Please complete this form and return to:
NYSSCPA Insurance Plan Administrator
1200 E. Glen Ave., Peoria Heights, IL 61616-5348
Questions: 800.342.6501

The United States Life Insurance Company in the City of New York (Herein called the Company)
Home Office: 175 Water Street, New York, NY 10038

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes you make.

50-PLUS GROUP TERM LIFE INSURANCE

STEP 1: SELECT 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: PERSONAL INFORMATION

Member Information

_____ ◯ Male ◯ Female
Name

Social Security # NYSSCPA Member ID #

Home Address

City State ZIP

Place of Birth Birthdate (mm/dd/yyyy)

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

Home Phone Work Phone

Email

Beneficiary Relationship

Name and Address of 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

_____ ◯ Male ◯ Female
Name

Social Security #

Home Address

City State ZIP

Place of Birth Birthdate (mm/dd/yyyy)

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

Home Phone Work Phone

Email

Beneficiary Relationship

Name and Address of Physician

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

*Hereforth, wherever the term "Spouse" appears, it will also read as "Domestic Partner."

STEP 3: SELECT YOUR PAYMENT MODE

I prefer to pay: ◯ Annually ◯ Semi-Annually ◯ Quarterly

Following your initial billing, you may choose to access a secure website to register and have your premium withdrawn from your bank account.

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

Underwritten by the **United States Life Insurance Company in the City of New York** (Herein called the Company)

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; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or tested positive for an immune disorder excluding HIV?	◯ YES ◯ NO	◯ YES ◯ NO
2. 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?	◯ YES ◯ NO	◯ YES ◯ NO
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	◯ YES ◯ NO	◯ YES ◯ NO
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	◯ YES ◯ NO	◯ YES ◯ 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

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.")	◯ NONE

Member/ Applicant	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?
						◯ YES ◯ NO
						◯ YES ◯ NO

STEP 6: PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW.

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 MIB, Inc., formerly known as 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 any time 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 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 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 the life insurance in New York.)**

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

Member's Signature: *(PLEASE SIGN AND DATE IN INK)* Date

Spouse's Signature: *(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)* Date

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

G-19430 NY

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