AMERICAN GENERAL FINANCIAL GROUP

THE UNITED STATES LIFE Insurance Company In the City of New York

Member American General Financial Group

APPLICATION FOR GROUP INSURANCE

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

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.

IN NY: The above statement does not apply to life coverage, but only to accident and health coverage. Such a crime 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.

APPLICANT DATA:

1. Full name of Applicant: _____

2. Street Address: _____

   City: _____ State: _____ Zip: _____ Telephone: (_____)_____

   Mailing Address (if different): _____ Fax: (_____) _____

   City: _____ State: _____ Zip: _____ SIC Code: _____

3. Applicant is a: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Union

   ☐ Other (Explain): _____

4. Nature of Business: _____

5. Are the employees of any affiliated or subsidiary companies to be covered? ☐ Yes ☐ No If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	Nature of Business	Full Address	# of Full-Time Employees

6. Have you ever applied for, or been insured for group insurance with United States Life? ☐ Yes ☐ No If yes, give details below.

   Group policy number(s) _____ Date Insurance Ended/Declined _____

   _____ Effective Date (if still insured) _____

7. List each group insurance plan you now have, such as Life, AD&D, STD, LTD, Dental Care, Prescription Drugs. Include plans with non-profit organizations, HMO's and self-funded plans.

Type of coverage	Insurer/Organization	Effective Date	Proposed Date of Termination

8. Are you now applying for any other group insurance? ☐ Yes ☐ No If yes, give details below.

   Highest amount of Life Insurance _____ Insurer _____ Proposed Effective Date: _____

9 Is coverage applied for in this application replacing other group insurance? ☐ Yes ☐ No

   If yes, give reason _____

Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

HOME OFFICE USE ONLY

Supply Ordering Number - 00305201-1069- 1100

G-19099
APP-NO M-1

EMPLOYEE ELIGIBILITY

A FULL-TIME EMPLOYEE is one who:

- **works at least 30 hours per week; and**
- works the Applicant's regular work schedule; and
- performs his job for full pay; and
- works at the Applicant's place of business.

10. 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: _____

_____

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. present employees means employees who are at work on a full-time basis on the effective date.

11. Waiting period: Present Employees_____ months Future Employees _____ months

Each Full-Time employee who is at work on the effective date and has **already** satisfied the Waiting Period will be eligible on the effective date.

Each Full-Time employee who is at work on the effective date and has **not** satisfied the Waiting Period, and each full-time employee who begins work after the effective date will be eligible on the first day after he satisfies the Waiting Period.

12. a. Number of Full-Time Employees (include employees not to be covered)..... _____

b. Number of persons being continued pursuant to a continuation of insurance, extension of benefits, or like provision, as provided by state or federal law (COBRA) (Attach a list of continuee names, qualifying events, and dates continuations began)..... _____

c. Number of Full-Time Employees in the Waiting Period as of the requested Effective Date (see item 11) ..... _____

d. Number of Full-Time Employees excluded by class (see item 10) ..... _____

e. Number of Full-Time Employees **waiving all coverages** ..... _____

f. **Total** Number of Full-Time Employees and continued persons eligible for coverage on the requested Effective Date..... _____

13. Do you employ 20 or more employees? (Include part-time, union, etc.) ☐ Yes ☐ No

If yes, United States Life will provide primary medical coverage for working employees age 65 and over who become insured, and the benefits for such employees will be the same as for those under age 65.

CONTRIBUTION DATA

14. Will the employees be required to contribute toward the cost of the insurance? ☐ Yes ☐ No

If yes, indicate the percentage of the cost of each coverage the **employee** will pay.

Coverage	Life/AD&D	Dep Life	EE Den	Dep Den	EE Vision	DEP Vision	STD	LTD	INT DI
Employee %									

Note: If the employer pays the entire cost for the employees, then 100% of the eligible employees **must** apply for coverage.

15. Premiums will be paid: ☐ annually ☐ semi-annually ☐ quarterly ☐ monthly

EMPLOYEE/DEPENDENT DATA

16. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? ☐ **Yes** ☐ **No** If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **Note: This question must be answered regardless of the coverage(s) for which application is made.**

Name of Employee	Date Disability Began	Current Amount Of Group Life Insurance in Force	Describe Nature of Injury/Sickness

ANCILLARY COVERAGE DATA

1a. LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE with waiver of premium
Reduction Formula: Life Insurance and AD&D insurance reduce by 50% at age 70.
Note: For Ultimate Advantage, AD&D Insurance terminates at age 70.

INSURANCE SCHEDULE (Life and AD&D insurance will be written in equal amounts, subject to the AD&D insurance maximum of $500,000.)

Class of Employees (By salary, job title, union membership, or other employment conditions– "Executives", "Management" are not acceptable classes)	Life / AD&D Amounts Maximum issue	Life / AD&D Amounts Subject to EOI	Total Amount Requested per life Life	AD&D

BASIC ANNUAL PAY means the employee's annual salary or wages paid by the employer. "Basic annual pay" does **not** include bonuses, overtime pay, or other special compensation such as commissions.

CHANGE IN AMOUNT OF INSURANCE: A change in the amount of Life and AD&D insurance will take effect on:
☐ the date of change ☐ other: _____

SEAT BELT BENEFIT ☐ Yes ☐ No
NOTE: STANDARD WITH ULTIMATE ADVANTAGE LIFE. NOT AVAILABLE IN ALL STATES FOR LIFE PLANS A& B.

ACCELERATED DEATH BENEFIT (Must have basic life volume of at least $20,000) ☐ Yes ☐ No
NOTE: STANDARD WITH ULTIMATE ADVANTAGE LIFE. NOT AVAILABLE IN ALL STATES FOR LIFE PLANS A& B.

DEPENDENT LIFE INSURANCE ☐ Yes ☐ No

Amounts:			
	Spouse	☐ $10,000	☐ $5,000
	Children	2,000	1,000

1b. **LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE** *(NON-STANDARD PROVISIONS– available to groups of 10+ lives, but not available in connection with the Ultimate Advantage Series and subject to PRIOR Home Office approval.)*

☐ Life insurance with waiver of premium (No AD&D)
☐ Life insurance without waiver of premium (No AD&D)
☐ Life insurance without waiver of premium but with AD&D
☐ Dependent Life Insurance
Dependent means ☐ legal spouse of employee
☐ children ages 15 days to _____ years, _____ if student

Amount: Spouse $_____ Children $_____ (Maximum spouse $10,000/Children $5,000)

☐ Reduction Formula (Specify)
Life _____
AD&D _____
☐ Other (Specify) _____

HOME OFFICE USE ONLY

Supply Ordering Number - 00305201-1069- 1100

2. DENTAL INSURANCE

☐ employee only
☐ employee and dependents (if Medical Insurance is also applied for, the answer to this question must be the same for Medical and Dental Coverages.)

☐ Ultimate Advantage Dental *(Reasonable and Customary Plan, available 2–24 lives)*

	Deductible	Coinsurance	Deductible Waived for Preventive	Annual Maximum
☐ Plan 1	$50	100%/80%/50%	☐ Yes ☐ No	☐ $1,000 ☐ $1,500
☐ Plan 2	$100	100%/80%/50%	☒ No	☐ $1,000 ☐ $1,500
☐ Plan 3	$50	100%/80%/50%	☐ Yes ☐ No	☒ $1,000

☐ UltraDent Dental *(Reasonable and Customary Plan, available 10+ lives)*
Annual Deductible: $ _____ Family Limit: 3X
Coinsurance: Preventive _____%
Basic _____%
Major _____%
Annual Maximum: ☐ $1,000 ☐ $1,500 *or* ☐ $2,000
Deductible waived for preventive: ☐ Yes ☐ No
Orthodontia: ☐ Yes; Lifetime Deductible $0 ☐ No
50% Coinsurance
Lifetime Maximum: ☐ $1,000 ☐ Other: _____
Adult (Age 19+) Orthodontia: ☐ Yes ☐ No
NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

☐ Reimbursement Dental *(Available 5+ lives)*
Annual Deductible: ☐ $0 ☐ $25 ☐ $50 ☐ $100
Conversion Factor ($10–$20): $_____
Annual Maximum: ☐ $500 ☐ $750 ☐ $1,000 ☐ $1,500 *(10+ lives only)*
Preventive dentistry covered at 100% of Reasonable and Customary with deductible waived: ☐ Yes ☐ No
Orthodontia: ☐ Yes; Lifetime Deductible $50 ☐ No
50% Coinsurance
Lifetime Maximum: $1,000
NOTE: Orthodontia is available only to groups of 10 or more lives and is paid at Reasonable and Customary.

☐ Healthplex Comprehensive Dental *(Available 1+ lives in specific areas. Consult your agent for information.)*
Option (circle one): High, $18 Medium, $14 or Low $10 Orthodontia: ☐ Yes ☐ No

☐ Healthplex Comprehensive Voluntary – Dental *(Available 1+ lives in specific areas. Consult your agent for information.)*
* Employees may choose High, Medium, Low, or Economy Options on their individual enrollment forms.
Orthodontia: ☐ Yes ☐ No

☐ Voluntary Dental *(Fee for service plan, available 1+ lives)*
Network (circle one): ☐ Dental Carenet (MA) ☐ Careington International (AR, CO, LA, OK, TN, TX) ☐ UHP (All other states)
* 25% reduction on fees for network orthodontists *(Orthodontia for child only to age 17.)*

☐ Trudent Point of Service Dental *(Available to groups of 2+ lives in specific areas. Consult your agent for network information.)*
☐ 2–9 lives ☐ 10 or more lives
Annual Deductible: $_____

		IN	OUT
Coinsurance:	Preventive	_____% /	100%
	Basic	_____% /	80%
	Major	_____% /	50%

Annual Maximum: $ _____ / $ _____
Orthodontia: ☐ Yes; Lifetime Deductible $0 ☐ No
Coinsurance _____%
Lifetime Maximum: ☐ $1,000 ☐ Other: _____
Adult (Age 19+) Orthodontia: ☐ Yes ☐ No
NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.
Networks available: (Check network applicable to your area)
☐ Delta Dental of Colorado ☐ National PPO Network (Careington) ☐ First Dental Health (CA)
☐ Delta Dental of Illinois ☐ Delta Dental of Connecticut ☐ Healthplex (NY)
☐ Delta Dental of New Jersey ☐ Premier ☐ Preferred
☐ Premier ☐ Preferred

☐ Dual Option Dental *(Available 5+ lives in specific areas. Consult your agent for information.)*

Reimbursement/Healthplex Comprehensive Plan Benefits

Conversion Factor/Benefit level ☐ $10 (Low) ☐ $14 (Medium) ☐ $18 (High)

Annual Reimbursement Deductible: $ _____

Annual Reimbursement Maximum: $ _____

Preventive Dentistry Covered at 100% with deductible waived (Reimbursement) ☐ Yes ☐ No

Orthodontia: ☐ Yes ☐ No

Reimbursement Lifetime Deductible: $50

Reimbursement Coinsurance: 50%

Reimbursement Lifetime Maximum: $1,000

NOTE: Orthodontia is available only to groups of 10 or more lives. (Must be made available on both plans.)

☐ Ultra Choice Reasonable and Customary/Healthplex Comprehensive Dental *(Available 10+ lives in specific areas. Consult your agent for information.)*

	Reasonable and Customary Plan Benefits Deductible/Coinsurance/Annual Maximum			**Comprehensive Plan Benefits** Benefit Level
☐	$50	100/80/50	$1,500	High
☐	$100	100/80/50	$1,000	Medium
☐	$100	80/50/50	$1,000	Low

Deductible waived for preventive: ☐ Yes ☐ No

Orthodontia: ☐ Yes ☐ No

Adult (Age 19+) Orthodontia: ☐ Yes ☐ No

NOTE: Orthodontia is available only to groups of 25+ lives or 10+ dependent units enrolled. For child only orthodontia, there must be 10 dependent units consisting of employee/child and family units.

☐ Informal Dual Option/UltraDent Dental *(Available 10+ lives. UltraDent plan sold alongside another Company's prepaid plan.)*

☐ Plan I

$50 annual deductible

Coinsurance:

Preventive	100%
Basic	80%
Major	50%

Annual Maximum: (circle one) $1,000 or $1,500

☐ Plan II

$50 annual deductible

Coinsurance:

Preventive	100%
Basic	80%
Major	50%

Annual Maximum: (circle one) $1,000 or $1,500

Deductible waived for preventive: ☐ Yes ☐ No

☐ Informal Dual Option/Trudent Dental *(Available 10+ lives in specific areas. Consult your agent for information. Trudent plan sold alongside another Company's prepaid plan.)*

Annual Deductible: $50

		IN	/	OUT
Coinsurance:	Preventive	100%	/	100%
	Basic	80%	/	80%
	Major	50%	/	50%
Annual Maximum:		$1,000	/	$1,000

*Deductible is waived for preventive in-network only.

Networks available: (check network applicable to your area.)

☐ National PPO Network (Careington)

☐ First Dental Health (CA)

☐ Healthplex (NY)

3. VISION INSURANCE

	IN-NETWORK	OUT OF NETWORK
☐ **TruVision: Plan 1**		
Comprehensive Eye Exam:	No Copay	$35 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	20% Discount	Not Applicable
Eyewear Frequency:	Unlimited	Not Applicable
☐ **TruVision: Plan 2**		
Comprehensive Eye Exam:	$10 Copay	$25 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	$70 Total Allowance Plus 20% Discount On Materials Exceeding Allowance	$40 Reimbursement
Eyewear Frequency: Allowance:	Biennial	Biennial
Discount:	Unlimited	Not Applicable
☐ **TruVision: Plan 3**		
Comprehensive Eye Exam:	$10 Copay	$25 Reimbursement
Exam Frequency:	Biennial	Biennial
Eyewear Allowance: Lenses/Frames or Contacts	$125 Total Allowance Plus 20% Discount On Materials Exceeding Allowance	$75 Reimbursement
Eyewear Frequency: Allowance:	Biennial	Biennial
Discount:	Unlimited	Not Applicable

4. LONG TERM DISABILITY BENEFITS

	☐ **2–24 Lives** **The Ultimate Advantage Series**	☐ **10 or more lives**
Elimination Period	☐ 90 ☐ 180 days	_____ days
Benefit per Month of Disability	60% of Basic Monthly Pay, up to a maximum of $_____ ($1,000 to $6,000 in $1,000 increments)	_____% of Basic Monthly Pay, up to a maximum of $_____
Integration	☒ Family	☐ Family ☐ Primary ☐ 70% of all Sources
Own Occupational Period	☒ 2 Years	☐ 2 Years ☐ 3 Years ☐ 5 Years ☐ Extensive ☐ Other _____
Minimum Benefit	The greater of $50 or 10% of gross monthly benefit	$_____
Maternity as any other sickness	☒ Yes	☐ Yes ☐ No ☐ Self funded
Pre-Existing Conditions Limit	12/24	☐ 12/6/24 ☐ 3/6/12 ☐ Other _____
Survivor Benefit	3 Months	☐ 3 Months ☐ Other _____
Mental, Nervous, Drug & Alcohol Limitation	☒ 12 Months	☐ 24 Months ☐ Other _____
Benefit Duration	☒ Age 65 RBD	☐ Age 65 RBD ☐ 5 Year RBD ☐ Other _____
Partial Definition	☒ Partial	☐ Partial ☐ Progressive Partial ☐ Other _____

- Is the Disability Plan part of a Flexible Benefit, under Section 125? ☐ Yes ☐ No
- If so, what percentage of the employees' contribution is paid with pre-tax dollars? _____%
- Is the business run from the home? ☐ Yes ☐ No
- Are there any employees who do not participate in the Social security or Worker's Compensation? ☐ Yes ☐ No If yes, please explain _____

5. SHORT TERM DISABILITY BENEFITS

	☐ **2–24 Lives** **The Ultimate Advantage Series**	☐ **10 or more lives**
Benefit per Week Disability	☐ 60% of Basic Weekly Pay, $_____ (not to exceed $750)	☐ _____% of Basic Weekly Pay, not to exceed $_____
	☐ Flat Amount $_____ Not to exceed 60% of Basic Weekly Pay	☐ Flat Amount $_____ Not to exceed 60% of Basic Weekly Pay
Benefit Begins	1st day for accident 8th day for sickness	_____ day for accident _____ day for sickness
Include Partial Disability Benefits	Not Available	☐ Yes ☐ No
Elimination Period Waived if Hospitalized	Not Available	☐ Yes ☐ No
Maximum Weeks per Disability	☐ 13 ☐ 26 ☐ 52 Weeks	_____ Weeks
Maternity as any other sickness	☐ Yes ☐ No (Available for 2–14 lives only if required by law)	☐ Yes ☐ No (Available for 10–14 lives only if required by law)

- Is the Disability Plan part of a Flexible Benefit, under Section 125? ☐ Yes ☐ No
- If so, what percentage of the employees' contribution is paid with pre-tax dollars? _____%
- Is the business run from the home? ☐ Yes ☐ No
- Are there any employees who do not participate in the Social security or Worker's Compensation? ☐ Yes ☐ No If yes, please explain _____

6. INTEGRATED DISABILITY BENEFITS

	☐ 2–24 Lives The Ultimate Advantage Series	☐ 10 or more lives
Benefit Begins (accident/sickness)	☐ 8/8 ☐ 15/15 ☐ 30/30 Days	☐ 8/8 ☐ 15/15 ☐ 30/30 ☐ _____ Days
Integration	☒ Family	_____
Benefit per Month of Disability	60% of Basic Monthly Pay up to a maximum of $_____ ($1,000–$6,000 in $1,000 increments)	_____% of Basic Monthly Pay up to a maximum of $_____
Own Occupation Period	☒ 2 Years	☐ 2 ☐ 3 ☐ 5 ☐ _____ Years
Maternity as any other sickness	☒ Yes	☐ Yes ☐ Self-funded
Minimum Benefit	The greater of $50 or 10% of gross monthly benefit	$_____
Mental, Nervous, Drug & Alcohol Limitation	☒ 12 Months	☐ 24 Months ☐ Other _____
Pre-Existing Conditions Limit	12/24	☐ 12/6/24 ☐ 3/6/12 ☐ Other _____
Survivor Benefit	3 Months	☐ 3 Months ☐ Other _____
Benefit Duration	☒ Age 65 RBD	☐ Age 65 RBD ☐ 5 Year RBD ☐ Other _____
Partial Definition	☒ Partial	☐ Partial ☐ Progressive Partial ☐ Other _____

- Is the Disability Plan part of a Flexible Benefit, under Section 125? ☐ Yes ☐ No
- If so, what percentage of the employees' contribution is paid with pre-tax dollars? _____%
- Is the business run from the home? ☐ Yes ☐ No
- Are there any employees who do not participate in the Social security or Worker's Compensation? ☐ Yes ☐ No If yes, please explain _____

_____

GENERAL REQUESTS

Specify _____

_____

_____

_____

REQUESTED EFFECTIVE DATE

I request that the coverage(s) chosen take effect on:

☐ the date the application is approved in writing by United States Life; or

☐ _____ If the application is approved in writing by United States Life, this will be the Effective Date.

Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be attached.

APPLICANT'S DECLARATION

1. To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.
2. The agent(s) appointed for this application is (are): _____
3. I understand that this application may be an application to participate in a Multiple Employer Trust, as determined by the underwriting rules of United States Life. If it is, this item 3 applies. 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.
4. I understand and agree that:
   - no agent may change or waive any of the provisions of this application or of any plan of insurance;
   - any change or waiver may be made only by an officer of United States Life; and
   - this application will be accepted or declined partly on the basis of the statements and answers given in this application.

_____

DATE *PRINT NAME OF OFFICER, PARTNER, PROPRIETOR*

_____

WITNESS *SIGNATURE OF OFFICER, PARTNER, PROPRIETOR*

Note: If there are any modifications to the statements and answers given in this application (i.e., crossed-out, whited-out, erased information), the applicant must attest to the modification(s) by giving a complete signature in the margin of each page which includes a modification.

HOME OFFICE USE ONLY

Supply Ordering Number - 00305201-1069-1100

PRODUCING AGENT'S DECLARATION

1. To the best of my/our knowledge and belief, all the statements and answers given in this application are true and complete.
2. I/we have no knowledge or information about the Applicant, his employees, the dependents of such employees, or any continued persons which is not fully stated in this application.

Producing Agent

PRINT NAME AS LICENSED	SIGNATURE	PRODUCER #	SS #/TAX ID #	% COMM

Date: _____ City and State where Signed: _____

Telephone #: _____ Fax #: _____

General Agent

PRINT NAME	AGENT #	SS #/TAX ID #

Telephone #: _____ Fax #: _____