MASTER APPLICATION FOR EMPLOYEE BENEFITS

The United States Life Insurance Company in the City of New York
Home Office: One World Financial Center, 200 Liberty Street, New York, NY 10281

Administrative Office: 3600 Route 66, P. O. Box 1591, Neptune, NJ 07754

Important Notice

The Company's group underwriting rules will be used to determine whether the applicant, if accepted, will participate in a Trust, or will be issued a group policy.

(A group proposal is required as part of this application. If any of the data on this application conflicts with the data in the group proposal, the data in the group proposal will supercede.)

Applicant Data

1. Full Name of Applicant (Company): _____
2. Group Contact Name: _____
3. Street Address: _____

   City: ___ _____ State _____ Zip _____ Telephone: _____

   Mailing Address (if different) _____ Fax: _____

   City: _____ State: _____ Zip: _____

   E-Mail Address: _____ SIC Code: _____
4. Applicant is a: □ Proprietorship □ Partnership □ Corporation □ Union
   □ Other (Explain): _____
5. Nature of Business: _____ & Number of years in business _____
6. Are the employees of any affiliated or subsidiary companies or any other locations to be covered? □ Yes □ No
   If yes, give details below. If more space is needed, attach a separate sheet.

Name of Company	*Nature of Business*	*Full Address*	*# of Full-Time Employees*

7. Have you ever applied for, or been insured for, group insurance with any affiliated American General Companies, including United States Life? □ Yes □ No
   If yes, give details: Group Policy Number(s) _____
   Date Insurance Ended/Declined _____ Effective Date (if still insured) _____
8. Please complete the information below for those coverages being replaced:

Current Coverage				***Replacing with the Company's Plans?****	***Prior Plan Name & Effective Date***	***Proposed Termination Date***
Employer		***Employee Pay All***				
Life**	□	Life**	□	□ Yes □ No		
ADD	□	ADD	□	□ Yes □ No		
Dental	□	Dental	□	□ Yes □ No		
Vision	□	Vision	□	□ Yes □ No		
STD	□	STD	□	□ Yes □ No		
LTD	□	LTD	□	□ Yes □ No		

* Attach a copy of the present carrier's last bill, the insurance certificate, and the group policy (if applicable).

** Are there other Employer Sponsored plans in force which you are not replacing or currently applying for with another carrier?
□ Yes □ No
If yes, please indicate the highest benefit amount of each plan.

_____

_____

NOTE: The applicant may be required to furnish proof that duplication of coverage does not exist. If the application is approved based on the representation that existing insurance will be terminated, insurance under the Company plan may not take effect until the day after the existing insurance is terminated.

For Home Office Use Only	Group Number:	Division Number: _____

Employee Eligibility

A FULL-TIME EMPLOYEE is one who:

- works at least *30 hours (20 hours for Employee Pay All Life only) per week, or ____ hours per week (requires underwriting approval)
- works the Applicant's regular work schedule; and
- performs his/her job for full pay; and
- works at the Applicant's place of business.

9. Do you want to exclude any classes of full-time employees from coverage? □ Yes □ No **If yes, list each class by salary, job title, union membership, or other condition pertaining to employment:** _____ _____ Total # of excluded employees_____

* Amount of hours may vary by state law.

Participation Data

A **WAITING PERIOD** is a period of time that an employee must work on a full-time basis in an eligible class before becoming eligible for coverage. **PRESENT EMPLOYEES** means employees who are at work on a full-time basis on the effective date.

10. Waiting Period: Present Employees□ _____ months OR □ First of the month following _____months*
    Future Employees□ _____ months OR □ First of the month following _____months*

*Only option available for Employee Pay All Coverages. Available on Group coverages with the 1st of the month effective date only.

11. a. Number of Full-Time Employees (Include employees not to be covered and those being continued)**……** _____
    b. Number of Full-Time Employees **waiving all coverages ……..…….**_____
12. Do you employ 20 or more employees? (Include part-time, union, etc.) □ Yes □ No

Contribution Data – *Not applicable to Employee Pay All Coverages*

13. Will the employees be required to contribute toward the cost of the insurance? □ Yes □ No
    If yes, indicate the percentage of the cost of each coverage the **employer** will pay.

NOTE: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.

Coverage	Life	AD&D	Dep Life	EE Dental*	Dep Dental*	EE Vision*	Dep Vision*	STD	LTD
Employer %									

** The employer must contribute a minimum of 35% of the total dental and vision premiums.*

14. Premiums will be paid: □ Annually □ Semi-annually □ Quarterly □ Monthly □ EFT

Employee/Dependent Data

15. Are there any employees who, in the last 12 months, have been out of work due to injury or sickness for at least 5 consecutive working days? □ Yes □ No
    If yes, give details below. If more space is needed, attach a separate sheet, signed and dated by the Applicant. **NOTE: This question does not need to be answered for Life and AD&D groups with more than 50 employees insured, Dental coverages, for Disability coverages with ten (10) or more employees insured, or for EXACT replacement coverage for 2-50 Life and AD&D and 2-9 Disability.**

Name of Employee	*Date Disability Began*	*Current Amount of Group Life Insurance in Force*	*Describe Nature of Injury/Sickness*	*Date Return to Full-Time Work*

Requested Effective Date

I request that the coverage(s) chosen take effect on:

□ the date the application is approved in writing by the Company; or

□ ____ If the application is approved in writing by the Company, this will be the Effective Date, which may not be changed.

For Employer Plans: Premiums will be due as of the Effective Date. The premium for the first month of coverage **must** be included. For Employee Pay All Plans, the effective date must be the first of the month.

Applicant's Declaration

1. I verify that all employees applying for coverage listed on the census form are actively at work and working at least *30 hours per week, unless another minimum work requirement was authorized by the Company, and all employees meet the eligibility requirements as listed on the application.
2. I verify that the Company's benefit plan(s) have been offered to all employees. Completed waivers are attached for those employees and dependents electing not to participate in the plan(s). Note: Changes in the Census data may affect previously quoted rates.
3. To the best of my knowledge and belief, all statements and answers given in this application are true and complete.
4. The agent(s) appointed for this application is (are): _____.
5. I understand that this application may be an application to participate in a Trust, as determined by the underwriting rules of the Company. If it is, this item 5 applies. The Trust Agreement establishes the group insurance fund. A copy of the Trust Policy will be provided to me if I request it in writing. I agree to be bound by the terms of the Trust Policy.
6. I understand and agree that:
   - no agent may change or waive any of the provisions of this application or of any plan of insurance;
   - any change or waiver may be made only by an officer of the Company; and
   - this application will be accepted or declined partly on the basis of the statements and answers given in this application.
   - If the insurance contract compromises a part of an employee benefit plan, the Company is granted authority to determine eligibility, make all factual determinations and to construe all terms of the policy. The Company has no responsibility or control with respect to any other benefit which may be provided beyond this contract or any other plan of benefits.
7. It is understood and agreed that the group employer will maintain accurate records of all beneficiaries, changes of beneficiary or assignment, and that the Company may rely on this information in adjudicating any claim under the policy.
8. It is understood and agreed that the group employer will pay, in advance, the required premium for these coverages.

The following statement does not apply to an application for life insurance in 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.

_____ _____

DATE PRINT NAME & TITLE OF OFFICER, PARTNER, PROPRIETOR

_____

WITNESS SIGNATURE OF OFFICER, PARTNER, PROPRIETOR

_____

* Amount of hours my vary by state law

The Policyholder Participant Employer hereby agrees to accept certificates in electronic format for delivery to persons covered under a group policy issued by the Company.

Note: *If there are any modifications to the* statements *and answers given in this application (i.e. crossed-out, whited-out, erased information), the applicant must att*est *to the modification(s) by giving a complete signature in the margin of each page which includes a modification. Applicant Beneficiary Forms, Dependent Information Forms, or Refusal of Coverage Forms must be completed for coverage if applicable.*

Producing Agent's Declaration

Please Print	PRODUCING AGENT	
Producer #	Tax ID # / SS#	% Commissions split with other agents
Name **as Licensed**		License #
Mailing Address		
City / State / Zip		
Phone	Fax	E-Mail
Signature	*Date*	*City and State Where Signed*

Please Print	GENERAL AGENT	
General Agent #	Name	Tax ID # / SS#
Phone	Fax	E-Mail

HOME OFFICE USE ONLY

Policy No.	Premium Deposit $	Underwriter
Mode	Coverages	
Group Contact	Producer	GA

CENSUS INFORMATION (This form may be photocopied if additional supply is needed) – Not applicable for Employee Pay All Coverages

For H.O. Use Only Class/Div.	Employee's Soc. Security #	Name (Last, First, MI)	Sex M/F	City/State of Residence	Current Salary***	Occupation/ Title	Date of Birth M D Y	Date of Hire	Marital Status**	# of dependents	Coverage Election E-Employee S-Spouse, C-Child	Life	LTD	STD	INT. DIS	Dental	Vision	Spec. Dis.-CI	Spec. Dis.-CA
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**Please indicate state or federal coverage continuation here. Mark column with "C" along with date continuation began.*

***Marital Status Codes: S-Single, M-Married, W-Widowed, D-Divorced*

****Please state if salary is per hour, per week, per month or per year.*

For H.O. only:
Group Number: _____