

THE UNITED STATES LIFE Insurance Company in the City of New York
An **American General** Company

APPLICATION FOR ACCIDENTAL DEATH & DISMEMBERMENT

Name: _____ Date of Birth: _____ / _____ / _____ Sex: F ___ M ___
Month Day Year

Street Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (____) _____ Social Security #: _____ - _____ - _____

Please Check One:	Select benefit amount:	Annual Rates Per \$10,000:
<input type="checkbox"/> Individual Coverage for member only	<input type="checkbox"/> \$100,000	Member Only: \$ 5.70 Family: \$ 9.00 A billing fee of \$1.00 will be added to each account billed.
	<input type="checkbox"/> \$ 90,000	
	<input type="checkbox"/> \$ 80,000	
<input type="checkbox"/> Family Coverage for member, spouse, and/or child(ren)	<input type="checkbox"/> \$ 70,000	
	<input type="checkbox"/> \$ 50,000	
	<input type="checkbox"/> \$ _____	

Beneficiary _____ Relationship: _____
(Example: John S. Smith, Not Mr. Smith)

Complete the following, if you are enrolling for Family Coverage:

Birthdate:

Spouse's Name: _____ Social Security #: _____ - _____ - _____
Month Day Year

Child(ren)'s Name: _____
Month Day Year

_____ Month Day Year

_____ Month Day Year

You are the beneficiary in the event of death of your insured spouse or child(ren).

I hereby enroll with the United States Life insurance Company for coverage under the GEVBP Accidental Death and Dismemberment Plan. I have read and understand the conditions and exclusions of the program.

I understand that the insurance applied for shall become effective on the first day of the month after receipt of my Enrollment Form and the first premium payment.

 APPLICANT'S SIGNATURE Date: _____ / _____ / _____
Month Day Year

 SPOUSE'S SIGNATURE (If applying for Family Coverage) Date: _____ / _____ / _____
Month Day Year