AIG

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

Application Form for *Life to 95* Group Term Life Insurance

Applicant

OLA

_____
Title (Dr. / Mr. / Mrs. / Ms.), First Name, Middle Initial, Last Name

_____ _____
Mailing Address *Home Phone*

_____ _____
City *State* *Zip Code* *Work Phone*

_____ _____ _____
Social Security # *Email* *Cell Phone*

Birth Date_____ Location of Birth_____ Gender_____ Occupation_____
MM/DD/YYYY *M/F*

My eligibility status is (check one): ☐ Alumnus/a ☐ Student ☐ Eligible Family Member

If Eligible Family Member *(check one)*: ☐ Spouse ☐ Domestic Partner

Sponsoring college, university, school, or alumni/ae association: _____

A. Insurance Amount Requested. *(Refer to brochure for eligibility, insurance amounts, and coverage description.)* I request:

☐ $100,000 ☐ $75,000 ☐ $50,000 ☐ $25,000 ☐ Other $_____ *Amounts must be in $1,000 increments; minimum $10,000; maximum $100,000.*

B. Health Information. Please complete all questions below. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Name and Address of Applicant's Physician _____

		Yes	No
1.	Height _____*Ft* _____*In* Weight _____ *Lbs.*		
2.	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), or AIDS Related Complex (ARC)?	☐	☐
3.	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?	☐	☐
4.	Are you now taking prescription medication or receiving medical attention?	☐	☐

For "Yes" answers to questions 2-4 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 this box. ☐

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

C. Beneficiary Designation. I name the following to receive all the insurance on my life under this life insurance plan, and I revoke prior beneficiary designations. *(If you need more space, attach a separate sheet that you have signed and dated.)*

1. _____% _____ _____
Title (Dr. / Mr. / Mrs. / Ms.), First Name, Middle Initial, Last Name *Relationship*

2. _____% _____ _____

3. _____% _____ _____

EXISTING AND PENDING INSURANCE

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
					☐ Yes ☐ No

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. 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 transit 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 any time 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 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.*

SIGN & DATE

Applicant's Signature X_____ Date _____

G-19430 CA

Group Policy No. G-610,477 6/17 AG-11944

I apply to become a Subscriber to the Collegiate Alumni Trust. CAT enables members of sponsoring organizations to purchase insurance through a single group insurance policy. Subscribing to CAT costs nothing but is required to become insured. I request that any dividend resulting from my participation in this program be paid to the Sponsor named above or to any other entity designated by that Sponsor from time to time, unless I rescind this request by written notice to the Group Policyholder at least 90 days before the policy anniversary date.

SIGN & DATE

Applicant's Signature X_____ Date _____

M&A 6/2017 - GEN

Applicant signs two areas indicated above and mails this request to the Administrator:
Meyer and Associates ◆ 18 Washington Avenue ◆ Chatham, NJ 07928 ◆ 800-635-7801 Weekdays 8:30AM-6:00PM ET ◆ www.AlumLifeTo95.com