

APPLICATION FOR CATASTROPHE/EXCESS MAJOR MEDICAL INSURANCE



The United States Life Insurance Company in the City of New York

A subsidiary of American International Group, Inc. (AIG)

Covers catastrophic health care expenses to help keep your assets secure

COMPLETE THE INFORMATION BELOW. PLEASE PRINT OR TYPE.

Member's Name _____ Social Security No. _____

Date of Birth / / Place of Birth _____ Height ft. in. Weight lbs. Sex: Male Female

Billing Address _____ This address is my: Home Business Both

Phone () _____ Email Address _____

CHOOSE YOUR COVERAGE, INCLUDING

1. Please check the coverage you desire (*check only one*): Member Only Member and Spouse
 Member and Children Member and Family
2. Please select your deductible: \$30,000 \$50,000
3. Please select the payment method you prefer: Semi-annual

LIST ELIGIBLE DEPENDENTS YOU WISH TO INSURE (MEMBER MUST BE INSURED TO INSURE DEPENDENTS).

Relationship	Name of Proposed Insured	Age	Birth Date	Place of Birth	Height	Weight	Sex
SPOUSE			/ /		ft. in.	lbs.	M / F
CHILD			/ /		ft. in.	lbs.	M / F
CHILD			/ /		ft. in.	lbs.	M / F

Use separate sheet, if necessary, for additional children. Proposed insureds must have a basic health insurance plan or Medicare Parts A & B. If not, you do not qualify for this coverage.

HEALTH SECTION — ANSWER THE FOLLOWING QUESTIONS FOR ALL PROPOSED INSURED.

- A. Have you, your spouse or child(ren), if applying for insurance, ever had chest pains, disease or disorder of the heart, liver trouble, high blood pressure, albumin or sugar in the urine, tuberculosis, diabetes, cancer or ulcers?
- Member Yes No Spouse Yes No Child(ren) Yes No
- B. Have you, your spouse or child(ren), if applying for insurance, during the past five years, consulted any physician or other practitioner, or been confined or treated in any hospital or similar institution?
- Member Yes No Spouse Yes No Child(ren) Yes No

If you answered "Yes" to any part of question A or B, give details below. Use a separate sheet of paper, sign and date, if more space is needed for answers.

Question No.	Name of person question applies to	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses and Phone Numbers of Physicians, Hospitals or Clinics Consulted

PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW TO APPLY.

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. (Fraud provisions vary by state.)

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY – I hereby authorize any licensed physician, medical practitioner, 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 insurance company or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that 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 transmission 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 insurance company to collect and transmit such information. I understand that this information will be used by the insurance company solely 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 the insurance company has taken in reliance upon this authorization. I understand that this authorization will not be valid after 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 while there is no change in the insurability or health of such person from that stated in the application.

X _____ / /
Member's Signature (DO NOT PRINT) **Date**

X _____ / /
Signature of Spouse (IF APPLYING FOR SPOUSE COVERAGE) **Date**

G-19027 (EM) PICPA AG5932 (05/08) Group Policy No. E-185,688 06673611-1328 R06/08

Please fully complete, sign and date your application and mail it to:
Bollinger, Inc., 400 Market Street, Suite 450, Philadelphia, PA 19106 – Questions? Call 1-800-952-4050

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE (Retain for your records)
 Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York, or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file.
 Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112.
 The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.