

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

New York, New York

A Member of American International Group, Inc.

Administrative Office: 3600 Route 66, P.O. Box 1580, Neptune, NJ 07754-1580

Policy No. _____

1 A Full Name of Proposed Insured		C Occupation	Employer	General Agent	
B Date of Birth (Month, Day, Year)		D Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated <input type="checkbox"/>			
2 Were you ever rejected or discharged by the Armed Services? (Give date and reason)	6 Do you use or have you ever used: A beer, wine or liquor? B habit forming drugs? (If A or B yes, state extent)				
3 Have you ever applied for or received disability benefits from any source?	7 Have you ever been advised to: A change or restrict your diet? Why? B take insulin?				
4 Has any application for or reinstatement of Life, Accident or Health insurance ever been declined, postponed, rated or in any way modified? (If yes, give details, date and company)	8 A Have you any physical defect? B ARE YOU NOW IN GOOD HEALTH?				
5 Have you ever sought advice or treatment for alcohol or drug addiction? (Give details)					
9 HAVE YOU EVER HAD A Epilepsy, paralysis, nervous breakdown, dizziness, fainting spells, nervous or mental trouble? B High or low blood pressure, chest pain, shortness of breath, palpitation; disorder of heart or blood vessels? C Hemorrhage, habitual cough, chronic hoarseness, asthma, pleurisy, tuberculosis or disorder of respiratory system? D Indigestion, ulcer, fistula; disorder of stomach, gall-bladder, liver, digestive or abdominal organs? E Kidney colic or stone, stricture, diabetes, sugar or albumin in urine; disorder of kidneys, bladder, genito-urinary, male or female organs? F Rheumatic fever, arthritis, osteomyelitis; disorder of bones, joints or spine? G Impairment of vision or hearing or disease of eyes or ears? H Goiter, tumor, cancer, venereal disease; disorder of blood, glands or skin? I Treatment or observation in any hospital or institution? J X-rays or Electrocardiograms? When, why, by whom, with what results? K Any accident, injury or operation other than as stated above? L Consultations with any physicians or practitioners other than as stated above?	YES or NO	IF YES, GIVE DETAILS Description Dates Duration Doctor's names and addresses			
10 Family Record	LIVING		DEAD		
	Age	Health	Age	Cause of Death	
	Father				
	Mother				
	Brothers No. living () No. dead ()				
	Sisters No. living () No. dead ()				
Spouse					
11 A Height.....ftin.					
B Weightlbs.					
C Change in weight in past 12 months. (Give reason for change) Losslbs. Gainlbs.					
12 A Do you smoke cigarettes?		YES	NO		
B Do you smoke cigars?		<input type="checkbox"/>	<input type="checkbox"/>		
C Do you smoke pipes?		<input type="checkbox"/>	<input type="checkbox"/>		

All of the above answers are full, complete and true; are a continuation of, and form a part of the application for insurance on my life to The United States Life Insurance Company.

Signed at.....this.....day of.....
CITY AND STATE OR COUNTRY YEAR

Witness _____
AGENT OR MEDICAL EXAMINER SIGNATURE OF PROPOSED INSURED

Form No. GMS-1 00305101-1052 R05/03

AUTHORIZATION

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 The United States Life Insurance Company any such information.

To facilitate 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 the insurance company to collect and transmit such information.

A photographic copy of this authorization shall be as valid as the original.

WITNESS DATE SIGNATURE OF PROPOSED INSURED

DO NOT DETACH—MAIL ENTIRE FORM DIRECTLY TO

The United States Life Insurance Company, 3600 Route 66, P.O. Box 1580, Neptune, NJ 07754-1580

Employer of Proposed Insured _____ Policy No. _____
Full Name of Proposed Insured _____
Date of Birth _____ Place of Birth _____

N.B.—Fees for examinations are paid only by The United States Life Insurance Company. This stub must be completed by the Medical Examiner at the time of the examination and mailed to the

