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.

APPLICATION FOR GROUP TERM LIFE INSURANCE

STEP 1: PERSONAL INFORMATION

Name of Association: _____

Member Information

_____ ◯ Male ◯ Female
Name

Social Security # NYSSCPA Member ID #

Home Address

City State ZIP

Place of Birth Birthdate (mm/dd/yyyy)

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)

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 2: COVERAGE

Term of Coverage: ◯ 10-Year ◯ 20-Year Children's Insurance: ◯

Member Amount: ◯ $250,000 ◯ $500,000 ◯ $1,000,000 ◯ $2,000,000 ◯ Other $ _____

Spouse/Domestic Partner Amount: ◯ $250,000 ◯ $500,000 ◯ $1,000,000 ◯ Other $ _____

Complete the following for the applicant/member, spouse and children** for whom coverage is requested.

Insured	Name	Age	Date of Birth (MM/DD/YR)	Place of Birth	Height	Weight	Gender
Member					Ft. In.	Lbs.	◯ Male ◯ Female
Spouse					Ft. In.	Lbs.	◯ Male ◯ Female
Child					Ft. In.	Lbs.	◯ Male ◯ Female
Child					Ft. In.	Lbs.	◯ Male ◯ Female
Child					Ft. In.	Lbs.	◯ Male ◯ Female

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Following your initial billing, you may choose to access a secure website to register and have your premium withdrawn from your bank account.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

	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 5 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 36 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	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

Name of Company	Type of Coverage	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?
					◯ YES ◯ NO
					◯ 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 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 MIB, 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.

** Dependent Child must be unmarried, up to 21 years of age or 25 years of age if a full-time student. (Subject to state variations.)

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 penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **(This warning does not apply to applications for life insurance in New York.)**

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

Member/Applicant's Signature: Date

Spouse/Domestic Partner's Signature: Date

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

G-19430-NY

NYSSCPA Group Term Life Insurance is administered by Pearl Insurance, 1200 E. Glen Ave., Peoria Heights, IL 61616, and underwritten by The United States Life Insurance Company in the City of New York. The underwriting risks, financial and contractual obligations, and support functions associated with products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility. This is only a brief summary of benefits and is subject to the terms, conditions, exclusions, and limitations of Group Policy Number G-195,983, Form Number G-19000. Coverage may vary and may not be available in all states.

NYSSCPA-TL-APP
AG-11722

NOTICES TO APPLICANT

Underwritten by:

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

Home Office: 175 Water Street, New York, NY 10038
(Herein called the Company)

THESE NOTICES MUST BE DETACHED AND RETAINED BY THE APPLICANT

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MIB-19431

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

FCRA-19432