

HOW TO COMPLETE STATEMENT OF INSURABILITY FORM

The United States Life Insurance Company in the City of New York
Member American General Financial Group
STATEMENT OF INSURABILITY FOR GROUP INSURANCE

GROUP POLICY NO.: _____ SOCIAL SECURITY NO. _____

Any person who is eligible for life insurance under this plan is free to withdraw or to terminate his membership in the plan at any time. The purpose of this form is to provide information concerning the insurability of the person who is applying for life insurance under this plan.

EMPLOYEE/MEMBER DATA
 1. Your name: WILLIAM JONES
 2. Mailing address: 423 EAM STREET SPRINGFIELD N.Y. 13404
 3. Employed by: A.B.C. MANUFACTURING CO. Date employed: JULY 27, 1989
 4. Are you now working at least 30 hours per week with your present employer? Yes No

PERSONAL DATA
 5. Your date of birth: MARY JONES
 6. Address of your spouse (if you are getting a statement of insurability):
 a. Name: MARY JONES
 b. Date of birth: 3/24/51 Place of birth: BROOKLYN, N.Y. Height: 5, 3 Weight: 128

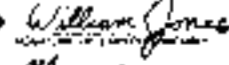

INSURABILITY QUESTIONS
 Write the following questions "Yes" or "No" in each column below. If you are not sure, check the "Yes" or "No" box as it applies.

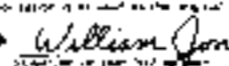
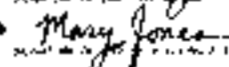
QUESTION	YES	NO
1. Have you ever had or been treated for any of the following conditions? a. Cancer (not basal or squamous cell carcinoma of the skin)	<input checked="" type="checkbox"/>	<input type="checkbox"/>
2. Have you ever had or been treated for any of the following conditions? a. Heart disease (not coronary artery disease)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
3. Have you ever had or been treated for any of the following conditions? a. Diabetes (not gestational diabetes)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Have you ever had or been treated for any of the following conditions? a. Stroke (not transient ischemic attack)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. Have you ever had or been treated for any of the following conditions? a. High blood pressure (not hypertension)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
6. Have you ever had or been treated for any of the following conditions? a. Kidney disease (not kidney stones)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
7. Have you ever had or been treated for any of the following conditions? a. Liver disease (not cirrhosis)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
8. Have you ever had or been treated for any of the following conditions? a. Lung disease (not asthma)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
9. Have you ever had or been treated for any of the following conditions? a. Mental or nervous system disease (not epilepsy)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
10. Have you ever had or been treated for any of the following conditions? a. Alcoholism (not alcohol abuse)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
11. Have you ever had or been treated for any of the following conditions? a. Drug addiction (not drug abuse)	<input type="checkbox"/>	<input checked="" type="checkbox"/>
12. Have you ever had or been treated for any of the following conditions? a. Other conditions (not other conditions)	<input type="checkbox"/>	<input checked="" type="checkbox"/>

GIVE DETAILS BELOW IF "YES" IS AN ANSWER TO QUESTION 1 OR 11. "NO" TO QUESTION 1 FOR A CONDITION NOT SPECIFIED IN QUESTION 1.

Question No.	Name of Physician	Condition	Date Occurred	Duration	Degree of Disability	Name & Address of Physician (Please Print Name & Company)
6a	MARY	HYPERTENSION	4/26/86	on-going	UNDER CONTROL	PAUL JOHNSON, M.D., 115 PARK AVE, N.Y. N.Y. 10007
6b	WILLIAM	BACKSPRAIN	8/11/81	3 WEEKS	100%	JAMES DUNN, D.C., 4 MAIN ST., NEWARK, NJ 07102

DECLARATION OF EACH PERSON OWNING A STATEMENT OF INSURABILITY
 1. I am the best of my knowledge and belief of the contents of each above and that and complete.
 2. I understand that my application for group insurance will be accepted or declined on the basis of these statements.

10/20/89  _____
 Date: _____
10/20/89  _____
 Date: _____
 Witness: MG Rolling _____

AUTHORIZATION
 I authorize the above named doctor to provide information to the insurance company regarding my health. I understand that the information provided to the insurance company will be used for the purpose of determining my insurability.
10/20/89  _____
10/20/89  _____

Include Policy Number if known.

If more than four children are eligible, use an additional form(s). You must date and sign each form.

Provide details for "YES" answers to questions 6a-m or 7.

Employee's Name

Spouse's Name

Circle Applicable Condition

3 Include full names and addresses of physicians, hospital, etc. Use a separate sheet of paper (SIGNED & DATED by employee & spouse if applicable) if additional space is needed.

4 Date & sign (FULL SIGNATURE, NOT INITIALS) in all applicable spaces.

4 Date & sign (FULL SIGNATURE, NOT INITIALS) in all applicable spaces.

- Complete ALL items legibly. Missing information will cause delays.
- If you need to make a correction, either:
 - Make a legible correction on the same form. You (and your spouse, if applicable) should then sign (NOT INITIAL) and date the form next to the correction; OR
 - Complete a new form.
- Include full names and addresses of physicians, hospital, etc. Use a separate sheet of paper (SIGNED AND DATED by employee and spouse if applicable) if additional space is needed.
- Date and sign (FULL SIGNATURE, NOT INITIALS) in all applicable spaces.
- For new enrollees, submit this form with a completed enrollment card.
- Remove this instruction sheet prior to submission.

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

Member American General Financial Group

STATEMENT OF INSURABILITY FOR GROUP INSURANCE

GROUP POLICY NO.: _____ **SOCIAL SECURITY 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.

EMPLOYEE/MEMBER DATA

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

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

INSURABILITY QUESTIONS

In the following questions, "person" refers to *each person* (you only, or you and your spouse) *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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis, gout, bursitis or rheumatism?	<input type="checkbox"/>	<input type="checkbox"/>
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	<input type="checkbox"/>	<input type="checkbox"/>
g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	<input type="checkbox"/>	<input type="checkbox"/>
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	<input type="checkbox"/>	<input type="checkbox"/>
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	<input type="checkbox"/>	<input type="checkbox"/>
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	<input type="checkbox"/>	<input type="checkbox"/>
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental or emotional problem requiring help of a physician or psychologist?	<input type="checkbox"/>	<input type="checkbox"/>
m. A surgical operation? A surgical operation advised but not performed?	<input type="checkbox"/>	<input type="checkbox"/>
7. Have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>

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)

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 agree that this authorization is valid for 2 1/2 years from the date signed.
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)

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.

“MIB” DISCLOSURE NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that The United States Life Insurance Company in the City of New York may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange in behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

The United States Life Insurance Company In the City of New York may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.