

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

A member company of American International Group, Inc.

FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER GROUP POLICY FORM G-19000.

Policy Holder:		Value Benefits of America						
Applicant:	Date of Birth:	Place of Birth:	Age:	Sex:	Ht	Wt	Social Security Number:	
Home Address: (Include number & street, city, state and zip code)				Mailing or Billing Address (if other than Home Address)				
Home Phone:	Work Phone:	Email Address:			Occupation:			

DEPENDENT COVERAGE: I wish to apply for coverage for my following dependents:

First, Middle and Last Name	Date of Birth	Age	Sex	Ht	Wt	Social Security No.	Relationship

BENEFITS BEING APPLIED FOR:

	(check one)	<input type="checkbox"/> Classic	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
Daily Hospital Confinement Benefits.....	\$250	\$500	\$750	\$1,000	\$1,000
Daily Intensive Care/Coronary Care Unit Confinement Benefits.....	\$1,000	\$2,000	\$3,000	\$4,000	\$4,000
Maximum Emergency Accident Treatment Benefits.....	\$62.50	\$125	\$187.50	\$250	\$250
Maximum Ambulance Transportation Benefits.....	\$125	\$250	\$375	\$500	\$500
Maximum Surgical Benefits Per Schedule.....	\$5,000	\$10,000	\$15,000	\$20,000	\$20,000

QUALIFYING MEDICAL QUESTIONS:

- In the past 24 months, have you or your dependents, if applying for insurance, had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in the urine, diabetes, cancer, tumors or ulcers?..... Yes No
- Have you (or your dependents if applying for insurance) consulted any physician or practitioner for any reason other than a routine physical exam with normal results, or been confined or treated in a hospital or similar institution, during the past 24 months?.... Yes No
- Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and/or recommended and current status: _____

 _____ (Attach additional signed & dated sheet if more room needed.)

OTHER COVERAGE:

- Are you now covered under, or awaiting issuance of, any accident or health insurance?..... Yes No
 If "Yes", please list ALL accident and health coverages now in force or pending issuance (include coverage name and form number (if known), coverage type and benefit amount, and company name: _____
 _____ (Attach additional signed & dated sheet if more room needed)
Please note: This coverage is not meant to be a replacement for comprehensive benefits under a health insurance plan or health maintenance organization (HMO) plan and this is not a comprehensive plan.
- Will any existing coverage be replaced by the coverage you are applying for?..... Yes No
 If "Yes", please give company name, type of coverage and policy number: _____

PREMIUM:

Insurance Premium \$ _____ plus \$15.00 Monthly Administrative Fee
 Payment Mode: Monthly Bank Draft Monthly List Bill (2 or more) Semi-Annual Annual

I HEREBY APPLY for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the questions contained in this application are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be granted solely and entirely in reliance upon my answers to the questions contained in this application; (2) no coverage will exist until a Certificate of Coverage is issued, and will be in force only as of the Certificate Effective Date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a condition for which medical advice or treatment was received from a doctor during a twelve month period prior to the date of this application, will not be covered until my coverage has been in force for 12 months.

WARNING: Any person who, 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 may subject such person to criminal and civil penalties.

Dated at _____ this _____ day of _____, 20 _____

Signature of Applicant: **X** _____ date signed _____

I hereby certify that I personally saw the applicant and truly and accurately recorded the above information.

Agent's Signature: **X** _____ date signed _____

Print Agent's Name _____ Agent's Number(s) _____

Value Health Consumer Form

Each applicant who purchases the Value Health Plan must read & complete this form.

Please Print

Applicant's Name _____ **Agent's Name** _____

Applicant's Initials

1. The agent explained the provisions showing benefits, waiting periods, limitations and exclusions. I have received a Brochure for the plan for which I have applied. The agent advised me to read certificate of insurance if issued. _____

2. Are you presently enrolled in COBRA? Yes No
 - a. If yes, what date did you begin COBRA? _____
 - b. If yes, you need to know that you may have rights under the Health Insurance Portability and Accountability Act (HIPAA), to more comprehensive coverage that is not offered by these plans. Please contact your state's Department of Insurance for an explanation of these rights.
 - c. If yes, when does your COBRA terminate? _____

3. I understand that I may be eligible for insurance through a state health pool* or as a HIPAA eligible individual if I meet any of the following criteria:
 - a. have at least 18 months of creditable coverage without a significant break in coverage;
 - b. most recent coverage was under a group health plan, governmental plan or church plan;
 - c. not eligible for Medicaid or Medicare;
 - d. most recent coverage was not terminated due to non-payment of premium or fraud;
 - e. did not decline offer to continue coverage under a state program or under COBRA;
 - f. exhausted coverage under the elected continuation of coverage.**If you believe that you are an eligible person, you should contact your state's Department of Insurance for more information.** _____

4. I understand that this plan does not offer Major Medical coverage, and the Policy(s) I am purchasing may have limited benefits. I know that this policy(s) does not cover everything and that I will be responsible for the balance of these costs. _____

*AL, AK, AR, CO, CT, IL, IN, IA, KS, KY, LA, MN, MO, MS, MT, NE, NH, NM, ND, OK, OR, PA, SC, TX, UT, WA, WI, WY have high risk pools for eligible persons.

Applicant *(Parent or Legal Guardian if Applicant is under 18)*

Writing Agent

Signature

Signature

Agent #

Address

Print Name

City

State

Zip

REQUIRED FOR NEW VALUE HEALTH & VALUE HOSPITAL APPS

HIPAA AUTHORIZATION

This Authorization was prepared by for purposes of obtaining information necessary to underwrite my (our) application(s) for insurance.

**The United States Life Insurance Company in the City of New York
A member company of American International Group, Inc.
830 Third Avenue, New York, NY 10022**

I hereby authorize any licensed physician, medical practitioner, pharmacy benefit manager and other sources, 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 United States Life 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 submission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information.

I understand that this information will be used by United States Life 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 United States Life has taken in reliance upon this authorization. I understand 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 (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.

(Print Please) Name of Applicant

Signature of Applicant and Date