

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

APPLICATION FOR DISABILITY INCOME INSURANCE

For members of the Arkansas Society of CPAs

PERSONAL INFORMATION

Name of Organization: Arkansas Society of CPAs

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-dayDesired 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 Nob. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes Noc. Arthritis, gout, bursitis or rheumatism? Yes Nod. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? Yes Noe. Disease or disorder of rectum or anus? Varicose veins, or other vascular disorder? Yes Nof. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? Yes Nog. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? Yes Noh. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? Yes Noi. Menstrual, uterine, or ovarian disorder, disorder of the breast? Yes Noj. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? Yes Nok. Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes Nol. Mental or emotional problem requiring help of a physician or psychologist? Yes Nom. A surgical operation? A surgical operation advised but not performed? Yes No2. 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

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 Society of CPAs

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?
 Give Full Details:

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

Are you replacing any current disability income coverage you 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

