

APPLICATION FOR GROUP VOLUNTARY PROGRAMS

Please print or type all information requested.

Group Policy Number **V** Division _____
 Employee's annual salary \$ _____ Hire Date _____
 Job Title _____

1. Name of Employer/Association _____
 2. Employee's/Member's full name _____
 3. Home Address _____
NUMBER STREET CITY STATE ZIP HOME TELEPHONE NUMBER

4. Select coverages with specific amounts for Life, AD&D, LTD and STD. If increasing or decreasing coverage, list total amount of coverage requested and include copy of previously approved application or approval letter. If you have prior Dental coverage, please indicate your effective date. If no prior coverage, check "none".

	Life Amount	AD&D Amount	LTD Amount	STD Amount	Dental
Employee	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	<input type="checkbox"/> None <input type="checkbox"/> Date / /
Spouse	\$ _____ <input type="checkbox"/> refused	\$ _____ <input type="checkbox"/> refused	(Must be in multiples of \$100 Units - not to exceed max benefit) Salary must be completed above	(not to exceed maximum benefit) Salary must be completed above	<input type="checkbox"/> Employee
Child(ren):	\$ _____ <input type="checkbox"/> refused	//////			<input type="checkbox"/> Employee & Spouse <input type="checkbox"/> Employee & Child <input type="checkbox"/> Full Family

5. Complete the following for employee/member, spouse and dependents requesting coverage.

Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security #
EE					ft. in.	lbs.	
SP					ft. in.	lbs.	
CH					ft. in.	lbs.	
CH					ft. in.	lbs.	

6. Have you ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in your urine, tuberculosis, diabetes, cancer, tumors or ulcers?
 EMPLOYEE/MEMBER Yes No SPOUSE Yes No CHILD Yes No

7. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?
 Yes No Yes No Yes No

If "yes" to any part of questions 6 and 7, give details below (not required for child(ren) if employee or spouse is also applying). Use a separate sheet of paper if more space is needed for answers:

Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

8. Complete this item only if the plan description material offers smoker/non-smoker rates for life insurance. If not completed, you will be billed using smoker rates.

Have you smoked cigarettes, pipes or cigars during the past 12 months.	EMPLOYEE	SPOUSE
	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

- To the best of my knowledge and belief, all the 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 shall 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 and health of all such persons from that stated in this application.

AUTHORIZATION

- 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.
- I understand that this information will be used by United States Life to determine eligibility for insurance.
- I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which The United States Life Insurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier.
- I know that I have the right to receive a copy of this authorization if I request one.
- I agree that a photocopy of this authorization is as valid as the original.
- Employee authorizes deductions from earnings for the cost of the insurance.

(DATE SIGNED) _____ (SIGNATURE OF EMPLOYEE/MEMBER) _____

(DATE SIGNED) _____ (SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE) _____

Witness to above Signature(s): _____

BENEFICIARY DESIGNATION

Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and children insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Beneficiary of Employee and Relationship _____ Beneficiary of Spouse and Relationship _____

HOME OFFICE USE ONLY														
Underwriter/Date	Class	LIFE			AD&D			LTD			STD			
		Amount	Units	Eff. Date	Amount	Units	Eff. Date	Amount	Units	Eff. Date	Amount	Units	Eff. Date	
EE														
SP														
CH														
Dental		Prior Coverage <input type="checkbox"/> Yes <input type="checkbox"/> No			<input type="checkbox"/> Employee			<input type="checkbox"/> Employee & Spouse			<input type="checkbox"/> Employee & Child			<input type="checkbox"/> Full Family

	Takeover	GI
Employee		
Spouse		
Child(ren)		

SELF HOME