APPLICATION FOR GROUP SENIOR TERM LIFE INSURANCE

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

(Herein called the Company)

Member/Applicant information *Please print or type*

Name of Association: American Military Society

Name First Middle Last

Are you a member of AMS? _____Yes _____No

Age	Date of Birth / /	Place of Birth	Height ft. in.	Weight lbs.	Sex ☐M ☐F

Address

City | **State** | **ZIP**

Home Phone No. ( ) | **Work Phone No.** ( )

E-mail Address

Social Security #

Name and Address of Member/Applicant's Physician

It's Easy to Apply

(Spouses may apply for coverage, even if the member does not, by completing their own separate application.)

1. Fill out the personal information requested; then, answer the health questions as indicated and name your beneficiary or beneficiaries.
2. Select the benefit amount you want and the premium billing method you prefer. If you choose to pay monthly via EFT, complete the EFT authorization on the REVERSE SIDE.
3. Sign, date, and return your completed application with your check for your initial premium in the postage-paid reply envelope provided or mail to:

AmWINS Group Benefits, Inc.
AMS Insurance Plans
PO Box 153046, Irving, TX 75015-3046
Any questions? Call Toll Free
1-800-808-4514

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.)

Check Life Insurance plan desired

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☐ $50,000
☐ $60,000 ☐ $70,000 ☐ $80,000 ☐ $90,000 ☐ $100,000

Select your preferred payment mode

I wish to pay: ☐ Monthly EFT* ☐ Quarterly ☐ Semi-annually ☐ Annually

Please answer these brief questions

1. Have you ever had, 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; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder? **1.** ☐ YES ☐ NO
2. Have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above? **2.** ☐ YES ☐ NO
3. Are you now taking prescription medication or receiving medical attention? **3.** ☐ YES ☐ NO

G-19430 STL-NEBCO-STD Group Policy Nos. G-204,986; G-226,184 & G-226,186 AG-11641 06673611-1931

Please continue this application on the reverse side

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

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 (TTY 866-346-3642). 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.

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If Paying Premiums by EFT, Please Detach, Fill Out and Sign Other Side of This Authorization

PAYOR'S AUTHORIZATION TO FINANCIAL INSTITUTION

I hereby request and authorize you to pay and charge to my account electronic premium debits by AmWINS Group Benefits, Inc., Irving, Texas, provided there are sufficient collected funds in my account. I agree that this electronic debit shall be regarded in the same respect as if this were a check drawn on my account and signed by myself. This authority is to remain in effect until revoked by me in writing.

PAYOR'S AUTHORIZATION TO PLAN ADMINISTRATOR

I hereby authorize AmWINS Group Benefits, Inc., Irving, Texas, to electronically debit my banking institution checking account to make payment on my policy(ies).

It is understood that credit for the payment is conditioned upon the orders being honored when presented and that this Authorization may be terminated (1) at the option of AmWINS Group Benefits, Inc., if any debit is not honored when presented for payment or, (2) upon thirty (30) days prior written notice given by AmWINS Group Benefits, Inc., the Bank, or the undersigned.

*Electronic Funds Transfer: For your personal convenience, you can pay your premium monthly automatically by Electronic Funds Transfer. Use this EFT Authorization to ensure convenient, uninterrupted protection. If you choose to make payment by EFT, please include two (2) months' premium as your initial payment. This is necessary to allow sufficient time for your banking institution to arrange automatic deduction monthly, according to your instructions on this EFT Authorization.

PLEASE READ, SIGN AND DATE THE REVERSE

Please answer these brief questions (continued)

For "Yes" answers to questions 1-3, 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**

Question #	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**

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

Please read the following, then sign and date below to apply

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.

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.) (See below for state-specific variations.)

X **Member/Applicant's Signature**	**Date** / /

For residents of Arkansas, Louisiana, Rhode Island 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 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 Tennessee, Virginia 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 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.

PLEASE REPLY TODAY! It takes just minutes to apply to give you and your family this life insurance protection. A medical exam is typically not required for up to $100,000.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(s) (This notice must be detached and retained by the applicant)

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.

BANK INFORMATION

PLEASE PRINT ALL INFORMATION EXCEPT SIGNATURE

Banking Institution: _____

Branch: _____

Address of Branch: _____

City: _____ **State:** _____ **Zip Code:** _____

Account Number: _____ **Name of Account (Payor's Name):** _____

Payor's Signature: _____ **Date:** _____

Please detach, and include a blank check marked VOID to this form before returning your completed application.