

APPLICATION FOR GROUP DISABILITY INCOME INSURANCE

For Members of the American Society of Radiologic Technologists

Underwritten by The United States Life Insurance Company in the City of New York
(Herein called the Company)



Home Office: One World Financial Center, 200 Liberty Street, New York, New York 10281
Administrative Office: 3600 Route 66, Medical Underwriting 3-L, P.O. Box 1588 Neptune, NJ 07754-1588

APPLICANT INFORMATION *(Please print or type all information requested.)*

Are you applying as a: Member

Applicant's Name _____ Male Female
First Middle Last

Social Security No. ____ - ____ - ____ ASRT Membership # _____

Applicant's Address _____
Number Street City State Zip Code

Name and Address of Applicant's Physician _____

Home Phone No. (____) _____ Work Phone No. (____) _____

E-mail Address _____

PERSONAL DATA

Height _____ ft. _____ in. Weight _____ lbs. Age _____ Birth Date ____ / ____ / ____ Birth Place _____

Are you now, and have you been for the last 90 days, performing all of the duties of your regular occupation for at least 30 hours per week for your present employer? Yes No

Occupation _____ Annual Earned Income (after business expenses) \$ _____

Employer Name and Address _____ Date of Hire _____

DISABILITY INSURANCE REQUESTED:

Waiting period 30 days 90 days 180 days

Benefit period PLAN 1 (To Age 65) PLAN 2 (5 years)

Monthly Benefit Amount Desired: \$ _____

Member's may apply for \$100 to \$5,000, in \$100 increments, not to exceed 60% of your basic monthly pay. The monthly benefit amount is based upon your Annual Earned Income (after business expenses.)

Please note: To be eligible, all applicants must be under age 55.

I wish to pay: Quarterly Semi-Annually

INSURABILITY QUESTIONS:

Please answer these brief questions. To the best of your knowledge and belief:

1. During the past 5 years have you had or been treated for (Circle specific disorders experienced):

- a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm, or transient ischemic attack? Yes No
- b. Injury, pain, or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints, or muscles? Connective tissue disorder? Yes No
- c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis, or rheumatism, or any other neurological disorder? 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 the rectum? Vascular or blood disorder? Yes No

- f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? Yes No
 - g. Ulcer, or disorder of stomach, liver, gall bladder, or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine?..... Yes No
 - h. Prostate disorder? Nephritis, nephrosis, or other kidney disease or disorder? Yes No
 - i. Menstrual, uterine, or ovarian disorder? Complications of pregnancy? Disorder of the breast? Yes No
 - j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? Yes No
 - k. Cancer, tumor, or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? Yes No
 - l. Mental or emotional problem requiring help of a physician, psychologist, or counselor? Yes No
 - m. A surgical operation? Or a surgical operation advised but not performed? Yes No
 - n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system? Yes No
 - o. Alcohol or drug abuse? Yes No
2. Have you 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?..... Yes No
3. Are you now taking prescription medication or receiving medical attention? Yes No
- For "Yes" answers to questions 1- 3 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 Yes No

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

EXISTING AND PENDING INSURANCE SECTION

- Do you have any disability insurance in force or pending? (including group coverage) Yes No
 (If "Yes," please indicate companies and amounts) _____
- Will this coverage applied for replace any insurance now in force? Yes No
 (If "Yes," please indicate which insurance and the amount being replaced) _____

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 MIB, Inc., formerly known as 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 MIB, 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 date shown below, 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.

Important Notice: Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

A copy of this application will be attached to and made a part of your certificate.

Applicant's Signature _____ **Date Signed** _____

G-19463-CA **Questions? Call 1-877-212-8334** Group Policy No. G-610,214
Complete and mail your application today to: AG-8661 (6/11)
Plan Administrator, 159 E. County Line Road, Hatboro, PA 19040-1218 A-9302-1011 (CA) W
ASRT W102W31AS

The ASRT Insurance Program is administered by Aon Affinity, a division of Affinity Insurance Services, Inc.; in CA, MN & OK, a division of AIS Affinity Insurance Agency, Inc.; and in NY a division of AIS Affinity Insurance Agency. CA License # 0795465. AR License # 244489.

Retain for your records
MIB DISCLOSURE NOTICE

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.

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.