

The United States Life Insurance Company in the City of New York
Member American General Financial Group

Group
Voluntary
Programs

GROUP APPLICATION
LIFE, AD&D, LTD, STD AND DENTAL

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 American General Financial Group
(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

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

*\$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.

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

*\$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: _____

Group Term Life Insurance is underwritten by:
The United States Life Insurance Company
in the City of New York
Member of American General Financial Group
3600 Route 66 • PO Box 1580
Neptune, NJ 07754-1580

Group Insurance Administrator:
American General Assurance Company
Member of American General Financial Group

AMERICAN
GENERAL
FINANCIAL GROUP

American General Financial GroupSM is the marketing name for American General Corporation and its subsidiaries.