



Transport Workers Union - Air Transport Division



APPLICATION FOR GROUP TERM LIFE INSURANCE
Underwritten by The United States Life Insurance Company in the City of New York
(Herein called the Company)

- 1. Name of Association: Transport Workers Union - Air Transport Division
2. Member/Applicant's Name Social Security #
3. Member/Applicant's Address
4. Name and Address of Member/Applicant's Physician
5. Spouse's Name Social Security #
6. Name and Address of Spouse's Physician
7. Home Phone No. Work Phone No.
8. Beneficiary Relationship
(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise your beneficiary will be your children, parents, siblings, or estate, in that order.)
(Unless otherwise requested, the member will be the beneficiary of any spouse and/or children insurance applied for.)

- 9. Check Life Insurance plan(s) desired: Amount:
[] Life Insurance for member \$
[] Life Insurance for spouse \$
[] Life Insurance for child(ren) \$

Up to \$250,000 (\$125,000 for spouses) of coverage is available. Contact the Plan Administrator for more information and rates. Unmarried dependent children are eligible for \$2,500, \$5,000, \$7,500, or \$10,000 of coverage. One economical premium covers all eligible dependent children, no matter how many are being covered.

10. Complete the following for the applicant/member, spouse and children* for whom coverage is requested.

Table with 8 columns: Insured, Name, Age, Date of Birth (MM/DD/YR), Place of Birth, Height (Ft. In.), Weight (Lbs.), Sex (M F). Rows for Member, Spouse, Child, Child.

Please answer these brief questions.

- 1. Has the applicant/member or spouse, if applying ever had, been diagnosed with... Member Spouse
2. Has the applicant/member or spouse, if applying during the past 5 years, consulted any physician...
3. Has the applicant/member or spouse, if applying used tobacco or nicotine in any form during the past 12 months?
4. Is the applicant/member or spouse, if applying now taking prescription medication or receiving medical attention?

For "Yes" answers to questions 1-4 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right [] Yes [] No

Table with 8 columns: Question, Member, Spouse, Condition, Date Occurred, Duration, Degree of Recovery, Name and Address of Physicians, Hospitals or Clinics Consulted.

EXISTING AND PENDING INSURANCE SECTION Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None") None

Member	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?	
						Yes	No

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, 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. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes 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. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all 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 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 insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

*Dependent Child must be unmarried, up to 25 years of age. All dependents must be dependent in accordance with IRS guidelines.

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.) (For state specific variations(s) refer below.)

Date _____ Member / Applicant's Signature _____

Date _____ Spouse's Signature _____

Important Notice

For residents of Arkansas, Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **For residents of the District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **For residents of Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of Maine, Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. **For residents of 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **For residents of Oklahoma:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **For residents of Pennsylvania:** 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 subjects such person to criminal and civil penalties.