THE UNITED STATES LIFE Insurance Company

GROUP ENROLLMENT CARD (00302101-1011-0294)

Group Policy No.	Division No.	Social Security No.
G		

APPLICANT'S Last Name (Please Print)	First Name	Initial	USL Use State / Class	SEX ☐ Male ☐ Female

APPLICANT'S RESIDENCE	Street Address	City	State	Zip

Name of Employer, Association or Union	Location

Salary $ ______ per ______	☐ Union ☐ Non Union	Date of Birth	Mo. Day Year	Occupation	Title

Date Employed Full-Time	Mo. Day Year	No. Hours Worked per Week	USL Use

☐ Single ☐ Married ☐ Widowed ☐ Divorced Dep. Children # ______ ☐ None

A ☐ I Do Not Have Eligible Dependents B ☐ I Wish To Cover My Eligible Dependents As Checked Below:

☐ Spouse (Birth Date- Mo/Day/Year: ____/____/____)

☐ Children # ______ ☐ None

NOTE: If you wish to refuse any or all coverages, you must complete the attached Refusal of Insurance Card.
Benefits provided on a non-contributory basis cannot be refused.

BENEFICIARY DESIGNATION (Please Print) (Ex.: Mary A. Jones, Wife Not: Mrs. John Jones)	First Name	Initial	Last Name	Relationship

I (1) REQUEST THE GROUP INSURANCE COVERAGE FOR WHICH I AM OR MAY BECOME ELIGIBLE (2) AUTHORIZE DEDUCTIONS FROM MY PAY OR DUES FOR MY SHARE OF THE COST, IF ANY, AND (3) DESIGNATE THE BENEFICIARY NAMED ON THIS CARD TO RECEIVE THE PROCEEDS, IF ANY, PAYABLE IF I DIE. IF HEALTH CARE IS PROVIDED BY A PARTICIPATING PROVIDER, ANY BENEFITS PAYABLE WILL BE PAID DIRECTLY TO THE PROVIDER BY THE INSURER (PARTICIPATING PROVIDER ORGANIZATION MEDICAL PLANS ONLY).

X ____/____/____ X ______________________________

Date Signed Applicant's Signature

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

(Called United States Life)

REFUSAL OF INSURANCE CARD

GROUP POLICY NO. ______________ NAME OF EMPLOYER, ASSOCIATION OR UNION ______________

EMPLOYEE'S NAME ______________ (LAST, FIRST, MI) SOCIAL SECURITY NO. ______________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

NUMBER OF **ELIGIBLE** DEPENDENT CHILDREN: ______________

I was given the opportunity to enroll in this plan of group insurance offered by my employer/association and insured by UNITED STATES LIFE. I am refusing: **(Note: Benefits provided on a non-contributory basis cannot be refused)**

	Major Medical Refusal:	Dental Refusal:	Prescription Drug Refusal:
☐ All Coverages Offered	☐ Employee & Dependents	☐ Employee & Dependents	☐ Employee & Dependents
☐ Long Term Disability	☐ Spouse	☐ Spouse	☐ Spouse
☐ Short Term Disability	☐ Child(ren)	☐ Child(ren)	☐ Child(ren)
☐ Other: ______			

ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD MAJOR MEDICAL OR DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? ☐ YES ☐ NO

If yes: Policyholder's Name ______________ Carrier ______________

(Your dependent(s) may be insured by this Plan although they are covered elsewhere.)

I understand that I must furnish, at my expense, **evidence of insurability** satisfactory to United States Life if I later wish to enroll for any of the coverages refused, except Dental, which may be subject to reduced benefits

Signature of Employee ______________ Date ______

Signature of Witness ______________ Date ______

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