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

(Called United States Life)

STATEMENT OF INSURABILITY FOR GROUP INSURANCE

(For home office use only)
Group Policy No.: _____ Certificate No.: _____

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.

1. Your full name: _____ Male ☐ Female ☐

2. Mailing Address: _____ City _____ State _____ Zip _____

3. Employed by: _____ Date employed: _____

4. Are you now working at least 30 hours per week with your present employer? Yes ☐ No ☐

PERSONAL DATA

5. Give the following details about:

Spouse's full name: _____

a. yourself if you are giving a statement of insurability:

Date of Birth	Place of Birth	Height	Weight
Month/Day/Year		Ft. In.	Lbs.

b. your spouse if she or he is giving a statement of insurability:

Date of Birth	Place of Birth	Height	Weight
Month/Day/Year		Ft. In.	Lbs.

c. your eligible children if they are giving a statement of insurability:

Child's Name	Date of Birth	Child's Name	Date of Birth	Child's Name	Date of Birth	Child's Name	Date of Birth

INSURABILITY QUESTIONS

In the following questions, "person" refers to *each person* (you only, your spouse and/or each eligible child) *who is giving a statement of insurability.* Answer each question by checking the "Yes" or "No" box, as it applies.

6. HAVE YOU EVER HAD OR BEEN TREATED FOR: (Circle specific disorders experienced.)	Yes	No
a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	☐	☐
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	☐	☐
c. Arthritis, gout, bursitis or rheumatism?	☐	☐
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	☐	☐
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	☐	☐
f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	☐	☐
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	☐	☐
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	☐	☐
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	☐	☐
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	☐	☐
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	☐	☐
l. Mental or emotional problem requiring help of a physician or psychologist?	☐	☐
m. A surgical operation? A surgical operation advised but not performed?	☐	☐

7. Have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 5 years?	Yes	No
	☐	☐

GIVE DETAILS BELOW IF: (A) "Yes" to any part of question 6, or (B) "Yes" to question 7 for a condition not specified in question 6.

Question No.	Name of Person	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals or Clinics Consulted

Use a separate sheet of paper if more space is needed for answers.

DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

1. To the best of my knowledge and belief, all the statements made above are true and complete.
2. I understand that my application for group insurance will be accepted or declined on the basis of these statements.

_____ ➡ _____
(Date Signed) (Signature of Employee/Member)

_____ ➡ _____
(Date Signed) (Signature of Spouse, if giving a statement of insurability)

_____ ➡ _____
(Date Signed) (Signature of Child Who Is Not A Minor, if giving a statement of insurability))

Witness to above Signature(s): _____

AUTHORIZATION

1. I authorize the sources stated below to give to United States Life, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any insurer; the Medical Information Bureau; any consumer reporting agency; any employer.
2. I understand that this information will be used by United States Life to determine eligibility for insurance.
3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier.
4. I know that I have the right to receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.

_____ ➡ _____
(Date Signed) (Signature of Employee/Member)

_____ ➡ _____
(Date Signed) (Signature of Spouse, if giving a statement of insurability)

_____ ➡ _____
(Date Signed) (Signature of Child Who Is Not A Minor, if giving a statement of insurability)