

**APPLICATION FOR
GROUP TERM LIFE INSURANCE**
Underwritten by The United States Life Insurance Company in the City of New York
(Herein called the Company)

Member/Applicant information *Please print or type*

Name of Association				
Name				
First	Middle	Last		
Address				
Number	Street	City	State	ZIP
Home Phone No. ()	Work Phone No. ()	E-mail Address		
Social Security #	Beneficiary		Relationship	
Name and Address of Member/Applicant's Physician				

(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise, your beneficiary will be your children, parents, siblings, or estate.)

Spouse information *Please print or type*

Name			E-mail Address	
First	Middle	Last		
Social Security #	Beneficiary		Relationship	
Name and Address of Spouse's Physician				

(Unless otherwise requested, the member will be the beneficiary of any spouse insurance applied for.)

Check Life Insurance plan(s) desired

Life Insurance for Member: Amount \$ _____ (\$50,000–\$1,000,000, in \$25,000 increments)

Life Insurance for Spouse: Amount \$ _____ (\$50,000–\$1,000,000, in \$25,000 increments)

Life Insurance for Child(ren)*: Yes No

(Up to \$1 million of coverage is available. Contact the Plan Administrator for more information and rates. Unmarried, dependent children are eligible for \$1,000/child, age 15 days to less than six months and \$5,000/child, ages six months and older.)

Select your preferred payment mode

I wish to pay: Semi-annual Annual

Complete the following for the applicant/member, spouse and children* for whom coverage is requested

Insured	Name	Age	Date of Birth (MM/DD/YY)	Place of Birth	Height	Weight	Sex (M/F)
Member					ft. in.	lbs.	
Spouse					ft. in.	lbs.	
Child					ft. in.	lbs.	
Child					ft. in.	lbs.	
Child					ft. in.	lbs.	

G-19430 TL-AR PROF Group Policy Nos. G-610,102, G-610,103, G-610,104 AG8293 (01/11) 06673611-1647 R01/11

Please continue this application on the reverse side

MIB DISCLOSURE NOTICE (These Notices must be detached and retained by the applicant)

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.

Please answer these brief questions

	Member	Spouse
1. Has the applicant/member or spouse, if applying, ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder?	1. <input type="checkbox"/> YES <input type="checkbox"/> NO	1. <input type="checkbox"/> YES <input type="checkbox"/> NO
2. Has the applicant/member or spouse, if applying, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	2. <input type="checkbox"/> YES <input type="checkbox"/> NO	2. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	3. <input type="checkbox"/> YES <input type="checkbox"/> NO	3. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	4. <input type="checkbox"/> YES <input type="checkbox"/> NO	4. <input type="checkbox"/> YES <input type="checkbox"/> NO

For "Yes" answers to questions 1-4 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right. YES NO

Question #	Member/ Applicant	Spouse	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

Financial section Complete this section if application is for over \$500,000

Proposed Insured's Annual Income: Earned Income \$ Other Income: \$
 (Bonuses, Investments, Rental Income, etc.)

Occupation:

Total Assets: \$ Total Liabilities: \$ Net Worth: \$

Indicate Income of Proposed Insured's Spouse, if applying: \$

Existing and pending insurance section

Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None.") None

Member Please ✓	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?	
						Yes	No

Please read the following, then sign and date below to apply

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY: I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all 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 will 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 or health of such person from that stated in the application.

*Dependent child must be unmarried, age 15 days to 19 years (25 years if a full-time student). All dependents must be dependent in accordance with IRS guidelines.

IMPORTANT NOTICE — Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

<input checked="" type="checkbox"/> Member/Applicant's Signature	Date / /	<input checked="" type="checkbox"/> Spouse's Signature	Date / /
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PLEASE REPLY TODAY!

*It takes just minutes to give you and your family this solid life insurance protection.
 Send No Money Now! We'll send you a premium notice upon approval.*

Complete the application and return to:
 Regions Insurance, Inc., 1500 Riverfront Dr., Little Rock, AR 72202
 Questions? Call 1-888-272-6656

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 a 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.