



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

APPLICATION FOR GROUP DISABILITY INCOME INSURANCE

For Members of the American Society of Radiologic Technologists

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

Your Full Name _____
 Billing Address _____
 City _____ State _____ Zip _____
 Home Phone # (____) _____ Social Security No. ____ - ____ - ____
 E-mail Address _____ Male Female
 Height ____ ft. ____ in. Weight ____ lbs. Birth Date ____ / ____ / ____ Birth Place _____
 Name, address, and phone # of your physician: _____

Group Policy Number
#G-610,214

*For Office Use Only—
Policy No.*

EMPLOYMENT INFORMATION

Employer Name _____
 Employer Address _____ Phone Number _____
 City _____ State _____ Zip _____
 Occupation (Specialty) _____ Annual Earned Income \$ _____
 Description of Duties _____ (after business expenses)
 Are you now a member of the American Society of Radiologic Technologists? Yes No Membership # _____
 Are you now working at least 30 hours per week with your present employer? Yes No

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; 55 for CA residents.

I wish to pay: Quarterly Semi-Annually

INSURABILITY QUESTIONS Answer each question by checking the "Yes" or "No" box as it applies.

- | | | |
|--|---|---|
| | Member | Spouse |
| | Yes No | Yes No |
| 1. During the past 5 years, have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner for any disease, disorder, injury or other routine visit (including pregnancy)?
This includes any self-diagnosis, treatment, or medicine | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| 2. HAVE YOU EVER HAD OR BEEN TREATED FOR: (Circle specific disorders experienced) | | |
| a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| b. Injury, pain, or disorder of neck or back? Sciatica? Any disabling injury | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis, or rheumatism, or any other neurological disorder? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or eyes? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| f. Diabetes or elevated glucose? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| g. Duodenal or stomach ulcer, or other disorder of stomach, liver (including hepatitis), gall bladder, colitis, diverticulitis, or other disorder of small or large intestine?..... | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| i. Menstrual, uterine, or ovarian disorder? Disorder of the breast? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| l. Mental or emotional problem requiring help of a physician or psychologist? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |
| m. A surgical operation? A surgical operation advised but not performed? | <input type="checkbox"/> <input type="checkbox"/> | <input type="checkbox"/> <input type="checkbox"/> |

If you answered "Yes" to any part of questions 1 and 2, a-m, give details below. Should you require additional space, please use a separate piece of paper.

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

3. Do you have any disability insurance in force or pending?
 (If "Yes," please indicate companies and amount.)
4. Will this coverage applied for replace any insurance now in force?.....
 (If "Yes," please indicate which insurance.)

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, 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 United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that 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 transmission of such information, I authorize all said sources, except the MIB, you give such records or knowledge to any agency employed by United States Life to collect and transmit such information.

I understand that this information will be used by United States Life solely to determine eligibility for insurance.

I understand that I may revoke this authorization at anytime. I agree that such revocation will not affect any action, which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 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 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 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 or any 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)	(Date Signed)	(Signature of Spouse - if applying)
(Signature of Agent)			

G-19025

Questions? Call 1-877-212-8334
Complete and mail your application today to:
Plan Administrator, 159 E. County Line Road, Hatboro, PA 19040-1218

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

A-7267-0711 (MN, VT) 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.

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.