For Office Use Only-Policy No.

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

## APPLICATION FOR DISABILITY INCOME INSURANCE

*For members of the Arkansas Bar Association*

### PERSONAL INFORMATION

Name of Organization: Arkansas Bar Association

Name: _____

Social Security Number: _____

Company Name: _____

Home Telephone No.: _____

Billing Address: _____

_____

Business Telephone No.: _____

Fax Number: _____

E-mail: _____

*Please fill in your Daytime Phone Number to assist us in contacting you should the need arise in processing your application:* ( _____ ) _____

Occupation: _____

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

Beneficiary Name: _____

Relationship To You: _____

I wish to pay premiums: ❍ Annually ❍ Semi-Annually

### ✔ I WOULD LIKE TO APPLY FOR DISABILITY INCOME INSURANCE

Gross annual earned income: $_____

AD&D Principal Sum: $1,000

Indicate the Monthly Benefit desired: $_____

Indicate Waiting Period:

❍ 60-day ❍ 90-day ❍ 180-day ❍ 365-day

Desired Benefit Period: ❍ Plan 65/65 ❍ Plan 5/2

Optional Riders (check if desired):

❍ Residual Benefits

❍ Cost of Living Adjustment (check one):

____ Total Disability ____ Total and Residual Disability

❍ Guaranteed Purchase Option

❍ Hospital Indemnity Benefit:

❍ $100 ❍ $200 ❍ $300 ❍ Other $_____

❍ Recovery Benefit:

❍ $1,000 ❍ $2,000 ❍ $3,000 ❍ Other $_____

❍ Loss of Use of Hand Option: ❍ $25,000 ❍ $50,000

❍ Optional AD&D Additional Amount: $_____

*(up to $100,000, in $10,000 increments)*

### HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Height _____ ft. _____ in. Weight _____ lbs. Sex ❍ M ❍ F Date of Birth ____/____/____ Place of Birth _____

1. Have you ever had or been treated for: (Circle specific disorders experienced)
   - a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? ❍ Yes ❍ No
   - b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? ❍ Yes ❍ No
   - c. Arthritis, gout, bursitis or rheumatism? ❍ Yes ❍ No
   - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? ❍ Yes ❍ No
   - e. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder? ❍ Yes ❍ No
   - f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? ❍ Yes ❍ No
   - g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? ❍ Yes ❍ No
   - h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? ❍ Yes ❍ No
   - i. Menstrual, uterine, or ovarian disorder, disorder of the breast? ❍ Yes ❍ No
   - j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? ❍ Yes ❍ No
   - k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? ❍ Yes ❍ No
   - l. Mental or emotional problem requiring help of a physician or psychologist? ❍ Yes ❍ No
   - m. A surgical operation? A surgical operation advised but not performed? ❍ Yes ❍ No
2. Have you ever had treatment by, or consultation with, any hospital, institution, physician, or practitioner within the past five years? ❍ Yes ❍ No

**PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION**



Group Policy No. G-610,071
Form G-24026
06673611-1628 R03/11

### MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE (Retain for your records)

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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

# APPLICATION FOR DISABILITY INCOME INSURANCE

CONTINUED FROM FRONT SIDE OF APPLICATION

*For members of the Arkansas Bar Association*

Please print or type all information

If you answered "Yes" to questions 1 a-m or 2, please explain fully in the chart below.
Should you require additional space, please use a separate sheet of paper, signed and dated, and attach it to this form.

| Question | Condition | Date Occurred | Duration | Degree of Recovery | Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted |
|---|---|---|---|---|---|
| | | | | | |
| | | | | | |
| | | | | | |

What other Disability insurance do you now carry or have an application pending for? (If none, check "None.") ❍ None
Give Full Details:

| Type of Coverage | Insurance Company | Amount of Monthly Benefit | How long are benefits payable? Accident | Sickness |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Is the policy being applied for to replace, modify or supplement any similar insurance you now have? ❍ Yes ❍ No

If "Yes," provide name of Insurance Company and Policy Number: _____

## DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

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

## AUTHORIZATION

I authorize the sources stated on the MIB Disclosure to give to The United States Life Insurance Company in the City of New York, 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 The United States Life Insurance Company in the City of New York 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 that The United States Life Insurance Company in the City of New York 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.

**Fraud Statement —** 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 may be a crime. (Fraud provisions vary by state.)

_____ _____

*(Date Signed)* *(Signature of Proposed Insured)*



Just complete this application and return it today!

**Mail your application to:**

**Regions Insurance, Inc.** • 1500 Riverfront Drive • P.O. Box 3398 • Little Rock, AR 72203-3398

***Questions?*** *Call 1-888-272-6656*