

APPLICATION for  
**Group 10- and 20-Year  
 Level Term Life Insurance**  
 For Florida Residents

The United States Life Insurance Company in the City of New York  
 Home Office: 70 Pine Street, New York, New York 10270  
 (Herein called the Company)



**STEP 1: Select Your Coverage Amount (\$10,000 to \$100,000 in \$10,000 increments)**

**Member Amount:**       \$10,000     \$30,000     \$50,000     \$70,000     \$100,000     Other \$ \_\_\_\_\_

**Spouse/Domestic Partner Amount:**       \$10,000     \$30,000     \$50,000     \$70,000     \$100,000     Other \$ \_\_\_\_\_

**STEP 2: Member Information**      Please print or type

\_\_\_\_\_  Male  Female  
 Name

\_\_\_\_\_      \_\_\_\_\_  
 Social Security Number      NYSSCPA Member ID Number

\_\_\_\_\_  
 Member's Home Address

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 City      State      Zip Code

\_\_\_\_\_      \_\_\_\_\_  
 Place of Birth      Birthdate (mm/dd/yyyy)

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Age      Weight (lbs.)      Height (ft./in.)

(\_\_\_\_\_)      (\_\_\_\_\_)      \_\_\_\_\_  
 Home Phone      Work Phone

\_\_\_\_\_  
 Email address

\_\_\_\_\_      \_\_\_\_\_  
 Beneficiary      Relationship to you

\_\_\_\_\_  
 Name and Address of Member's Physician

Unless otherwise requested, your spouse/domestic partner, if living, will be the beneficiary. Otherwise, your beneficiary will be your children, parents, siblings, or estate, in that order.

**Spouse/Domestic Partner Information**      Please print or type

\_\_\_\_\_  Male  Female  
 Name

\_\_\_\_\_      \_\_\_\_\_  
 Social Security Number

\_\_\_\_\_  
 Applicant's Home Address

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 City      State      Zip Code

\_\_\_\_\_      \_\_\_\_\_  
 Place of Birth      Birthdate (mm/dd/yyyy)

\_\_\_\_\_      \_\_\_\_\_      \_\_\_\_\_  
 Age      Weight (lbs.)      Height (ft./in.)

(\_\_\_\_\_)      (\_\_\_\_\_)      \_\_\_\_\_  
 Home Phone      Work Phone

\_\_\_\_\_  
 Email address

\_\_\_\_\_      \_\_\_\_\_  
 Beneficiary      Relationship to you

\_\_\_\_\_  
 Name and Address of Applicant's Physician

Unless otherwise requested, the member will be the beneficiary of any spouse/domestic partner insurance applied for.

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

**STEP 3: Select Your Payment Mode**

**I prefer to pay:**     Automatic Monthly Withdrawal     Semiannual Direct Bill     Annual Direct Bill

**Automatic Monthly Withdrawal**

By selecting this option, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Remember to include a check for your first month's premium and a blank voided check with your application.**

Bank Name: \_\_\_\_\_

Bank Address: \_\_\_\_\_

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days' advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer \_\_\_\_\_

Date \_\_\_\_\_

**STEP 4: Answer Health Questions and Provide Details to Any "YES" Answers**

	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 by a licensed medical provider?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. Has the applicant/member or spouse, if applying, been tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. Has the applicant/member or spouse, if applying, during the past five 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="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
5. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
6. Has the applicant/member ever had life or health insurance declined, modified, or rated?	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

For "Yes" answers to Questions 1-6 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

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

**Step 5: Existing and Pending Insurance Section**

Life insurance in force and/or pending on proposed insured's life including Business Insurance (If none, check "None.")							<input type="radio"/> None
Member/Applicant	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?	
						Yes	No

**STEP 6: Please read the following, then sign and date below to apply.**

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

**IMPORTANT NOTICE:** Any person who knowingly and with intent to 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.

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's/Domestic Partner's Signature \_\_\_\_\_ Date \_\_\_\_\_  
 (if applying)



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

**APPENDIX 11:**

**INSURANCE DEPARTMENT OF THE STATE OF NEW YORK**

**DEFINITION OF REPLACEMENT**

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

(1) Lapsed, surrendered, partially surrendered, forfeited, assigned to the Insurer replacing the life insurance policy or annuity contract, or otherwise terminated?

YES\_\_\_\_ NO\_\_\_\_

(2) Changed or Modified into paid up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other case values?

YES\_\_\_\_ NO\_\_\_\_

(3) Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force?

YES\_\_\_\_ NO\_\_\_\_

(4) Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies?

YES\_\_\_\_ NO\_\_\_\_

(5) Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid-up additions is to be borrowed or withdrawn on one or more existing policies?

YES\_\_\_\_ NO\_\_\_\_

