

THE UNITED STATES LIFE Insurance Company In the City of New York

A US LIFE COMPANY

(Called United States Life)

APPLICATION FOR GROUP VOLUNTARY PROGRAMS

Please print or type all information requested.

Group Policy Number V Division _____

All applications missing information, will be returned

Employee's annual salary \$ _____

Employee's date of employment _____

Job Title _____

1. Name of Employer/Association _____

2. Employee's/Member's full name _____
FIRST MIDDLE LAST

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

4. Select coverages with specific amounts for Life, LTD and AD&D. Please check "none" if coverage is being refused.

	Status	Life Amount	AD&D Amount	LTD Amount
Employee	<input type="checkbox"/> New <input type="checkbox"/> Change	\$ _____ <input type="checkbox"/> none	\$ _____ <input type="checkbox"/> none	\$ _____ <input type="checkbox"/> none
Spouse	<input type="checkbox"/> New <input type="checkbox"/> Change	\$ _____ <input type="checkbox"/> none	\$ _____ <input type="checkbox"/> none	(Must be in multiples of \$100 Units) (not to exceed max benefit)
Child(ren):	<input type="checkbox"/> New <input type="checkbox"/> Change	\$ _____ <input type="checkbox"/> none	/// // // // // // //	

If this is the first time applying for voluntary coverages check "new". If increasing or decreasing coverage, list total amount of coverage requesting, check "change" and include copy of previous approved application or approval letter.

Dental None Employee Employee & Spouse Employee & Child Full Family

5. Complete the following for employee/member and spouse and dependents

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

6. Have you or your spouse ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in your urine, tuberculosis, diabetes, cancer, tumors or ulcers?
EMPLOYEE/MEMBER SPOUSE
 Yes No Yes No

7. Have you or your spouse, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?
 Yes No Yes No

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

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

Complete this item only if the plan description material offers smoker/non-smoker rates.

For group life insurance to be issued or continued at a discounted premium, I declare that:
 1. I have not smoked cigarettes during the past 12 months. **EMPLOYEE** **SPOUSE**
 True False True False
 2. I do not currently smoke pipes or cigars. True False True False

G-17851

8. Unless you otherwise request below, the employee/member named in 2 above will be the beneficiary of any spouse and children insurance applied for, and the spouse named in 5 above will be the beneficiary of any employee/member insurance applied for. For an employee/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 _____