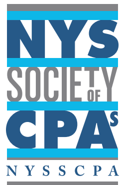

**Please complete this form and return to:**
NYSSCPA Insurance Plan Administrator,
1200 E. Glen Ave., Peoria Heights, IL 61616-5348
**Questions:** 800.342.6501

# 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.*

## GROUP LONG-TERM DISABILITY INSURANCE

### STEP 1: MEMBER INFORMATION

Name (First, Middle, Last) ◯ Male ◯ Female

Email | Home Phone | Work Phone | Age | Height | Weight

Billing Address | NYSSCPA Member ID #

City | State | ZIP

Birthdate (mm/dd/yyyy) | Place of Birth (City, State) | Name and Address of Member's Physician

Are you now, and have you been for the last 90 days, performing all duties of your regular occupation for at least 20 hours per week for your present employer? ◯ YES ◯ NO

Occupation | Date of Hire | Annual Earned Income (After Business Expenses) | Name and Address of Member's Employer

### STEP 2: INSURANCE REQUESTED

Select the plan and monthly benefit of your choice:

| ◯ **Plan 1** (Pays benefits up to age 70) | |
|---|---|
| Choice of Waiting Period: ◯ 30 Days ◯ 90 Days ◯ 180 Days ◯ 365 Days<br>Monthly Benefit Amount ($100 to $5,000, in units of $100): $ ____________<br>(Not to exceed 60% of your monthly income.) | Note: The monthly benefit amount is based upon your annual earned income (after business expenses). Those choosing a 30-day waiting period may only apply for up to $4,000. Applicants between 60-69 years of age may apply for $500 per month. |

| ◯ **Plan 2** (Pays benefits for two years) | |
|---|---|
| Waiting Period: 30 Days<br>Monthly Benefit Amount ($100 to $3,200, in units of $100): $ ____________<br>(Not to exceed 60% of your monthly income.) | Note: The monthly benefit amount is based upon your annual earned income (after business expenses). Applicants between 60-69 years of age may apply for $500 per month. |

Note: The Certificate may contain a provision regarding the benefits paid for "pre-existing conditions" and the applicable limitations. Pre-existing condition means an injury or sickness with 12 months before you were insured for which you: 1. incurred charges, 2. received medical treatment, consultation, care, or services, including diagnostic measures, 3. took prescribed drugs or medicines. There is a Waiting Period for benefits. No benefits will be paid until you have been continually insured for 12 months. The pre-existing condition waiting period and the Waiting Period are satisfied concurrently from the date of disability.

### STEP 3: SELECT YOUR PAYMENT MODE

I prefer to pay: ◯ Semi-Annual Direct Bill
Automatic Monthly Withdrawal ◯ 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: PLEASE ANSWER THESE BRIEF QUESTIONS. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

| | |
|---|---|
| 1. Have you ever had or been treated for (circle specific disorders experienced): | |
| a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm, or transient ischemic attack? | ◯ YES ◯ NO |
| b. Injury, pain, or disorder of neck or back? Sciatica? Any disabling injury or disorder of the bones, joints, or muscles? Connective tissue disorder? | ◯ YES ◯ NO |
| c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? | ◯ YES ◯ NO |
| d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? | ◯ YES ◯ NO |
| e. Disease or disorder of the rectum? Vascular or blood disorder? | ◯ YES ◯ NO |
| f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? | ◯ YES ◯ NO |
| g. Ulcer or disorder of stomach, liver, gall bladder, or pancreas? Colitis, hepatitis, or other disorder of small or large intestine? | ◯ YES ◯ NO |
| h. Prostate disorder? Nephritis, nephrosis, or other kidney disease or disorder? | ◯ YES ◯ NO |
| i. Menstrual, uterine, or ovarian disorder? Complications of pregnancy? Disorder of the breast? | ◯ YES ◯ NO |
| j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? | ◯ YES ◯ NO |
| k. Cancer, tumor, or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? | ◯ YES ◯ NO |
| l. Mental or emotional problem requiring help of a physician, psychologist, or counselor? | ◯ YES ◯ NO |
| m. A surgical operation? Or a surgical operation advised but not performed? | ◯ YES ◯ NO |
| n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system? | ◯ YES ◯ NO |
| o. Alcohol or drug abuse? | ◯ YES ◯ NO |
| 2. Have you, 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 |
| 3. Are you now taking prescription medication or receiving medical attention? | ◯ YES ◯ NO |

| | |
|---|---|
| For "Yes" answers to questions 1-3 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 # | Condition | Date Occurred | Duration | Degree of Recovery | Name and Address of Physicians, Hospitals, or Clinics Consulted |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

## STEP 5: EXISTING AND PENDING INSURANCE SECTION

1. Do you have any disability insurance in force or pending (including group coverage)? ◯ YES ◯ NO

   If "Yes," please indicate companies and amounts:__________

2. Will this coverage applied for replace any insurance now in force? ◯ YES ◯ NO

   If "Yes," please indicate which insurance and the amount being replaced: __________

## 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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

**BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE**



*NYSSCPA Group Term Life Insurance is administered by Pearl Insurance, 1200 E. Glen Ave., Peoria Heights, IL 61616. Policies issued by The United States Life Insurance Company in the City of New York (US Life). Policies issued by The United States Life Insurance Company in the City of New York (US Life). Issuing company US Life is responsible for financial obligations of insurance products and is a member of American International Group, Inc. (AIG). Products may not be available in all states and product features may vary by state. Policy #G-195,985 Form # G-19000.*
*This brochure is a brief description of benefits only and is subject to the terms, conditions, exclusions and limitations of the group policy.*