



**SEND NO MONEY NOW! It's Easy to Apply:**

- 1. Please print or type all your information.
- 2. Then send your completed form to:  
Plan Administrator  
Affinity Insurance Services, Inc.  
159 E. County Line Road  
Hatboro, PA 19040

*Members and spouses must be under age 65 to apply for the 10-year plan and under age 55 to apply for the 20-year plan.*

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

*(Herein called the Company)*

**Application For Group Level Term Life Insurance**

*For ASRT Members*

Please print or type all information requested

Member's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
First Middle Last

Member's Address \_\_\_\_\_  
Number Street City State Zip Code

ASRT Member ID # \_\_\_\_\_ Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_

Name and Address of Member's Physician \_\_\_\_\_

Member's Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise your beneficiary will be your children, parents, siblings, or estate.)

Spouse's/Domestic Partner's Name \_\_\_\_\_ Social Security # \_\_\_\_\_  
First Middle Last

Name and Address of Spouse's Physician \_\_\_\_\_

Member's e-mail address \_\_\_\_\_ Spouse's e-mail address \_\_\_\_\_

Spouse's Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
(Unless otherwise requested, the member will be the beneficiary of any spouse insurance applied for.)

Level Life Period Desired:  10 Years  20 Years

Check Life Insurance Plan(s) Desired: Amount:  
 Life Insurance for member \$ \_\_\_\_\_  
 Life Insurance for spouse \$ \_\_\_\_\_

Up to \$1 million (\$500,000 for spouses) of coverage is available, in \$10,000 increments. Contact the Plan Administrator for more information and rates.

I wish to pay:  Quarterly  Semi-annually  Annually

Complete the following for the member and spouse for whom coverage is requested.

Insured Name	Age	Date of Birth (month/day/year)	Place of Birth	Height ft. in.	Weight Lbs.	Sex M/F
Member						
Spouse						

**Please answer these brief questions.**

Member Spouse

- 1. Have you, or your 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) or AIDS Related Complex (ARC)? .....  Yes  No  Yes  No
- 2. Have you, or your 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? .....  Yes  No  Yes  No
- 3. Have you, or your spouse if applying, used tobacco or nicotine in any form during the past 12 months? .....  Yes  No  Yes  No
- 4. Are you, or your spouse if applying, now taking prescription medication or receiving medical attention? .....  Yes  No  Yes  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 No.	Member	Spouse	Condition	Date Occurred	Duration	Degree of Recovery	Name & Addresses of Physicians, Hospitals or Clinics Consulted

G-19430-CA

Group Policy No., G-610,212 (10 Year), G-610,213 (20 Year)  
AG-8660 (6/11)

Check here if the following statement applies to you: I am currently insured under the ASRT 5 year age banded term life plan and intend to replace my current coverage with an equivalent or greater amount of coverage under the ASRT 10 or 20 year term life plan.

*Application continued on reverse side...*

A-7625-0611(CA) W  
ASRT W101W31AS

**FINANCIAL SECTION** Complete this section if application is for over \$1,000,000.

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: \$ \_\_\_\_\_

Please Check (✓)		EXISTING AND PENDING INSURANCE SECTION					
		Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None".) <input type="checkbox"/> None					
Member	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?	
						Yes	No

**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 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.

\* Wherever the term spouse appears will read as Domestic Partner throughout the application.

**Important Notice:** 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.

**Applicant's Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_

**Spouse's Signature** \_\_\_\_\_ **Date Signed** \_\_\_\_\_  
 (if applying for insurance)

G-19430-CA

Group Policy No. G-610,212 (10 Year), G-610,213 (20 Year)  
 AG-8660 (6/11)

A copy of this application will be attached to and made part of your Certificate of Insurance.

**30 DAYS FREE LOOK**

*No risk...no obligation. Send no money now.*

*If your application is approved we will notify you to make your first premium payment. Upon its receipt, you will receive a Certificate of Insurance to review at your leisure. If you are not completely satisfied with its benefits and terms, return it within 30 days for a full no-questions-asked refund.*

**These Notices must be detached and retained by the applicant**

**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.