

The United States Life Insurance Company in the City of New York
A member company of American International Group, Inc.
APPLICATION FOR GROUP CATASTROPHIC MAJOR MEDICAL INSURANCE

Member Name _____ Birthdate ____/____/____
 Address _____ Birthplace _____
 City _____ State _____ Zip _____
 Social Security No. _____ - _____ - _____ Male Female Height _____ Weight _____
 Telephone (____) _____ - _____ Fax (____) _____ - _____

Please complete if insuring family members.

Spouse _____

FULL NAME	BIRTHDATE	BIRTHPLACE	SS#	HEIGHT/WEIGHT	GENDER
Child _____	_____	_____	_____	_____	_____
Child _____	_____	_____	_____	_____	_____

Are you and all those for whom coverage is requested covered under a basic major medical plan with the minimum requirements described in the brochure or covered by Medicare Part A & B? Yes No

If yes, name the insurer, including Medicare Part A & B, and indicate whether the coverage is group or individual.

If NO, you do not qualify for coverage.

Choice of Deductible: \$35,000 \$50,000

<input type="checkbox"/> Please send me a bill	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual
<input type="checkbox"/> Please withdraw premiums from my checking or savings account. <i>(Be sure to complete and return the enclosed Automatic Payment Option Form.)</i>	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual <input type="checkbox"/> Annual

A \$.50 per month administrative fee will be added to your bill.

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. (Fraud provisions vary by state.)

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, 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 submission of such information, I authorize all said sources, except the Medical Information Bureau, to 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 any time. 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 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.

To the best of my knowledge and belief, I attest that during the five (5) years immediately prior to completing this Application I, or anyone else for whom coverage is being requested, have not been treated for or diagnosed as having; heart disease, kidney disease, cancer, any immune disorder, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC), diabetes, neurological disease, mental or nervous dysfunction, alcohol or drug dependency, pulmonary, liver, and circulatory disease.

Exceptions

I understand that the insurance applied for will take effect on the date specified by The United States Life Insurance Company provided I, and those other persons indicated above for whom application is made, have not been hospitalized on that date. It is also understood that a sickness or injury caused by a pre-existing condition is not covered until treatment, care or advice has not been received for 12 consecutive months after coverage has been in force or after coverage has been in force for 24 straight months. A pre-existing condition is one for which medical treatment, care or advice was received within the 12 months just prior to the date the person's coverage takes effect.

I am a member in good standing of the Association.

I understand that this plan requires proposed insureds to remain covered under a basic medical plan with minimum requirements as described in the brochure. Otherwise, I understand that certain charges, as described in the brochure, will not be covered.

Applicant's Signature x _____ Date _____

Signature of Spouse (If applying for coverage) x _____ Date _____
 G-24075 Group Policy #E-233,701 AG5144 0507 CMM ACKERS NNY APP 0507ST

To apply, please complete this application, sign, date and return it with your first modal premium check made payable to Selman & Company:
 ACeS Members' Insurance Program • 6110 Parkland Boulevard • Cleveland, OH 44124 • 1-800-556-7614

The United States Life Insurance Company in the City of New York - A Member of American International Group, Inc.
Retain for your records

IMPORTANT NOTICE ABOUT THE MEDICAL INFORMATION BUREAU.

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

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 MIB, 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 in its file.

Upon receipt of a request from you MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866 692-6901 (TTY 866 346-3642). If you question the accuracy of 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information in 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.



Automatic Payment Option (APO)
Savings or Checking Account Deduction Authorization Form

1. Applicant's Information *(proposed insured)*

Applicant's Name _____ Date of Birth ____/____/____

Street Address _____

City _____ State _____ Zip Code _____

Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:

Policy Number: _____ Type of Insurance: _____

2. Financial Institution Information

Depositor Name (Payor) _____

(As it appears on Financial Institution Records)

Financial Institution Name _____ Account Number _____

(Include Branch Name)

Financial Institution City _____ State _____ Zip Code _____

3. Account Selection: I authorize an automatic deduction from my *(please choose one)*:

Checking Account. Attach a sample VOIDED check.

Savings Account. Account Number: _____ Routing Number: _____

Premium deduction should be made:

Monthly **Quarterly** **Semi-Annually** **Annually**

Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.

4. Signature/Authorization

In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.

Signature of **Depositor** _____

Print Name of **Depositor** _____ **Date** ____/____/____

Signature of **Applicant/Insured** *(If different from Depositor)* _____

Print Name of **Insured/Applicant** _____ **Date** ____/____/____

5. Agreements & Conditions

Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of \$15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

OFFICE USE ONLY Insured ID: _____ APO Effective Date: _____
