

# 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)



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. For members age 60 through 64, the maximum monthly benefit amount requested is \$1,500. 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 65.*

I wish to pay:  Quarterly  Semi-Annually

## INSURABILITY QUESTIONS:

**In the absence of fraud, all statements made by the applicant or the policyholder shall be deemed representative and not warranties.**

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

1. Have you ever 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, except for HIV? .....  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?  
**Answer this question NO if you have tested for HIV but have not developed symptoms of the disease AIDS or ARC ..**  Yes  No
- o. Alcohol or drug abuse? .....  Yes  No

2. Other than those stated above, for any reason have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, except HIV?.....  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 United States Life Insurance Company in the City of New York, as well as representatives of The United States Life Insurance Company in the City of New York 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). This authorization excludes disclosure of the results of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. 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 that such revocation may be a basis for denying benefits. 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. Failure to sign this authorization may impair the ability of The United States Life Insurance Company in the City of New York to evaluate or Process your application or claim and may be a basis for denying an application or claim for benefits. 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:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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

**Applicant's Signature** \_\_\_\_\_

**Date Signed** \_\_\_\_\_

**Questions? Call 1-877-212-8334**

**Complete and mail your application today to:  
 Plan Administrator, 159 E. County Line Road, Hatboro, PA 19040-1218**

G-19463-ME

Group Policy No. G-610,214  
 AG-8661 (6/11)

A-8986-0711 (ME) W  
 ASRT W102W31AS

**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](http://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.