

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

**APPLICATION FOR ACCIDENTAL DEATH & DISMEMBERMENT**

Member's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Sex: F \_\_\_ M \_\_\_  
Month Day Year

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Daytime Phone: (\_\_\_\_) \_\_\_\_\_ Social Security #: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

E-mail Address: \_\_\_\_\_

| Please Check One:  | Select benefit amount:             | Annual Rates Per \$25,000:   |
|--|------------------------------------|--|
| <input type="checkbox"/> Individual Coverage<br>for member only                      | <input type="checkbox"/> \$250,000 | Member Only: \$17.50<br><br>Family: \$23.75<br><br>A billing fee of \$2.00 will be added<br>to each annual bill. |
|  | <input type="checkbox"/> \$200,000 |  |
|  | <input type="checkbox"/> \$150,000 |  |
| <input type="checkbox"/> Family Coverage for<br>member, spouse,<br>and/or child(ren) | <input type="checkbox"/> \$100,000 |  |
|  | <input type="checkbox"/> \$ 50,000 |  |
|  | <input type="checkbox"/> \$ 25,000 |  |

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

\_\_\_\_\_

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 NAPUS 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