Application for the Trust for Insuring Educators Excess Major Medical Plan

4S
0800

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

PLEASE TELL US ABOUT YOURSELF:

Please print application after you have completed it. NOTE: If you have previously applied for insurance, a copy of that application must be attached.

1. Member's Full Name _____ Social Security No. _____
2. Spouse's Full Name _____ Social Security No. _____
3. Name of Association _____ Daytime Phone No. _____
4. Home Address _____
   No. Street City State ZIP

PLEASE SELECT YOUR COVERAGE:

5. Deductible: ☐ $25,000 ☐ $30,000 ☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000

Payment Schedule: ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual

Billing Options: ☐ Direct Bill ☐ MasterCard_____ Exp. Date _____ ☐ VISA_____ Exp. Date _____

Credit card payment not available in AL, ME, NC, NH or OK.

PLEASE ANSWER A FEW QUESTIONS:

6. Complete the following for member, spouse and/or children, if applying for insurance. Use a separate sheet of paper if more space is needed.

Name	Age	Date of Birth (mo/day/yr)	Place of Birth	Height (ft. in.)	Weight (lbs.)	Sex (M/F)
Member						
Spouse						
Child						
Child						

	Member		Spouse		Child	
	Yes	No	Yes	No	Yes	No
7. Have you, your spouse, or your children, if applying for insurance, ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in the urine, tuberculosis, diabetes, cancer, tumors, or ulcers?	☐	☐	☐	☐	☐	☐
8. Have you, your spouse, or your children, 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?	☐	☐	☐	☐	☐	☐

If you answered "Yes" to any part of question 7 or 8, give details below. Use a separate piece of paper if more space is needed.

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

Please continue to the second page.

PLEASE GIVE US YOUR AUTHORIZATION

Authorization and Declaration of Each Person Giving a Statement of Insurability

1. I authorize the sources stated below to give to United States Life, or any consumer reporting agency on its behalf, information about me and my children, if applying for insurance. Such information will pertain to employment, 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; any employer.
2. I understand that this information will be used by United States Life to determine eligibility for insurance.
3. 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 will not be valid after 30 months, if not revoked earlier.
4. I know that I have the right to receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.
6. To the best of my knowledge and belief, all the statements made above are true and complete.
7. 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 and (b) while there is no change in the insurability and health of all such persons from that stated in this application.
8. I understand that this plan will not pay benefits during the first two years after the effective date for any injury or sickness any proposed insured has now, or has had in the past 12 months.

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 VA. PLEASE SIGN BELOW:

Date _____ Applicant's Signature _____

Date _____ Spouse's Signature _____

G-19027(EM) 999-31468 599 (if applying for insurance) Policy No. E-145,852

Please print out your completed application and mail to:
Forrest T. Jones Consulting Company
3130 Broadway, P.O. Box 418131
Kansas City, MO 64141-9131

Administered by the Trust for Insuring Educators Group Insurance Administrator:
Forrest T. Jones Consulting Company, Kansas City, MO
Underwritten by the United States Life Insurance Company in the City of New York

DO NOT COMPLETE _____
Signature of Florida licensed resident agent

PLEASE DETACH HERE AND SAVE FOR YOUR RECORDS:

MIB DISCLOSURE NOTICE (This notice must be detached and retained by the applicant.)

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

Information regarding your insurability will be treated as confidential except that the United States Life Insurance Company in the City of New York may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau will supply such company with the information it may have in its files.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureaus' information office is P.O. Box 105, Essex Station, Boston, MA 02112; telephone number (617) 426-3660.

The United States Life Insurance Company in the City of New York also may release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.