

Application for Coverage AFT + Catastrophic Major Medical Plan

Questions “A” & “B” are used to ascertain what, if any, pre-existing medical conditions an applicant may have. Below is a FAQ that may help you complete the application.

Question A

Q. Will an affirmative answer to Question A or B on the insurance application necessarily disqualify me from obtaining coverage?

A. Not necessarily. The underwriter will make a decision based on the nature of the information provided in accordance with the company’s underwriting practices.

Q. Will an affirmative answer on the insurance application result in the need to provide additional information?

A. Not necessarily. You should provide as much information as possible in the columns provided and the underwriter will determine if additional information is required.

If you need additional space, please attach a separate sheet of paper. Important: You must sign and date any separate sheets accompanying the application.

Question B

Q. Under question B, is it necessary for me to remember the specific dates of each routine consultation or test (e.g., Pap smear, physicals, mammography, prostate and sigmoidoscopy)?

A. No. This question is included to capture your medical history on any pre-existing medical condition not listed in Question A (e.g., asthma). The year and the approximate dates of any consultation, hospital confinement or treatment is sufficient. However, you *must* disclose all reasons and medical conditions or confinement or treatment in any hospital or similar institution.

If you have questions about completing the application which are not addressed, please call the program administrator, Alliant, **800/221-8740** at for more information. Phones are staffed Monday through Friday, 8:30 a.m. to 5:00 p.m. (ET).

Application for Group Catastrophic Major Medical Insurance

For Members of the American Federation of Teachers
The United States Life Insurance Company in the City of New York
A subsidiary of American International Group, Inc. (AIG)

Member's Full Name _____ Social Security No. _____

Home Address _____
Street *City* *State* *ZIP*

Phone (Home) _____ (Work) _____ Email address _____

CHOOSE YOUR COVERAGE, INCLUDING DEPENDENTS, DEDUCTIBLE AND PAYMENT METHOD

1. Please check the coverage you desire (*check only one*):
- Member Only Member and Spouse/Partner Member and Child(ren) Member, Spouse and Child(ren)
2. Your deductible: \$25,000 \$50,000

Complete the following for member, spouse and/or children, if applying for insurance. Use a separate sheet if more space is needed for answers. Proposed insured must have basic health insurance plan or Medicare Parts A&B. If not, you do not qualify for this coverage.

Name of Proposed Insured	Age	Birth Date	Place of Birth	Height	Weight	Sex
Member		/ /		Ft. in.	lbs.	M/F
Spouse		/ /		Ft. in.	lbs.	M/F
Child		/ /		Ft. in.	lbs.	M/F
Child		/ /		Ft. in.	lbs.	M/F

- A. Have you, your spouse or your 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, tumor or ulcers?
- Member **Yes No** Spouse/Partner **Yes No** Child(ren) **Yes No**
- B. Have you, your spouse or your 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/Partner **Yes No** Child(ren) **Yes No**

If "Yes" to any part of questions A or B, give details below. Use a separate sheet of paper if more space is needed for your answers.

Question Number	Member, Spouse or Child	Condition	Date Occurred	Duration	Degree of Recovery	Name and Addresses of Physicians, Hospitals or Clinics consulted
			/ /			
			/ /			
			/ /			
			/ /			

PLEASE READ THE FOLLOWING, THEN SIGN BELOW TO APPLY

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.

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.)

X _____ / / **X** _____ / /
 Member's Signature (DO NOT PRINT) DATE Signature of Spouse/Partner (IF APPLYING FOR COVERAGE) DATE

G-19027 (EM) Group Policy Number: E-610,278 AG-6095

MEDICAL INFORMATION BUREAU (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 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.