The United States Life Insurance Company in the City of New York
APPLICATION FOR TERM LIFE INSURANCE

1. Name of Association: Government Employees Voluntary Benefit Program

2. Member's Full Name: _____ Social Security No._____
FIRST MIDDLE LAST

3. Spouse's Full Name: _____ Social Security No._____
FIRST MIDDLE LAST

4. Home Address: _____
NUMBER STREET CITY STATE ZIP CODE +4

5. Home Telephone No. (_____)_____ Work Telephone No. (_____)_____

6. Billing Address _____
(if other than home address) NUMBER STREET CITY STATE ZIP CODE +4

7. Check Life Insurance Plan(s) desired: INFLATION GUARD OPTION: _____ Member _____ Spouse

a) Life Insurance for member? ☐ $250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $_____

b) Life Insurance for spouse? ☐ $250,000 ☐ $200,000 ☐ $150,000 ☐ $100,000 ☐ $_____
(Spouse coverage cannot exceed member's coverage)

c) Children coverage? ☐ Yes ☐ No

8. Complete the following for member, spouse and children if applying for insurance.

Name	Age	Date of Birth (month/day/year)	Place of Birth	Height ft. in.	Weight lbs.	Sex M F
Employee:						
Spouse:						
Child:						
Child:						

Employee Spouse

9. Have you, or your spouse if applying, ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in your urine, tuberculosis, diabetes, cancer, tumors or ulcers? ☐ Yes ☐ No ☐ Yes ☐ No

10. Have you, or your spouse if applying, during the past 5 years, consulted any physician or other practitioner or been confined to or treated in any hospital or similiar institution? ☐ Yes ☐ No ☐ Yes ☐ No

11. Have you used tobacco or nicotine in any form during the past 12 months? ☐ Yes ☐ No ☐ Yes ☐ No

If you answered "Yes" to any part of question 9 and 10 give details below. Use a separate sheet of paper, sign and date it, if more space is needed.

Question Number	Name of Proposed Insured	Condition	Date Occurred	Duration	Degree of Recovery	Names & Addresses of Physicians, Hospitals or Clinics Consulted

Unless you otherwise request below, the member named in #2 above will be the beneficiary of any spouse and children insurance applied for, and the spouse named in #3 above will be the beneficiary of any member insurance applied for. For a member, if you have no spouse or children and no one is named below, proceeds will be payable to the estate of the insured.

Name of proposed insured_____Name of beneficiary_____ Relationship_____

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I authorize the sources stated below to give to United States Life, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional; any hospital, clinic or other medical care institution; any insurer; the Medical Information Bureau; any consumer reporting agency. I understand that this information will be used by United States Life 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 on the authorization. I understand that this authorization shall not be valid after 30 months, if not revoked earlier. I know that I have the right to receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all the 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 shall 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 (b) while there is no change in the insurability and health of all such persons from that stated in this 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. This notice does not apply in Virginia.

DATE_____ Member's Signature_____

DATE_____ Spouse's Signature _____