RUTGERS
University Alumni Association

Group Term Life Insurance Application

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

Are you a/an: ☐ Alumnus ☐ Spouse – *If you are a spouse, name of alumnus:* _____

1.) Alumnus/Spouse information: *(Please print or type)*

Name
(First, Middle, Last)

Address

City | State | ZIP

Home Phone No. | Work Phone No. | Email Address

Beneficiary | Relationship

Name and Address of Physician

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.

2.) Check Life Insurance plan(s) desired:

Life Insurance for Applicant: ☐ $150,000 ☐ $100,000 ☐ $50,000

Life Insurance for Child(ren)*: ☐ Yes ☐ No

Up to $500,000 of coverage is available. Contact the plan administrator for more information and rates. Unmarried, dependent children are eligible for $100/child, age 15 days to less than six months, and $4,000/child, age six months to age 23 (subject to state variations). If an alumnus and spouse are both applying for insurance, the alumnus or spouse may apply for dependent child(ren)'s insurance, but not both.

3.) Select your payment preferences:

Payment Method: ☑ Bill Me by Mail

Payment Frequency: ☑ Semi-Annually

4.) Complete the following for the alumnus/spouse and children for whom coverage is requested:

Insured	Name	Age	Date of Birth *(MM/DD/YY)*	Place of Birth	Height	Weight	Sex *(M/F)*
Alumnus/Spouse					ft. in.	lbs.	
Child					ft. in.	lbs.	
Child					ft. in.	lbs.	
Child					ft. in.	lbs.	
Child					ft. in.	lbs.	

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5.) Please answer these brief questions:

1. Have you ever been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor by a licensed medical provider? ☐ Yes ☐ No
2. Have you tested positive for exposure to the HIV infection or been diagnosed as having AIDS Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection? ☐ Yes ☐ No
3. Have you, during the past 5 years, consulted a licensed medical provider or been confined or treated in any hospital or similar institution, for any reason other than those stated above? ☐ Yes ☐ No
4. Are you now taking prescription medication or receiving medical attention? ☐ Yes ☐ No
5. Have you ever had life or health insurance declined, modified, or rated? ☐ Yes ☐ No

For "Yes" answers to questions 1-5 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

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

6.) Tell us about your existing and pending insurance:

Please list Life Insurance in force and/or pending on proposed insured's life, including Business Insurance. If none, check "None." ☐ None

Name of Company	Type of Coverage	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?
					☐ Yes ☐ No
					☐ Yes ☐ No

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7.) Please read the following, then sign and date below:

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 MIB, Inc., formerly known as 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 MIB, 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, age 15 days up to age 23 (subject to state variations). All dependents must be dependent in accordance with IRS guidelines.

IMPORTANT NOTICE — 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.

✓ Signature Alumnus/Spouse Date (MM/DD/YY)

G-19430 FL TL-RUTGERS-FL Group Policy No. G-188,812 AG11830 (02/17) 06673611-1201 R02/17

License numbers: AR-100101639; CA Insurance License No. 0441679; MN-20270565; OK-100101074; TX-14468

SEND NO MONEY NOW!

Upon approval, we will send you a premium notice.
If you wish to apply by mail, complete, sign and return your application to:

Willis Towers Watson • 6110 Parkland Boulevard • Cleveland, Ohio 44124 • 1-800-343-5433
Or, you can fax your completed application to Willis Towers Watson at 973-410-4600.

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 the MIB, Inc., formerly known as Medical Information Bureau, 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 about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901. If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such a consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.