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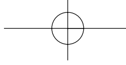


APPLICATION

NYSUT Member Benefits-Endorsed Term Life Insurance Plan

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

A member company of American International Group, Inc.

NYSUT/UUP DB 14212/14214/1004/41996
UFT DB 19630/19631/1004/41997
NYSUT/UUP PRD 12380/12381/1004/41996
UFT PRD 19058/19059/1004/41997

Note: If you need another application for your spouse or certified domestic partner, please call the Plan Administrator at 1-888-386-9788.

PLEASE COMPLETE ALL QUESTIONS TO AVOID PROCESSING DELAYS.
Please print or type all information.

Applicant ______________________ ❑ Male ❑ Female

Address ______________ City ______________ State ______ ZIP ______

Date of Birth ______________ Place of Birth ______________ Height ______ Weight ______

Telephone # ______________ E-mail Address ______________

Name of NYSUT Member ______________ NYSUT Member's Social Security# ______________

Name of Applicant's Beneficiary ______________ Relationship ______________

I am a: ❑ NYSUT Member ❑ Spouse ❑ Certified domestic partner*

**If applying as a certified domestic partner, please contact the Plan Administrator's office for an affidavit that must accompany your application.*

Payment Option: ❑ Payroll Deduction ❑ Semi-Annual Individual Billing

You may purchase up to 200 units of coverage which provides up to $1 million of insurance.

Number of units desired:______________ (A minimum of 5 units or $25,000 (one unit is $5,000) must be purchased.)

If you are increasing your current coverage, please indicate the number of additional units you desire here:___

MUST BE COMPLETED

1. Have you been actively engaged full-time in the duties of your occupation for the past 10 days? ❑ Yes ❑ No
If no, explain ______________

2. Is Dependent Coverage desired? ❑ Yes ❑ No
(If "Yes", list first name and date of birth of your unmarried children age 15 days to age 23.)

Child's Name ______________ Date of Birth (Mo./Day/Year) ______/______/______

Child's Name ______________ Date of Birth (Mo./Day/Year) ______/______/______

If additional space is needed, attach a separate sheet, sign and date it. Beneficiary for children shall be in all cases the applicant.
Remember: If the total amount applied for, plus existing NYSUT Member Benefits-endorsed Term Life Insurance Plan coverage, equals or exceeds $200,000, and in certain other circumstances, a physical examination will be required.

3. Have you or any of the dependents named above ever had life or health insurance declined, modified, or rated? ❑ Yes ❑ No

4. Are you or any of the dependents named above now taking medication or receiving medical attention? ❑ Yes ❑ No

5. Have you or any of the dependents named above had disease or disorder of the heart, high blood pressure, albumin or sugar in your urine, liver disorder, Acquired Immune Deficiency Syndrome (AIDS), cancer, tumor, ulcers, lung disease, mental or nervous disorder? ❑ Yes ❑ No

6. Have you or any of the dependents named above been confined in the last 5 years to a hospital or sanitarium or seen a doctor for any reason other than stated in #5? ❑ Yes ❑ No

If "YES" to any part of Questions 3-6, give full details below. (If additional space is needed attach a separate sheet, sign and date it)

Question#	Person	Condition	Dates	Treatment	Names and Addresses of Doctors, Hospitals, or Clinics Consulted

7. Is this insurance intended to replace or modify any insurance with this or any other company? ❑ Yes ❑ No

I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or 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. 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.
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.

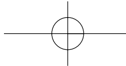
Applicant's Signature X ______________ **Date** ______________

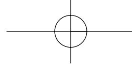
FOR OFFICE USE ONLY Eff. ______________ Paid ______________ ID ______________

GL-168-1A

GROUP POLICY NUMBERS G-233,615 and G-170,468

United States Life's Term Life Plan is a NYSUT Member Benefits-endorsed program. Member Benefits receives an expense reimbursement/endorsement arrangement of 5% of total premiums for this program. All such reimbursements are used solely to defray the costs of administering Member Benefits programs and, where appropriate, to enhance them.
Member Benefits acts as your advocate; please contact Member Benefits if you experience a problem with any endorsed program.





NYSUT Member Benefits Payroll Deduction Authorization Card (Please Print)

Member's Last Name	First Name	Middle Initial	Member's Social Security No.

Street Address	City	State	Zip	Home Telephone No. ( )

Please check your union membership affiliation:

❑ *UFT* ❑ *UUP* ❑ *PSC/CUNY** ❑ *All other NYSUT Locals*

**This authorization card cannot be used to authorize deductions for PSC-CUNY Welfare Fund Benefits.*

The amount of deduction will be determined by the NYSUT Member Benefits based on the programs chosen.

To the Employer:

I hereby authorize you to deduct from each of my salary checks the deduction necessary for the purpose of the NYSUT Member Benefits. I understand that this authorization may be revoked at any time by written notice to you.

Signature of Employee ______________________________ Date ____________________

New York State United Teachers Member Benefits * 800 Troy-Schenectady Road, Latham, NY 12110-2455 01