



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

**Please answer these brief questions.**

- |  | Member   | Spouse   |
|--|--|--|
| 1. Has the applicant/member or spouse, if applying ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV? | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 2. Has the applicant/member or spouse, if applying 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?  | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 3. Has the applicant/member or spouse, if applying used tobacco or nicotine in any form during the past 36 months?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| 4. Is the applicant/member or spouse, if applying now taking prescription medication or receiving medical attention?   | <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Yes <input type="checkbox"/> 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" in the box at the right  Yes  No**

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

**EXISTING AND PENDING INSURANCE SECTION** Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None".)  None

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

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

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

\*Wherever the term spouse appears will read as Domestic Partner throughout the application.

\*\* Dependent Child must be unmarried, up to 23 years of age if a full-time student.

**Important Notice:** 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. **(This warning does not apply to application for life insurance in New York.)**

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

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

Date \_\_\_\_\_ Spouse/ Domestic Partner's Signature \_\_\_\_\_

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

## **These Notices must be detached and retained by the applicant**

### **MIB DISCLOSURE NOTICE**

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted. Information regarding your insurability will be treated as confidential except that the Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau, Inc., will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901 [TTY (866) 346-3642].

The Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

MIB-19431

### **NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)**

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

FCRA-19432