The United States Life Insurance Company in the City of New York
Home Office: One World Financial Center, 200 Liberty Street, New York, NY 10281
(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 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), AIDS Related Complex (ARC) or tested positive for an immune disorder excluding HIV?	☐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-NY

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.

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

1. Please print, sign and date your application.

2. Then send your completed application and Appendix 11 forms 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.

Application continued on reverse side…

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

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".) ☐ 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.

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

Applicant's Signature ____ **Date Signed** ____________________

Spouse's Signature ____ **Date Signed** ____________________
(if applying for insurance)

Group Policy No. G-610,212 (10 Year), G-610,213 (20 Year)

G-19430-NY AG-8660 (6/11)

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.

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.

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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.

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.

MIB-19431

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.

FCRA-19432

Definition of Replacement
Important Instructions

1. This "Definition of Replacement (Appendix 11)" form is included with your application. In accordance with the Insurance Department of the State of New York's Regulation 60, the Appendix 11 form must be completed, signed, dated and returned with your completed application even if you indicate "None" in the Existing And Pending Insurance Section on your application. Your application for life insurance coverage cannot be processed without this completed, signed and dated form.
2. If you answer "Yes" to any of the questions on the Appendix 11 form, in accordance with the Insurance Department of the State of New York's Regulation 60, the "Important Notice Regarding Replacement Or Change Of Life Insurance Policies Or Annuity Contracts (Appendix 10C)" form will be sent to you for your review. The Appendix 10e form must be signed, dated and returned, acknowledging you have read and received this notice.
3. Should you have any questions, please contact The Plan Administrator. A Certificate of Insurance can not be issued until Appendix 11 and Appendix 10C, if applicable, are completed, signed, dated and returned.

NY Term Life Application Only
The United States Life Insurance Company in the City of New York

APPENDIX 11: INSURANCE DEPARTMENT OF THE STATE OF NEW YORK DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, PLEASE ANSWER THE FOLLOWING QUESTIONS.

As part of your purchase of a new life insurance policy or a new annuity contract, has existing coverage been, or is it likely to be:

1. Lapsed, surrendered, partially surrendered, forfeited, assigned to the Insurer replacing the life insurance policy or annuity contract, or otherwise terminated? . . . . . . ☐ Yes ☐ No
2. Changed or Modified into paid up insurance; continued as extended term insurance or under another form of nonforfeiture benefit; or otherwise reduced in value by the use of nonforfeiture benefits, dividend accumulations, dividend cash values or other case values? . . . . . . ☐ Yes ☐ No
3. Changed or modified so as to effect a reduction either in the amount of the existing life insurance or annuity benefit or in the period of time the existing life insurance or annuity benefit will continue in force? . . . . . . ☐ Yes ☐ No
4. Reissued with a reduction in amount such that any cash values are released, including all transactions wherein an amount of dividend accumulations or paid-up additions is to be released on one or more of the existing policies? . . . . . . ☐ Yes ☐ No
5. Assigned as collateral for a loan or made subject to borrowing or withdrawal of any portion of the loan value, including all transactions wherein any amount of dividend accumulations or paid up additions is to be borrowed or withdrawn on one or more existing policies? . . . . . . ☐ Yes ☐ No
6. Continued with a stoppage of premium payments or reduction in the amount of premium paid? . . . . . . ☐ Yes ☐ No

If you have answered yes to any of the above questions, a replacement as defined by New York Insurance Department Regulation No. 60 has occurred or is likely to occur and you will be provided with the Important Notice Regarding Replacement OR Change Of Life Insurance Policies or Annuity Contracts.

_______________________________ _______________
Applicant's Signature and Printed Name **Date**

_______________________________ _______________
Applicant's Signature and Printed Name **Date**

Please list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

Insurer Name	Contract or Policy #	Insured of Annuitant	Replaced (R) or Financing (F)

Make sure you know the facts. Be sure that you are making an informed decision. Contact your existing company or its agent for information about the old policy or contract. If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. (A fee may be charged for your inforce illustration).

G-19000 APPENDIX 11