Dependent children are not eligible for AD&D. For groups domiciled in Florida and Texas, spouse amounts limited to 50% of employee's amount. New York spouses limited to employee's amount.**

3. **LONG-TERM DISABILITY:**  Yes  No

**2-199 LIVES**

- A. Rate chart used: \_\_\_\_\_
- B. Benefit percentage: \$100 units to a maximum of  50%  60%
- C. Benefit maximum: \$6,000
- D. Benefit duration:  Ages 65 RBD  5 year RBD  Other: \_\_\_\_\_
- E. Elimination period:  30 Days\*  60 Days\*  90 Days  180 Days

\*30 and 60 day elimination periods are not available with age 65 RBD plans.

**Please note: Spouses and dependent children are not eligible for LTD.**

**200+ LIVES**

- A. Attach copy of proposal
- B. Benefit percentage: \$100 units to a maximum of  50%  60%  Other \_\_\_\_\_
- C. Benefit maximum: \$ \_\_\_\_\_
- D. Benefit duration: \_\_\_\_\_  Ages 65 RBD  5 year RBD  Other: \_\_\_\_\_
- E. Elimination period:  30 Days\*  60 Days\*  90 Days  180 Days  Other: \_\_\_\_\_

4. **SHORT-TERM DISABILITY:**  Yes  No

**2-199 LIVES**

- A. Female percentage rate chart used: \_\_\_\_\_
- B. Benefit percentage:  50%  60%
- C. Benefit maximum: \$ \_\_\_\_\_
- D. Benefit duration:  13 Weeks  26 Weeks
- E. Elimination period: (for accident and/or sickness)  15 Days  30 Days  Other \_\_\_\_\_
- F. Pre-existing conditions limitation  12/12  Other \_\_\_\_\_

**Please note: Spouses and dependent children are not eligible for STD.**

**200+ LIVES**

- A. Attach copy of proposal
- B. Benefit percentage: maximum of  50%  60%  Other \_\_\_\_\_ \$50 units  Yes  No
- C. Benefit maximum: \$ \_\_\_\_\_
- D. Benefit duration:  13 Weeks  26 Weeks  Other \_\_\_\_\_
- E. Elimination period: (for accident and/or sickness)  15 Days  30 Days  Other \_\_\_\_\_
- F. Pre-existing conditions limitation  12/12  Other \_\_\_\_\_

5. **DENTAL:**  Yes  No

- Voluntary Discount Dental Plan
- Voluntary Indemnity Dental – 10 plus eligible lives (minimum 5 enrolled lives)
  - Plan A - 100/50/25/0 – First year
  - Plan B - 80/50/0/0 – First year
  - Takeover  Non-takeover
- Orthodontia  Yes  No

**NOTE: EFFECTIVE DATES FOR ALL COVERAGES WILL BE DETERMINED BY THE UNDERWRITER AT TIME OF APPROVAL.**

Remarks: \_\_\_\_\_

To the best of my knowledge and belief, all statements and answers given in this application are true and complete. I understand that this application is an application in a Trust, as determined by the underwriting rules of United States Life. The Trust Agreement establishes the group insurance fund. A copy of the Trust Agreement will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Agreement.

\_\_\_\_\_  
PRINT NAME OF OFFICER, PARTNER

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF OFFICER, PARTNER

\_\_\_\_\_  
DATE

General Agent: \_\_\_\_\_ # \_\_\_\_\_

Producer: \_\_\_\_\_ # \_\_\_\_\_

Regional Office/Rep: \_\_\_\_\_