Staple

Statement of Insurability for Group Programs

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

New York, New York
(Herein called the Company)

Administrative Office: P.O. Box 30083 Tampa, FL 33630-3083

These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The Company 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, MA 02184-8734.

The Company, 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.

G-MIB-60013

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.

G-FCRA-60014

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Please print or type all information requested.

Please complete all sections of the application to avoid delays.

Group Policy Number 99X542 **Billing Location**_____

Employee's salary $ _____

Supplemental Life Amount $ _____
(if applicable)

1. Employer name West Babylon Schools

2. Employee's full name _____
FIRST *MIDDLE* *LAST*

3. Home Address _____
NUMBER *STREET* *CITY* *STATE* *ZIP* *HOME TELEPHONE NUMBER*

4. Complete the following for employee spouse and dependents requesting coverage.

	Name	Age	Date of Birth mm/dd/yy	Sex	Place of Birth	Height	Weight	Social Security # Employee ID #
EE						ft. in.	lbs.	
SP						ft. in.	lbs.	
CH						ft. in.	lbs.	
CH						ft. in.	lbs.	

5. Have you ever been diagnosed with or treated for any disease or disorder of the heart, kidneys, liver or lungs; cancer or tumor; AIDS (Acquired Immune Deficiency Syndrome); AIDS related complex, or other immune disorder, excluding HIV (Human Immunodeficiency Virus); diabetes or high blood pressure, mental or nervous disorder, alcohol or drug dependency, arthritis, or other musculoskeletal disease or disorder?

EMPLOYEE ☐ Yes ☐ No **SPOUSE** ☐ Yes ☐ No **CHILD** ☐ Yes ☐ No

6. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?

EMPLOYEE ☐ Yes ☐ No **SPOUSE** ☐ Yes ☐ No **CHILD** ☐ Yes ☐ No

7. Are you presently taking any medications?

EMPLOYEE ☐ Yes ☐ No **SPOUSE** ☐ Yes ☐ No **CHILD** ☐ Yes ☐ No

8. Have you, in the last 12 months, missed more than 5 consecutive days of work due to illness or injury?

EMPLOYEE ☐ Yes ☐ No

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If "yes" to any part of questions 5, 6, 7, and 8, give details below. Use a separate sheet of paper if more space is needed for answers:

Question No.	Does Question Apply to Employee, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians Hospitals/Clinics Consulted

AUTHORIZATION

1. 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 the Company, or its reinsurers, any such information, excluding drug and alcohol treatment records, if any. 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 the Company to collect and transmit such information. **2.** I understand that this information will be used by the Company solely to determine eligibility for insurance. **3.** I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which the Company has taken in reliance upon this authorization. I understand this authorization will not be valid after 24 months, if not revoked earlier. I understand that such revocation can be made by notifying the Company of my decision to do so. **4.** I know that I should retain a copy of this authorization for my records. **5.** I agree that a photocopy of this authorization is as valid as the original. **6.** To the best of my knowledge and belief, all statements made above are true and complete. All statements are representations and not warranties. **7.** 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 insured's; and (b) while there is no change in the insurability or health of such person from that stated in the application, subject to the Incontestability provision. **8.** I authorize deductions from earnings for the costs of this insurance. **9.** I designate the beneficiary named on this form to receive the proceeds, if any payable upon my death.

This application is attached to and made a part of the certificate.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no discount associated with the acceleration, and no administrative charge applies upon the exercise of this benefit.

SIGNATURE IS REQUIRED ON THE NEXT PAGE.

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The following statement does not apply to an application for life insurance in New York:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or 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 is a crime, and will be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

BENEFICIARY DESIGNATION

Unless you otherwise request below, the employee named in 2 will be the beneficiary of any spouse and children insurance applied for, and the spouse named in 4 will be the beneficiary of any employee insurance applied for. For an employee, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured:

Beneficiary of Employee and Relationship _____

Beneficiary of Spouse and Relationship _____

_____
(DATE SIGNED)

➧ _____
(SIGNATURE OF EMPLOYEE)

_____
(DATE SIGNED)

➧ _____
(SIGNATURE OF SPOUSE, IF APPLYING FOR INSURANCE)

➧ Witness to above Signature(s): _____