New Business Checklist for United States Life Applications

This checklist provides instructions for submitting a USL application. Do not submit this checklist with the application packet.

New York state requires that you are **LICENSED** with the Company **before soliciting an application.**

A Life Insurance Buyer's Guide must be provided to the applicant at the time of application.

Definition of Replacement Form:
Must be completed before an application is taken. If any question on the Definition of Replacement Form (USL1002N) is answered 'Yes', follow instructions for Replacement Transaction below.

Non-Replacement Transaction:

- ☐ Reminder: NY Regulation 187 training for policy issuance
- ☐ Definition of Replacement Form
- ☐ Signed Illustration / Quotation, if applicable based on product requested
- ☐ Bank Draft Authorization and voided check (if desired method of payment is automatic check withdrawal)
- ☐ New Business Application Transmittal
- ☐ Application - signed and dated
- ☐ HIV Consent Form (if Blood Profile is needed)
- ☐ HIPAA Authorization
- ☐ Index Universal Life Supplemental Application, if an index product is requested

Replacement Transaction:

- ☐ Reminder: NY Regulation 187 training for policy issuance
- ☐ See Steps for Completing Appropriately Dated USL / REG 60 Forms before Submission of a New York Life Application
- ☐ Application
- ☐ 1035 Exchange – need Absolute Assignment Form and Original Policy, if available
- ☐ Signed Illustration / Quotation, if applicable based on product requested
- ☐ Bank Draft Authorization and voided check (if desired method of payment is automatic check withdrawal)
- ☐ New Business Application Transmittal
- ☐ HIV Consent Form (if Blood Profile is needed)
- ☐ HIPAA Authorization
- ☐ Index Universal Life Supplemental Application, if an indexed product is requested

Initial Premium Paid:
Please review with the applicant the Limited Temporary Life Insurance Agreement before accepting any premium.

Mailing Addresses for USL Business

Regular Mail	Overnight Mail
The United States Life Insurance Company in the City of New York P.O. Box 650857 Dallas, TX 75265-0857	The United States Life Insurance Company in the City of New York ATTN: Lockbox # 650857 JPM TX1-0029 14800 Frye Rd, 2nd Floor Fort Worth TX 76155

TOOLS & TIPS
• tip sheets •

Steps for Completing Appropriately Dated USL / REG 60 Forms before Submission of a New York Life Application

1. **DEFINITION OF REPLACEMENT FORM (USL1002N Rev0515)**

   The Definition of Replacement Form is required for all New York Applications, even if the applicant does not have existing coverage. This form is included in the application packet.

   The Definition of Replacement form must be completed before all other forms to determine whether the transaction will involve replacement. Both the agent and applicant must sign and date the Definition of Replacement. A copy must be provided to the applicant. Note, the Definition of Replacement form must be signed and dated on or before the application.

   - If all questions are answered "No" the transaction does not involve a replacement and no additional forms need to be completed. Submit the Definition of Replacement form with the Application Part A.
   - If ***any*** of the questions are answered "Yes" additional REG 60 forms are required – see steps 2-5 below.

     Note: An application is EXEMPT from REG 60 if:
     - a group life insurance policy or group annuity contract, except when an insurance agent or broker or insurer directly solicits the certificateholder for the new coverage and a portion of the premium or consideration is borne, directly or indirectly, by the certificateholder.
     - an individual life insurance policy or individual annuity contract where the cost of the policy or contract is borne wholly by the applicant's employer or by an association of which the applicant is a member. In this situation an Employer Paid Exemption form (USL1012) is required.

2. **NOTICE TO EXISTING INSURER / REQUEST FOR POLICY INFORMATION (USL1003N Rev0114)**

   If a replacement has been indicated the agent will obtain from the applicant the policies to be replaced and list them on the Notice to Existing Insurer form. This form must be signed by the applicant and sent to the existing insurer. A copy of the completed form should also be submitted with the Application Part A.

   The agent must allow 20 calendar days (plus mailing time) for the existing insurer to respond. Note: By faxing this form to the existing insurer, the fax confirmation is proof of mailing and proof of the date that it was sent.

3. **IMPORTANT NOTICE (USL1004N Rev0515)**

   The Important Notice is also completed at the time of sale. **This form must be signed by the applicant on or before the Application Part A and submitted to USL with the Application Part A.** A copy of this form must be left with the applicant.

4. **APPLICATION PART A**

   When a case involves a replacement, the Application Part A **cannot be dated prior to the Definition of Replacement or the Important Notice**

5. **DISCLOSURE STATEMENT (USL1001N Rev0515)**

   The Disclosure Statement is to be completed **after** a response to the policy information request is received from the existing insurer.

   If the existing insurer does not respond within 20 calendar days good faith approximations based on the information available may be used in completing the Disclosure Statement. The approximation field on page 1 should be checked to indicate that approximations were used.

   The completed Disclosure Statement signed by the agent must be received by the USL Home Office before the policy can be issued for delivery. A copy of the signed Disclosure Statement will be included in the policy provided to the policy owner.

Requests for Enhanced REG 60 Processing:

If you would like USL to request values from the existing insurer on your behalf the Enhanced REG 60 Processing Request Form (AGLC105743 Rev0515) must be submitted with the forms identified in steps 1-4 above. Please note, upon receipt of values from the existing insurer USL will send a Disclosure Statement to the agent for review and completion.

DO NOT submit this instruction sheet with the application packet.

New York State Insurance Regulation 187: Quick guide to requirements

Carrier-specific product training is available at:

Kaplan Corebridge Life Portal

We will also accept Best Interest Rule Training from the following vendors:

- **Kaplan**
- **Quest CE**
- **RegEd**
- **Success CE**

Note: If your agency requires use of another training provider, we will work with you to review your request and accommodate your needs when possible.

More resources

For additional information and resources, please see the **NY Reg 187** tab on our **New York Products Playbook**.

New York Regulation 187, **Suitability and Best Interests in Life Insurance and Annuity Transactions** (also known as the **Best Interest Rule**), has several obligations for financial professionals who sell US Life's life insurance policies in the State of New York.

These requirements include training, disclosures, and monitoring. It is the responsibility of all New York licensed financial professionals to comply with these requirements.

Training requirements

As a reminder, you must complete training on the ***Best Interest Rule***, as well as applicable ***carrier-specific product training***.

- **New policies:** Both of the trainings noted above must be completed prior to making a recommendation and the application signature date for Term Life Insurance, Term Conversions, and Universal Life Insurance.
- **Inforce policies:** If you are involved with the recommendation of a rider addition or face-increase transaction, you must complete ***Best Interest Rule training*** prior to making the recommendation and the inforce policy change form signature date.
- Best Interest Rule training is available from Kaplan, Quest CE, RegEd, and Success CE.
- Corebridge Financial-specific product training is offered through Kaplan.

Required disclosures and documenting the basis for recommendation

You have an obligation to disclose to clients the basis for your recommendation and the manner that you will be compensated for the sale of the life insurance policy.

To demonstrate compliance with the disclosure of the basis for the recommendation, any client discussions should be reasonably and reliably documented and retained. Use the applicable fields in the Agent's Report to document your basis for the recommendation, being sure to include the facts and analysis to support your recommendation.

Policies issued by **American General Life Insurance Company** (AGL), Houston, TX except in New York, where issued by **The United States Life Insurance Company in the City of New York** (US Life).

New York Regulation 187 (cont.)

As a reminder of the requirements of New York Regulation 187, you must provide the client with certain disclosures regarding your compensation at or prior to the time of application. To assist you in meeting this requirement, you may use US Life's version of the State of New York Compensation Disclosure Form.

If the client requests further information about your compensation prior to policy issuance, or after issuance of the policy but less than 30 days after issuance, US Life's version of the State of New York Additional Compensation Disclosure Form may be used to meet the additional compensation requirement.

Neither of these forms are required to be submitted to US Life as part of the application process. For your convenience, these forms are available for you in our forms repository.

In all cases, if you have oral discussions with your clients, be sure to retain any audio recordings or subsequent correspondence between you and the client confirming your recommendations and compensation disclosures.

Monitoring

We will perform post-issue audits of certain sales transactions to ensure full compliance with the NY Reg 187 Best Interest Rule requirements. **You have an obligation to respond to such audits in a full and timely manner.** Documentation that may be requested could include, but not be limited to:

- Evidence of the required compensation disclosures
- Documentation of all relevant suitability considerations, including basis for recommendation
- Verification of the methodology used to ensure that the transaction is in the client's best interest, including any financial analysis software, proprietary software, or other strategy to determine the product was in the client's best interest.
- Best Interest Rule analysis for Other Than Applied For (OTAF) cases.
- Any documentary evidence of any oral discussions around these matters .

Failure to meet these requirements, including failure to respond to our inquiries, may lead to possible enforcement actions by Corebridge Financial, up to and including termination.

Questions?

If you have questions, please contact Corebridge Financial. Contact information can be found at corebridgefinancial.com/support.

corebridge financial

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

28 Liberty Street, 45th Floor, New York, NY 10005-1400

The insurance company named above ("Company") is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

1. Primary Proposed Insured

First Name__________ MI____ Last Name __________ Gender ☐ M ☐ F
SSN __________ Birthplace* (US State, or country) __________ DOB__________ Current Age_____
Tobacco Use Has the Primary Proposed Insured ever used any form of tobacco or nicotine products? ☐ yes ☐ no
Type and *Quantity* Used __________ If yes, a current user? ☐ yes ☐ no If no, date of last use __________
Driver's License ☐ yes ☐ no License State __________ Number __________
If over age of 16 and no license, please explain. __________
Address __________ City__________ State ______ ZIP__________
Primary Phone __________ Alternate Phone __________ Email __________
Employer __________ Occupation __________ Date of Employment (mm/dd/yy) __________
Job Duties__________ Average No. of hours worked per week_______
Actively at work? ☐ yes ☐ no Able to perform all job duties? ☐ yes ☐ no If either is no, explain __________
Personal Earned Income (Annual): $ __________ Household Income (Annual): $ __________ Net Worth $ __________
Personal Earned Income means monies received for work performed.
If Primary Proposed Insured is not self-supporting or is a child under age 18, what amount of insurance is in force and/or pending on:
Owner $________ Spouse $________ Father $________ Mother $________ Siblings $________ Premium Payor $________
Citizenship U.S. Citizen or Permanent Resident Card holder ☐ yes ☐ no If no, answer the following:
Country of Citizenship__________ Date of Entry __________ Visa Type __________(Copy of Visa Required)
Own property or have a mortgage in the U.S.? ☐ yes ☐ no Plan to remain in the U.S.? ☐ yes ☐ no

2. Owner - Complete if Primary Proposed Insured is not the Owner - *(If Owner is a business, charitable entity or trust, answer question 5 below.)*

First Name__________ MI____ Last Name __________ Gender ☐ M ☐ F
SSN __________ DOB __________ Relationship to Proposed Insured __________
Driver's License ☐ yes ☐ no License State __________ Number __________
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship __________ Date of Entry__________
Visa Type__________ Exp. Date __________
Address __________ City__________ State ______ ZIP__________
Primary Phone __________ Email__________
(If contingent Owner is required, use question 12.)

3. Reason for Insurance - *(If Business, complete Financial Questionnaire)* __________

4. Beneficiary - *(If Beneficiary is a business, charitable entity or trust, answer question 5 below.)*

No.	Name	DOB mm/dd/yy	SSN	Phone Number	Relationship	Share %	Beneficiary Type
1							☐ Primary ☐ Contingent
	Address:			Email:			
2							☐ Primary ☐ Contingent
	Address:			Email:			
3							☐ Primary ☐ Contingent
	Address:			Email:			

**for identification purposes only*

5. **Entity Information** - *Complete if Owner or Beneficiary is a business, charitable entity or trust. If applicable, complete the Certification of Trust.*
(Check the applicable boxes information applies to: ☐ Owner and/or ☐ Beneficiary. If also the Premium Payor, complete section 9E.)
Exact Name____ Tax ID #______________________
Address ______________________________ City ________________ State ______ ZIP __________
Current Trustee Name __________________________________ Date of Trust __________________
Corporate Officer Name _________________________________ Title ______________________
Email Address of applicable Trustee or Corporate Signer_______________________________________
Relationship to Proposed Insured ________________________ Type of Entity (SCorp, CCorp , DBA, etc.)__________

6. **Product** - *Signed Illustration/Quotation is required for all UL & VUL products.*
Plan Name (Complete appropriate supplemental application if applicable. For Index UL, complete the Index UL Supplemental Application.)
____
Term Duration** ____________________________ Premium Class Quoted ____________________
Amount Applied For: Base Coverage $ ____________________ Supplemental Coverage** $__________________
Death Benefit Compliance Test Used**: ☐ Guideline Premium ☐ Cash Value Accumulation | Automatic Premium Loan**: ☐ yes ☐ no

7. **Death Benefit Options** - *(For UL & VUL only)* ☐ Level ☐ Increasing

8. **Riders/Benefits** - *Refer to Rider Reference Page for riders and benefits available per product.*
☐ Accidental Death Benefit $ __________
☐ Child Rider[1] $____________________
☐ No current children
☐ Lifestyle Income Withdrawal Benefit Basis %__________
☐ Waiver of Monthly Deduction
☐ Waiver of Premium
☐ Other #1 ______________________ Amount/Unit(s)________________
☐ Other #2 ______________________ Amount/Unit(s)________________
☐ Other #3 ______________________ Amount/Unit(s)________________
☐ Other #4 ______________________ Amount/Unit(s)________________
1 - Complete Child Rider Supplement

9. **Premium Payment** ☐ Modal $________________ ☐ Single $______________ ☐ Additional/Lump Sum $__________
A. **Frequency of modal premium:** ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ Monthly (Bank Draft only)
B. **Method:** ☐ Direct Billing ☐ Bank Draft (Complete Bank Draft Authorization) ☐ List Bill: Number____________________
N/A Credit Card - Initial Premium Only (Complete Credit Card Authorization) ☐ Other (Please explain) __________________
C. **Amount submitted with application $**__________________________
D. **Special Dating** *(not applicable for VUL products):* Save Age .... ☐ yes ☐ no
E. **Premium Payor** *(Complete if Payor is other than Owner or if Owner is Trustee.)*
First Name ___________________________ MI ____ Last Name _________________________ Gender ☐ M ☐ F
SSN or Tax ID #___________________ Relationship to Primary Proposed Insured ____________________________
Driver's License ☐ yes ☐ no License State __________ Number_______________________ DOB______________
U.S. Citizen ☐ yes ☐ no If no, Country of Citizenship___________________________ Date of Entry ______________
Visa Type ____ Exp. Date________________
Address__________________________________ City ___________________ State________ ZIP___________
If Payor is different from the Insured or the Owner and Bank Draft or Credit Card is not the chosen form of payment, also complete the Payor Authorization Form.

10. **Existing Coverage and Replacements**
"Replace" means that the life insurance policy being applied for may replace, change or use monetary value from an existing or pending life insurance policy or annuity contract. If you intend for the transaction to be a replacement, also complete the replacement-related form for the state where the application is signed.
A. **Does the Primary Proposed Insured have any existing annuity, life insurance, or disability insurance or have any application pending for such coverage with this Company or any other company?**............................... ☐ yes ☐ no

***Complete only if applicable*

B. If question 10A is answered "yes", please provide the following information:

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period (if DI)	Type (see below)	Coverage Being Replaced?	1035 Exchange?
1						☐Y ☐N	☐Y ☐N
	Company Name:________________				Amount of Coverage $__________		
2						☐Y ☐N	☐Y ☐N
	Company Name:________________				Amount of Coverage $__________		
3						☐Y ☐N	☐Y ☐N
	Company Name:________________				Amount of Coverage $__________		

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC, DI= Disability Income **Type:** i=individual, b=business, g=group, p=pending

11. Background Information - *Provide details specified for all "Yes" answers or complete applicable questionnaires.*

A. Does the Primary Proposed Insured intend to travel or reside outside of the United States or Canada within the next two years? *(If yes, list country(ies), city(ies), date, length of stay(s), and purpose or complete the Foreign Travel and Residence Questionnaire)*. . . . . ☐yes ☐no

____

B. In the past five years, has the Primary Proposed Insured flown as a pilot, student pilot or crew member of any aircraft, or have any intention to do so in the next two years? *(If yes, complete the Aviation Questionnaire)* . . . . . ☐yes ☐no

C. In the past five years, has the Primary Proposed Insured engaged in motor sports events or racing (auto, truck, motorcycle, boat, etc.); rock or mountain climbing; skin or scuba diving; aeronautics (hang-gliding, sky diving, parachuting, ultra light, soaring, ballooning,) or have any intention to do so in the next two years? *(If yes, complete the Avocation Questionnaire)* . . . . ☐yes ☐no

D. Has the Primary Proposed Insured ever had an application for insurance modified, rated, declined, postponed or withdrawn? *(If yes, list type of coverage, date and reason)* . . . . ☐yes ☐no

____

E. Has the Primary Proposed Insured ever filed for bankruptcy, or have the intention to seek bankruptcy protection within the next 12 months? *(If filed, list chapter filed, date, reason, and discharge date)*. . . . . ☐yes ☐no

____

F. In the past five years, has the Primary Proposed Insured been convicted of, or currently charged with, any driving violations to include driving under the influence of alcohol or drugs? *(If yes, list date, state, license #, and specific violation)* . . . . ☐yes ☐no

____

G. Has the Primary Proposed Insured ever been convicted of, or is currently charged with, a felony or misdemeanor, or currently incarcerated or on parole or probation? (If yes, list date, county, state, charge, and current status) . . . . ☐yes ☐no

____

H. Is the Primary Proposed Insured an active duty service member of the U.S. Armed Forces? *(If yes, provide Pay Grade, Rank and any known foreign assignments, and complete any required Military Sales Disclosure)* . . . . ☐yes ☐no

____

I. Is there an intention that any party, other than the listed Owner or Beneficiary, will obtain any right, title, or interest in any policy issued on the life of the Primary Proposed Insured as a result of this application? . . . . ☐yes ☐no

J. Does the Owner or Primary Proposed Insured intend to finance any of the premium required to pay for this policy through a financing or loan agreement? . . . . ☐yes ☐no

K. Is the Owner, Primary Proposed Insured, or any person or entity, being paid (cash, services, or any other form of payment) as an incentive to enter into this transaction? *(If yes, describe the incentive)* . . . . ☐yes ☐no

____

12. The space below may also be used to elaborate on answers to any questions on this application.

____

____

____

Agreement, Authorization to Obtain and Disclose Information and Signatures

I, the Primary Proposed Insured (and any Owner signing below) acknowledge that I have read the statements contained in this application and any attachments or they have been read to me. My answers to the questions in this application are true and complete to the best of my knowledge and belief. I understand that this application: (1) consists of Part A, Part B, and if applicable, related attachments including certain questionnaire(s), supplement(s) and addendum(s); and (2) is the basis for any policy and any rider(s) issued. I understand that a copy of the application will be attached to the policy when issued. I understand that no information about me will be considered to have been given to the Company by me unless it is stated in the application. I agree to notify the Company of any changes in the statements or answers given in the application between the time of application and delivery of any policy. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the policy if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the policy is within its contestable period.

Except as may be provided in any Limited Temporary Life Insurance Agreement ("LTLIA"), I understand and agree that, even if I paid a premium, no insurance will be in effect under this application or under any new policy or any rider(s) that may be issued by the Company unless or until all three of the following conditions are met: (1) the policy has been delivered and accepted; (2) the full first modal premium for the issued policy has been paid; and (3) there has been no change in the health of any Proposed Insured(s) that would change the answer to any question in the application before items (1) and (2) in this paragraph have occurred. I understand and agree that, if all three conditions above are not met: (1) no insurance will be in effect; and (2) the Company's liability will be limited to a refund of any premiums paid, regardless of whether loss occurs before premiums are refunded.

If I have received and accepted the LTLIA, I understand and agree that such insurance is available only on the life of the Primary Proposed Insured under the life policy (and the Other Proposed Insured under a joint and survivorship life policy, if applicable) and only if the conditions set forth in the LTLIA are met. I understand and agree that such temporary insurance is not available as to any riders or any accident and/or health insurance.

I understand and agree that no agent is authorized to accept risks or pass upon insurability, make or modify contracts, or waive any of the Company's rights or requirements.

I have received a copy of or have been read the Notices to the Proposed Insured(s). I understand the company may have one of its representatives call me by telephone, at my convenience, to obtain additional underwriting information.

I authorize any medical professional; any hospital, clinic or other health care facility; any pharmacy benefit manager or prescription database; any insurance or reinsurance company; any consumer reporting agency or insurance support organization; my employer; or the MIB, LLC (MIB); or any other person or organization that has any records or knowledge of me or my physical or mental health (excluding psychotherapy notes) or insurability, or that of any minor child for whom application is being made, to disclose and give to the Company, its legal representatives, its affiliated service companies, and its affiliated insurers all information they have pertaining to: medical consultations; treatments; surgeries; hospital confinements for physical and/or mental conditions (excluding psychotherapy notes); drug prescriptions; or any other information concerning me or any minor child for whom application for insurance is being made. Other information may include, but is not limited to, items such as: personal finances including credit as permitted; habits; hazardous avocations; motor vehicle records from the Department of Motor Vehicles; court records; or foreign travel, etc.

I understand that the information obtained will be used by the Company to determine: (1) eligibility for insurance; (2) eligibility for benefits under an existing policy; and (3) verification of answers and statements on this application. I further authorize the Company to conduct a media or electronic search on me. Any information gathered during the evaluation of my application may be disclosed to: other insurers to whom I may apply for coverage; reinsurers; the MIB; other persons or organizations performing business or legal services in connection with my application or claim; me; any physician designated by me; or any person or entity required to receive such information by law or as I may further consent.

I, as well as any person authorized to act on my behalf, may, upon written request, obtain a copy of this consent. I understand this consent may be revoked at any time by sending a written request to the Company, Attn: Underwriting Department at P.O. Box 1931, Houston, TX 77251-1931. This consent will be valid for 24 months from the date of this application. I agree that a copy of this consent will be as valid as the original. I authorize the Company, its affiliated insurers, and its affiliated service companies to obtain an investigative consumer report on me. I understand that I may: (1) request to be interviewed for the report; and (2) upon written request, receive a copy of such report.

☐ Check if you wish to be interviewed.

IRS Certification: Under penalties of perjury, I certify that: 1. The number shown on this form is my correct taxpayer identification number (or I am waiting for a number to be issued to me), and 2. I am not subject to backup withholding because: (a) I am exempt from backup withholding (enter exempt payee code*, if applicable: _____), OR (b) I have not been notified by the Internal Revenue Service (IRS) that I am subject to backup withholding as a result of a failure to report all interest or dividends, or (c) the IRS has notified me that I am no longer subject to backup withholding, and 3. I am a U.S. citizen or other U.S. person*, and 4. The FATCA code(s) entered on this form (if any) indicating that I am exempt from FATCA reporting is correct (enter exemption from FATCA reporting code, if applicable: _____). **Certification instructions. You must cross out item 2 above if you have been notified by the IRS that you are currently subject to backup withholding because you have failed to report all interest and dividends on your tax return. For contributions to an individual retirement arrangement (IRA) and, generally, payments other than interest and dividends, you are not required to sign the certification, but you must provide your correct TIN. *See General Instructions provided on the IRS Form W-9 available from IRS.gov. ** If you can complete a Form W-9 and you are a U.S. citizen or U.S. resident alien, FATCA reporting may not apply to you. Please consult your own tax advisors.

The Internal Revenue Service does not require your consent to any provision of this document other than the certifications required to avoid backup withholding.

Owner Signature

X

Owner Title ____

(If Corporate Officer or Trustee)

Owner signed at (city, state) ____________________________

Owner signed on (date)__________________________________

Primary Proposed Insured Signature (if other than Owner)

X

(If under age 14 1/2, signature of parent or guardian)

Agent(s) Signature(s)

I certify that the information supplied has been truthfully and accurately recorded on the Part A application.

Writing Agent Name *(please print)*__________________________

Writing Agent # ____

Writing Agent Signature **X** _______________________________

Other Parent or Guardian Signature

X

(If under age 14 1/2 and coverage exceeds $150,000, signature of both parents required)

Agent's Report

Policy # (if known): ____________________

New York Version

The United States Life Insurance Company in the City of New York, 28 Liberty Street, 45th Floor, New York, NY 10005-1400

The insurance company named above ("Company") is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments.

Proposed Insured

First Name	MI	Last Name	Date of Birth	Social Security #

1. Is more than one application being submitted at this time or pending for the Proposed Insured(s), family members, or business associates? *(If Yes, provide details in the Remarks section below.)* ☐ yes ☐ no

2. Does any Proposed Insured(s) have any existing or pending annuities or life insurance policies? *(If yes, certain states require completion of replacement-related forms even when other life insurance or annuities are not being replaced by the policy being applied for - please attach such forms.)* ☐ yes ☐ no

3. If yes to question 2, do you have any information the Proposed Insured may replace, change, or use any monetary value of any existing or pending life insurance policy or annuity in connection with the policy being applied for? *(If yes, please provide details in the Remarks section below and attach replacement-related forms.)* ☐ yes ☐ no

3a. If yes to question 3, does this transaction involve a term to permanent replacement or exchange? If so, then please state in section 9 below (1) if the client had the ability to convert the existing term insurance policy and (2) why they did not exercise this option. ☐ yes ☐ no

4. Are you aware of any other information that would adversely affect the eligibility, acceptability, or insurability of any Proposed Insured(s)? ☐ yes ☐ no

5a. Will a medical exam be conducted? ☐ yes ☐ no

5b. If no, did you personally see all Proposed Insured(s) when the application was written? *(If no, provide explanation in the Remarks section below.)* ☐ yes ☐ no

6. If accidental death is applied for, what is the total amount of accident coverage inforce and applied for? ____________________

7. Is applicant applying for an applicable QoL Advantage option available on select QoL Products? *(If yes, complete QoL Advantage Form)* ☐ yes ☐ no

8. Did you provide the Owner with a Limited Temporary Life Insurance Agreement? ☐ yes ☐ no

9. **Remarks, Details, and Explanations** *(Please include information on any policy collateral assignments, etc.)*

9. Remarks, Details, and Explanations *(continued)*

10. Agent/Agency Information *(Please list servicing agent first)*

Note: The commission designation cannot be 100% for an agent other than the writing agent. Total allocations must equal 100%. Use whole percentages only; 0% is not a valid entry.

Agent(s) Splitting Application	Agency Number	Local Office Code	Agent Number	Percentage of Split
Servicing Agent:				%
				%
				%
				%
				%

11. Agent Agreement and Signature

By signing below, I certify the above information is true and complete to the best of my knowledge and belief. If I become aware of information contrary to any of the answers contained in the life insurance application to which this Agent's Report relates or contained in any supplemental applications, questionnaires, or other forms, I will notify the company of such information.

I attest to the following NY Regulation 187 statements:

- It is my reasonable belief, based on the information the owner(s) provided and on all the circumstances known to me at the time the recommendation was made, and after considering other life insurance and/or financial products that I am designated and licensed to offer, that the life insurance product being applied for, based on my recommendation, meets the owner(s)' needs and/or objectives.
- I understand that I must act in the best interest of the owner(s). I only considered the interests of the owner(s) when making the recommendation to purchase this life insurance product. I may receive a commission from, or have another financial interest in, the recommended transaction. However, my recommendation is based solely on the owner(s)' financial interests.

11. Agent Agreement and Signature *(continued)*

- My recommendation was made with the care, skill, prudence, and diligence that a prudent person acting in a like capacity and familiar with such matters would use under the prevailing circumstances.
- I reviewed the owner's needs and objective, including the financial resources used for funding the policy and the owner(s)' financial time horizon, including duration of existing liabilities and obligations, and have determined that the owner(s) has the ability to meet the financial commitments under the policy.
- If this purchase will result in a replacement of an existing life insurance or annuity policy, I reviewed the proposed replacement policy and the original policy and determined that the replacement policy meets the owner(s)' needs and/or objectives, considering without limitation any previous replacements within the last 36 months; changes in benefits or decreases in coverage; increases in premium, fees or loads; decrease in death benefits; adverse changes in health rating; any potential surrender charges or additional surrender period; and any potential tax implications.
- I have informed the owner(s) of the various features of the policy and potential consequences of this life insurance purchase, both advantageous and disadvantages, and the basis of the recommendation, including the following to the extent each is applicable:
  - o Surrender period and surrender charge
  - o Equity-index features
  - o Availability of cash value
  - o Riders and rider fees
  - o Guaranteed and Non-guaranteed interest rates and other elements
  - o Policy exclusion or restrictions
  - o Limitations on interest returns
  - o Potential tax implications associated with various transactions
- I informed the owner(s) on how I will be compensated and provided the required compensation disclosures.
- I understand that if this policy is issued other than applied for, this is considered by the State of New York as a separate recommendation under Reg. 187, and I attest that I will comply with all of the above statements for that recommendation as well.
- Upon request, I will provide to USL accurate and complete documentation used to support the basis of my recommendation(s as well as any applicable documentation and disclosures provided to the customer.

If you do not attest to the above Reg. 187 statements, please check the appropriate box, explain, if required, and sign below:

☐ I did not make a recommendation to the Consumer regarding the purchase of this life insurance product.

Please explain: ______________________________

____

☐ The Consumer refused to provide some/all suitability information.

Please explain: ______________________________

____

☐ I made a recommendation to the Consumer regarding the purchase of this life insurance product, and the Consumer did not follow my recommendation.

Please explain: ______________________________

____

Writing Agent Name *(Please print)* ______________________ Date ______________

Writing Agent Signature **X** ______________________

State License # ______________________ Phone #______________

Email ______________________ Fax #______________

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT ("HIPAA")
Authorization to Obtain and Disclose Information

____ _____/_____/_____

Name of Insured/Proposed Insured (Please Print) **Date of Birth**

I, the Insured/Proposed Insured above or the Insured/Proposed Insured's Personal Representative acting on behalf of the Insured/Proposed Insured, hereby authorize all of the people and organizations listed below to give The United States Life Insurance Company in the City of New York ("US Life"), and any affiliated company, (US Life and affiliated companies collectively the "Companies"), and their authorized representatives, including agents and insurance support organizations, (collectively, the "Recipient"), the following information:

- any and all information relating to my health (except psychotherapy notes) and my insurance policies and claims, including, but not limited to, information relating to any medical consultations, treatments, or surgeries; hospital confinements for physical and mental conditions; use of drugs or alcohol; drug prescriptions; and communicable diseases including HIV or AIDS; and
- information about me, including my name, address, telephone number, gender and date of birth

I hereby authorize each of the following entities ("Providers") to provide the information outlined above:

- any physician, nurse or medical practitioner or practitioner group;
- any hospital, clinic, other health care facility, pharmacy, or pharmacy benefit manager;
- any insurance or reinsurance company (including, but not limited to, the Recipient or any of the Companies (as defined above) which may have provided me with life, accident, health, and/or disability insurance coverage, or to which I may have applied for insurance coverage, but coverage was not issued);
- any consumer reporting agency or insurance support organization;
- my employer, group policy holder, or benefit plan administrator; and
- MIB, LLC (MIB).

I understand that the information obtained will be used by the Recipient to:

- determine my eligibility for insurance;
- underwrite my application for insurance;
- determine my eligibility for benefits;
- if a policy is issued, determine my eligibility for benefits and contestability of the policy; and
- detect fraud or abuse or for compliance activities, which may include disclosure to MIB and participation in MIB's fraud prevention or fraud detection programs.

I hereby acknowledge that the Companies are subject to certain federal privacy regulations. I understand that information released to the Recipient will be used and disclosed as described in the Notice of Health Information Privacy Practices, but that upon disclosure to any person or organization that is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

I may revoke this authorization at any time, except to the extent that action has been taken in reliance on this authorization or other law allows the Recipient to contest a claim under the policy or to contest the policy itself, by sending a written request to: American General Life Companies Service Center, P.O. Box 9000, Amarillo, TX 79105-9000. I understand that my revocation of this authorization will not affect uses and disclosures of my health information by the Recipient for purposes of underwriting, claims administration and other matters associated with my application for insurance coverage and the administration of any policy issued as a result of that application. I understand that the signing of this authorization is voluntary; however, if I do not sign the authorization, the Companies may not be able to obtain the information necessary to consider my application.

This authorization will be valid for 24 months. A copy of this authorization will be as valid as the original. I understand that I am entitled to receive a copy of this authorization.

MIB ACKNOWLEDGEMENT

I also authorize the Company, its reinsurers or authorized third party administrators to make a brief report to MIB.

Signature of Insured/Proposed Insured or Insured/Proposed Insured's Personal Representative

X

Signed on (date) ________________________

Signor name (printed) ________________________

Relationship ________________________

Description of Authority of Personal Representative

(if applicable) ________________________

____

Control Number/Policy Number____________________

____

Bank Draft Authorization

☐ **American General Life Insurance Company,** 2727-A Allen Parkway, Houston, TX 77019
☐ **The United States Life Insurance Company in the City of New York,** 28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

How Automatic Bank Draft Works: Automatic bank draft is a debit service that offers a convenient way to pay insurance premiums. The Company will collect the insurance premiums from your bank account electronically – you do not need to write checks or mail in any payments. Premium withdrawals will appear on your bank statement, and your statements will be your receipts for payment of your premium.

Policy Number, if available	Name of Insured Applicant	Policy Number, if available	Name of Insured Applicant

PAYMENT OPTIONS: Please select ONLY one payment option:

☐ Draft Initial Premium and Draft Subsequent Premiums

Initial Premium: $____________.______ ☐ At Issue ☐ At Submit (Not available for all products or Employer Sponsored Plans)

- Initial premium at issue will be drafted at the time each policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.
- Initial premium will be drafted at Submit for those policies that qualify for this option. Additional initial premium due will be drafted at the time the policy is placed inforce.
  - o Subsequent premiums will occur on the requested draft date, if one is requested, or the policy effective date, per the requested mode, if no date is specified.

Subsequent Premiums, if different: $____________.______

☐ Draft Only Subsequent Premiums

Check/Complete one of the following for Initial Premium payment:

☐ Check submitted with application in the amount of $____________.______.
☐ Check submitted on delivery.

DRAFT DETAILS: Please provide the requested details.

Preferred Withdrawal Date (1st-28th) ____________________ **Please debit my account for all outstanding premiums due.**

If a preferred withdrawal date is chosen and draft at issue is selected, we will draft subsequent premiums on this date.

Frequency: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Financial Institution Name ________________________________

Financial Institution Address ____________________ City, State ____________________ ZIP ____________

Type of Account: ☐ Checking ☐ Savings

Routing Number ____________________ (For checking account draft use routing # listed on check)

Account Number ____________________ (DO NOT use credit/debit card)

Bank Account Owner(s): (For business accounts, list Business and Authorized Signer Name)

Name 1 First Name (Please Print) ____________________ Last Name ____________________

Email Address 1 ________________________________

Date of Birth 1 (MM-DD-YYYY) ____/____/________ SSN1 / TIN 1 ____________________

Name 2 First Name (Please Print) ____________________ Last Name ____________________

Email Address 2 ________________________________

Date of Birth 2 (MM-DD-YYYY) ____/____/________ SSN1 / TIN 2 ____________________

Bank Account Owner's Address: (For business accounts, list Business Address)

Street ____________________ City ____________________ State __________ ZIP ____________

AGREEMENT:

I (we) hereby authorize and request the Company or its representative to initiate electronic or other commercially accepted-type debits against the indicated bank account in the depository institution named ("Depository") for the payment of premiums and other indicated charges due on the contract(s) listed, and to continue to initiate such debits in the event of a conversion, renewal, or other change to any such contract(s) even if such debits differ in amount from those specified in this form. I (we) hereby agree to indemnify and hold the Company harmless from any loss, claim, or liability of any kind by reason of dishonor of any debit or otherwise related to this authorization.

I (we) understand that this Authorization will not affect the terms of the contract(s), other than the mode of payment, and that if premiums are not paid within the applicable grace period, the contract(s) will terminate, subject to any applicable non-forfeiture provision. I acknowledge that notice of premiums due shall be waived and that the debit appearing on my bank statement shall constitute my receipt of payment, but no payment is deemed made until the Company receives actual payment in its Service Center.

I (we) authorize the Company to obtain information and/or reports from a consumer reporting agency or other company(ies) in order to verify, validate and/or authenticate the information and answers presented on this form. Any information gathered may be disclosed to any person or entity required to receive such information by law or as I may further consent.

I (we) agree that this Authorization may be terminated by me or the Company at any time and for any reason by providing thirty (30) days' written notice of such termination to the non-terminating party and may be terminated by the Company immediately if any debit is not honored by the Depository named for any reason. This request must be dated and all required signatures must be written in ink, using full legal names. This request must be dated and signed by the Bank Account Owner(s) as his/her name appears on bank records for the account provided on this authorization.

Signature of Bank Account Owner

X

Date ____________________

Signature of Bank Account Owner, if joint account

X

Date ____________________

Please attach voided check for checking account draft or deposit slip for savings account draft.

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

DEFINITION OF REPLACEMENT

IN ORDER TO DETERMINE WHETHER YOU ARE REPLACING OR OTHERWISE CHANGING THE STATUS OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS, AND IN ORDER TO RECEIVE THE VALUABLE INFORMATION NECESSARY TO MAKE A CAREFUL COMPARISON IF YOU ARE CONTEMPLATING REPLACEMENT, THE AGENT OR BROKER IS REQUIRED TO ASK YOU THE FOLLOWING QUESTIONS AND EXPLAIN ANY ITEMS THAT YOU DO NOT UNDERSTAND.

AS PART OF YOUR PURCHASE OF A NEW LIFE INSURANCE POLICY OR A NEW ANNUITY CONTRACT, HAS EXISTING COVERAGE BEEN, OR IS IT LIKELY TO BE:

(1) LAPSED, SURRENDERED, PARTIALLY SURRENDERED, FORFEITED, ASSIGNED TO THE INSURER REPLACING THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, OR OTHERWISE TERMINATED?

YES_____ NO _____

(2) CHANGED OR MODIFIED INTO PAID-UP INSURANCE; CONTINUED AS EXTENDED TERM INSURANCE OR UNDER ANOTHER FORM OF NONFORFEITURE BENEFIT; OR OTHERWISE REDUCED IN VALUE BY THE USE OF NONFORFEITURE BENEFITS, DIVIDEND ACCUMULATIONS, DIVIDEND CASH VALUES OR OTHER CASH VALUES?

YES _____ NO _____

(3) CHANGED OR MODIFIED SO AS TO EFFECT A REDUCTION EITHER IN THE AMOUNT OF THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT OR IN THE PERIOD OF TIME THE EXISTING LIFE INSURANCE OR ANNUITY BENEFIT WILL CONTINUE IN FORCE?

YES _____ NO _____

(4) REISSUED WITH A REDUCTION IN AMOUNT SUCH THAT ANY CASH VALUES ARE RELEASED, INCLUDING ALL TRANSACTIONS WHEREIN AN AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE RELEASED ON ONE OR MORE OF THE EXISTING POLICIES?

YES _____ NO _____

(5) ASSIGNED AS COLLATERAL FOR A LOAN OR MADE SUBJECT TO BORROWING OR WITHDRAWAL OF ANY PORTION OF THE LOAN VALUE, INCLUDING ALL TRANSACTIONS WHEREIN ANY AMOUNT OF DIVIDEND ACCUMULATIONS OR PAID-UP ADDITIONS IS TO BE BORROWED OR WITHDRAWN ON ONE OR MORE EXISTING POLICIES?

YES _____ NO _____

(6) CONTINUED WITH A STOPPAGE OF PREMIUM PAYMENTS OR REDUCTION IN THE AMOUNT OF PREMIUM PAID?

YES _____ NO _____

IF YOU HAVE ANSWERED YES TO ANY OF THE ABOVE QUESTIONS, A REPLACEMENT AS DEFINED BY NEW YORK INSURANCE REGULATION 60 HAS OCCURRED OR IS LIKELY TO OCCUR AND YOUR AGENT OR BROKER IS REQUIRED TO PROVIDE YOU WITH THE **IMPORTANT** NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. YOU WILL ALSO RECEIVE A COMPLETED DISCLOSURE STATEMENT NO LATER THAN THE TIME YOUR NEW POLICY OR NEW CONTRACT IS DELIVERED.

Date: _______________ **Signature of Applicant:** ____

Date: _______________ **Signature of Applicant:** ____

TO THE BEST OF MY KNOWLEDGE, A REPLACEMENT IS INVOLVED IN THIS TRANSACTION: YES ____ NO ____

Date: _______________ **Signature of Agent or Broker:** ____

LEAVE THIS FORM WITH THE PROPOSED INSURED(S)

NOTICES TO THE PROPOSED INSURED(S)

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

You have applied for life insurance with the insurance company identified above ("Company"). This notice is provided on behalf of that Company.

FAIR CREDIT REPORTING ACT

Pursuant to the Federal Fair Credit Reporting Act, as amended (15 U.S.C. 1681d), notice is hereby given that, as a component of our underwriting process relating to your application for life or health insurance, the Company may request an investigative consumer report that may include information about your character, general reputation, personal characteristics and mode of living.

This information may be obtained through personal interviews with your neighbors, friends, associates and others with whom you are acquainted or who may have knowledge concerning any such items of information. You have a right to request in writing, within a reasonable period of time after receiving this notice, a complete and accurate disclosure of the nature and scope of the investigation the Company requests. You should direct this written request to the Company at:

P.O. Box 1931
Houston, TX 77251-1931

Upon receipt of such a request, the Company will respond by mail within five business days.

MIB, LLC

Information regarding your insurability will be treated as confidential. The Company or its reinsurers may, however, make a brief report thereon to MIB, LLC (MIB), which operates an information exchange on behalf of its members of MIB Group, Inc. 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 it may have in your file. Please contact MIB at 866-692-6901. 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company, 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

INSURANCE INFORMATION PRACTICES

To issue an insurance policy, we need to obtain information about you. Some of that information will come from you, and some will come from other sources. This information may in certain circumstances be disclosed to third parties without your specific authorization as permitted or required by law.

You have the right to access and, if necessary, correct, amend, or delete personal information, except information that relates to a claim or a civil or criminal proceeding. This requires a written request to access your personal information and to request correction, an amendment, or deletion. We do not have to change our records if we do not agree with your request, but we will place your statement in our file. You have the right to receive a response within 30 business days of submitting a request to access, correct, amend, or delete your personal information.

Upon your written request, the Company will provide you with a more detailed written notice explaining the types of information that may be collected, the types of sources and investigative techniques that may be used, the types of disclosures that may be made and the circumstances under which they may be made without your authorization, a description of your rights to access, correct, amend, or delete information and the role of insurance support organizations with regard to your information.

If you desire additional information on insurance information practices you should direct your requests to the Company at: P.O. Box 1931, Houston, TX 77251-1931.

TELEPHONE INTERVIEW INFORMATION

To help process your application as soon as possible, the Company may have one of its representatives call you by telephone, at your convenience, and obtain additional underwriting information.

USA PATRIOT ACT (This notice is printed in compliance with Section 326 of the USA Patriot Act)

IMPORTANT INFORMATION ABOUT PROCEDURES FOR APPLYING FOR AN INSURANCE POLICY OR ANNUITY CONTRACT

To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions, including insurance companies, to obtain, verify, and record information that identifies each person who opens an account, including an application for an insurance policy or annuity contract.

What this means for you: When you apply for an insurance policy or annuity contract, we will ask for your name, address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Limited Temporary Life Insurance Agreement (Agreement)

THIS AGREEMENT PROVIDES A LIMITED AMOUNT OF LIFE INSURANCE COVERAGE FOR A LIMITED PERIOD OF TIME, SUBJECT TO THE TERMS AND CONDITIONS SET FORTH BELOW. SUCH INSURANCE IS NOT AVAILABLE FOR ANY RIDERS OR ACCIDENT AND/OR HEALTH INSURANCE. PLEASE FOLLOW STEPS 1 - 4.

1. **Company:**
   The United States Life Insurance Company in the City of New York, New York, NY

   In this Agreement, "Company" refers to the insurance company whose name is shown above, which is responsible for the obligation and payment of benefits under any policy that it may issue. No other company is responsible for such obligations or payments. In this Agreement, "Policy" refers to the Policy or Certificate applied for in the application. In this Agreement, "Proposed Insured(s)" refers to the Primary Proposed Insured under the life policy and the Other Proposed Insured under a joint life or survivorship policy, if applicable.

2. **Complete the following:** *(please print)*

Primary Proposed Insured ______________________________

Other Proposed Insured ______________________________
(applicable only for a joint life or survivorship policy)

Owner *(if other than Primary Proposed Insured)* ______________________________

Modal Premium Amount Received ______________________________

Date of Policy Application ______________________________

3. **Answer the following questions:**

	Yes	No
a. Has any Proposed Insured ever been diagnosed with, suffered from, or sought treatment for any of the following: a heart attack; stroke; coronary artery disease or other heart disease; cancer; diabetes; or been diagnosed or treated by a member of the medical profession for a disorder of the immune system, including but not limited to Acquired Immune Deficiency Syndrome (AIDS)?	☐	☐
b. Has any Proposed Insured, during the last two years: (1) been confined in a hospital or other health care facility (except for childbirth without complications); (2) received medical treatment or counseling for alcohol or drug use; or (3) been advised to have any diagnostic test (exclude HIV testing) or surgery not yet performed?	☐	☐
c. Is any Proposed Insured either less than 14 days old or over age 70 1/2?	☐	☐

STOP If the correct answer to any question above is YES, or any question is answered falsely or left blank, coverage is not available under this Agreement and it is void. This form should not be completed and premium may not be collected. Any collection of premium will not activate coverage under this Agreement.

4. **Complete and sign this section:**

   Any misrepresentation contained in this Agreement and relied on by the Company may be used to deny a claim or to void this Agreement. The Company is not bound by any acts or statements that attempt to alter or change the terms of this Agreement.

   I, the Owner, have received a copy of this two-page Agreement and read it or have had it read to me and agree to be bound by the terms and conditions stated herein on the following page.

Owner Signature

X

Owner signed on (date)______________________________

Primary Proposed Insured (PPI) Signature (if other than Owner)

X

(If under age 14 1/2, signature of parent or Guardian)

PPI signed on (date) ______________________________

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

Other Proposed Insured (OPI) Signature (if other than Owner)

X

(If under age 14 1/2 and coverage exceeds $150,000, signature of both parents required)

OPI signed on (date) ______________________________

Writing Agent Name (please print) ______________________________

Writing Agent # ______________________________

TERMS AND CONDITIONS OF COVERAGE UNDER THIS AGREEMENT

A. Eligibility for Coverage: If the correct answer is YES to any of the questions listed above, temporary insurance is NOT available and this Agreement is void.

Agents do not have authority to waive these requirements or to collect premium by any means including cash, check, bank draft authorization, credit card authorization, salary savings, government allotment, payroll deduction or any other monetary instrument if any Proposed Insured is ineligible for coverage under this Agreement.

B. When Coverage Will Begin:
COVERAGE WILL BEGIN WHEN ALL OF THE FOLLOWING CONDITIONS HAVE BEEN MET:

- Part A of the application must be completed, signed and dated; and
- The first modal premium must be paid; and
- Part B of the application must be completed, signed and dated and all medical exam requirements satisfied.

Coverage under this Agreement will not exist until all of the conditions listed above have been met.

The first modal premium will be considered paid, if one of the following valid items is submitted with Part A of the application and that payment is honored: (i) a check in the amount of the first modal premium; (ii) a completed and signed Bank Draft Authorization; (iii) a completed and signed Credit Card Authorization form; (iv) a completed and signed salary savings authorization; (v) a completed and signed government allotment authorization; (vi) a completed and signed payroll deduction authorization. Temporary life insurance under this Agreement will not begin if any form of payment submitted is not honored. All premium payments must be made payable to the Company checked above. Do not leave payee blank or make payable to the agent. The prepayment for this temporary insurance will be applied to the first premium due if the policy is issued, or refunded if the Company declines the application or if the policy is not accepted by the Owner.

C. When Coverage Will End:
COVERAGE UNDER THIS AGREEMENT WILL **END** at 12:01 A.M. ON THE **EARLIEST** OF THE FOLLOWING DATES:

- The date the policy is delivered to the Owner and all amendments and delivery requirements have been completed;
- The date the Owner receives notice that the Company **did not** approve the requested coverage at the premium amount quoted and a counter offer is **being** made by the Company;
- The date the Owner receives notice that the Company has declined or cancelled the application;
- The date the Owner receives notice that the application will not be considered on a prepaid basis;
- The date the Owner receives a premium refund; or
- 60 calendar days from the date coverage begins under this Agreement.

Any notice or refund given by mail may be deemed by the Company to be received by the Owner on the 5th day after the mailing of such notice or refund.

D. The Company will pay the death benefit amount described below to the beneficiary named in the application if:

- The Company receives due proof of death that the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) died, while the coverage under this Agreement was in effect, except due to suicide; and
- All eligibility requirements and conditions for coverage under this Agreement have been met.

The total death benefit amount pursuant to this Agreement and any other limited temporary life insurance agreements covering the Primary Proposed Insured (and the Other Proposed Insured if the application was for a joint life or survivorship policy) will be the **lesser** of:

- The Plan amount applied for to cover the Proposed Insured(s) under the base life policy; or
- $1,000,000 plus the amount of any premium paid for coverage in excess of $1,000,000 ; or
- If death is due to suicide, the amount of premium paid will be refunded, and no death benefit will be paid.

Agent Instructions: Complete, sign, and date page 1. Leave page 1 and page 2 with Owner. Return a copy, or a duplicate original, of page 1 with the application.

Supplemental Application for Life Insurance Policy to Contain Terminal Illness Accelerated Death Benefit Rider

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

Supplemental Application for Life Application Dated ______________________________

Name of Owner ______________________________

Name of Primary Proposed Insured ______________________________ DOB ______________

Policy Number (if known) ______________________________

1. **Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.**
2. There is no premium charge for the rider.
3. The accelerated death benefit plus accrued interest on that amount will be treated as a lien against the policy's death benefit amount.
4. An administrative fee, not to exceed $250, is subtracted from the amount to be paid under the rider.

I agree that this Application will be attached to and made a part of my application/policy for life insurance.

Signed at ______________________________ Date ______________

Primary Proposed Insured's Signature

X

Proposed Owner's Signature

X

Licensed Agent's Signature

X ______________________________

HIV Testing Notice and Consent
New York Version

The United States Life Insurance Company in the City of New York
Administrative Office • P.O. Box 90503 • Amarillo, TX 79105-4003

Examiner ____

____

The Tests. To evaluate your eligibility for insurance or insurance benefits, it is requested that you provide a sample of a body fluid for testing and analysis. The testing will be performed by a licensed laboratory. Tests may be performed on this sample to determine the presence of antibodies to the Human Immunodeficiency Virus (HIV), also known as the AIDS virus. The HIV antibody test is actually a series of tests done by a medically accepted procedure which is extremely reliable.

Pre-Testing Considerations. Many public health organizations have recommended that before taking an AIDS-related test, a person seek counseling to become informed concerning the implications of such a test. You may wish to consider counseling, at your expense, prior to being tested.

Disclosure of Test Results. All test results will be treated confidentially. The results of the test will be reported to the Insurer named above. The results also may be reported to the Insurer's employees who have the responsibility to make underwriting decisions on behalf of the Insurer, the Insurer's affiliates, reinsurers, or legal counsel who need such information to effectively represent the Insurer in connection with insurance you have or have applied for. In addition, if your HIV antibody test is abnormal (positive), a generic code signifying a non-specific test abnormality may be made known to MIB, LLC (MIB) as described in the notice given you at the time of application. The fact that the test has been done and the results of the test will not be otherwise disclosed except as may be required by law or as authorized by you. You are also requested to designate the person to whom positive or indeterminate test results are to be reported.

1) a) ☐ Your physician or health care provider
   b) ☐ Other

Name of physician, health care provider or other designee for reporting a possible positive or indeterminate test result:

____

Address: ____

2) ☐ Yourself

The result will be sent to you at the address provided, by registered mail with delivery restricted to you only.

Meaning of Test Results. The HIV antibody test is extremely accurate. However, in rare instances the test may be positive in persons who are not infected with the virus. Additionally, the test may occasionally be negative in persons who are infected with HIV (a false negative) especially when the infection occurred with the previous 3-6 months.

If your antibody test is positive, it does not mean that you have AIDS. A positive test indicates that you have been infected with HIV. It also means that HIV is present in your body fluids (such as blood, semen, vaginal secretions) and that you could infect other people through sexual contact, by sharing intravenous needs, by having a baby, or by donating blood, semen, or body organs. Persons who have a positive HIV antibody test should see a physician as soon as possible. You may also wish to consider having further testing done by an independent testing facility. Positive HIV antibody test results will adversely affect your insurance application.

The New York Department of Health may be contacted for further information about AIDS, the meaning of HIV related test results, and the availability and location of HIV related counseling services. The Department of Health's statewide toll-free number is 1-800-541-AIDS.

A negative test result means no antibodies to the HIV virus were found. Because of various incubation periods, absence of HIV antibodies does not mean that you have not been infected with the virus. Nor does absence of HIV antibodies mean that you are immune to the virus.

Consent

I have read and I understand this Notice of AIDS Virus (HIV) Antibody Testing and Consent for Testing. For my information, I have been given written material about AIDS. I voluntarily consent to the testing of my blood and the disclosure of the test results as described above. I understand that this consent shall be valid for six months following the date shown below.

Proposed Insured's Signature

X

Proposed Insured's Name (Printed) ______________________ **State of Residence** ______________________

Proposed Insured's signed on (date) ______________________ **Birth Date** ______________________

Submit this form with the application

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

The policy you are applying for has both a current premium and a maximum guaranteed premium. The current premium is the premium charged during the level premium period. The premium cannot change during the level premium period. After the level premium period, the premium may change and a premium up to maximum guaranteed premium can be charged.

Acknowledgment

I acknowledge that I have reviewed and received a copy of this Disclosure.

Owner's Signature

X

Owner signed on (date)______________________________

The applicant was shown a copy of this Disclosure prior to executing an application.

Licensed Agent's Signature

X ______________________________________

Licensed Agent on (date) ______________________________

Use this form for issue ages thru age 69.

Preliminary Information Statement

(Policy Form 19311N)

Date Prepared: ____________________

The United States Life Insurance Company in the City of New York, 28 Liberty Street, 45th Floor, New York, New York 10005-1400

NOTE: If you have any questions, please contact your agent or financial advisor. If no agent is involved with this Preliminary Information Statement, you may direct your written inquiry to our **Administrative Center located at 2727-A Allen Parkway, Houston, Texas 77019-2191 or you may call 1-800-247-8837**.

Plan Name: ______________________________

Name of Applicant: ______________________________

Age: _________ Sex: ___________ Underwriting Class: ______________________________

Level Premium Period: ______ Years

Initial Amount of Insurance: ______________________________ Initial Annual Policy Premium: ______________________________

Rider: ______________________________ Rider Annual Premium: ______________________________

Rider: ______________________________ Rider Annual Premium: ______________________________

Rider: ______________________________ Rider Annual Premium: ______________________________

Rider: ______________________________ Rider Annual Premium: ______________________________

Total Annual Premium: ______________________________

Policy Description

The Plan Name as indicated above is an Indeterminate Premium Term Life Insurance Policy with a Change in Face Amount After the Level Premium Period (the "Policy") offered by The United States Life Insurance Company in the City of New York (the "Insurance Company"). After the Level Premium Period, the Policy is renewable annually until the policy anniversary nearest the Insured's 95th birthday. Premiums are guaranteed level for the Level Premium Period. The Face Amount decreases immediately following the Level Premium Period. The post-Level Premium Period premiums generally remain the same immediately following the Level Premium Period but often become greater in ensuing years.

The Policy is convertible to a permanent life insurance policy at any time during the conversion period. There is no loan provision for this policy. This policy does not have any cash values.

When the policy is issued, a complete Statement of Policy Cost and Benefit Information including cost data, based on the benefits, premiums and dividends (if any) of the policy as issued will be furnished. Following receipt of the policy and the Statement of Policy Cost and Benefit Information, the policy may be returned within a period of not less than ten (10) days for an unconditional refund of premiums paid.

Life insurance cost indexes for the basic policy

Based on guaranteed premium scale	Ten years	Twenty years
Surrender cost index		
Net payment cost index		

An explanation of the intended use of these indexes is provided in the Buyer's Guide.

I acknowledge that I understand: 1) the Preliminary Information Statement and the options available in this policy form, including any riders; 2) that the policy has non-guaranteed elements, including premiums that increase following the level premium paying period and that any changes in the company's interest earnings, expenses or claim experience may result in lower or higher premium payments; 3) that I have reviewed this disclosure for the applied for policy and understand how the policy will perform during and after the level premium paying period; and 4) that the company will not accept my application for insurance without this properly completed, signed, and dated Preliminary Information Statement.

Applicant's Signature

X

Applicant's name (printed) ______________________________

Applicant signed on (date) ______________________________

Agent Signature **X** ______________________________

Agent signed on (date) ______________________________

Agent's name (printed) ______________________________

Agent's address ______________________________

AGENT INSTRUCTIONS – 2 copies of this form must be completed.
Copy 1 - Leave signed and dated copy with Applicant.
Copy 2 - Attach completed, signed, and dated original to application and submit to company.

Use this form for ages 70 and over.

Preliminary Information Statement

(Policy Form 19310N)

Date Prepared: ____________________

The United States Life Insurance Company in the City of New York
28 Liberty Street, 45th Floor, New York, New York 10005-1400

NOTE: If you have any questions, please contact your agent or financial advisor. If no agent is involved with this Preliminary Information Statement, you may direct your written inquiry to our **Administration Center located at 2727-A Allen Parkway, Houston, Texas 77019-2191** or you may call **1-800-247-8837**.

Plan Name: ____________________

Name of Applicant: ____________________

Age: ________ Sex: __________ Underwriting Class: ____________________

Level Premium Period: ______ Years

Initial Amount of Insurance: ____________________ Initial Annual Policy Premium: ____________________

Rider: ____________________ Rider Annual Premium: ____________________

Rider: ____________________ Rider Annual Premium: ____________________

Rider: ____________________ Rider Annual Premium: ____________________

Rider: ____________________ Rider Annual Premium: ____________________

Total Annual Premium: ____________________

Policy Description

The Plan Name as indicated above is an Indeterminate Premium Term Life Insurance Policy with a Change in Face Amount After the Level Premium Period (the "Policy") offered by The United States Life Insurance Company in the City of New York (the "Insurance Company"). After the Level Premium Period, the Policy is renewable annually until the policy anniversary nearest the Insured's 95th birthday. Premiums are guaranteed level for the Level Premium Period. The Face Amount decreases immediately following the Level Premium Period. The post-Level Premium Period premiums generally remain the same immediately following the Level Premium Period but often become greater in ensuing years.

There is no loan provision for this policy. This policy does not have any cash values.

When the policy is issued, a complete Statement of Policy Cost and Benefit Information including cost data, based on the benefits, premiums and dividends (if any) of the policy as issued will be furnished. Following receipt of the policy and the Statement of Policy Cost and Benefit Information, the policy may be returned within a period of not less than ten (10) days for an unconditional refund of premiums paid.

Life insurance cost indexes for the basic policy

Based on guaranteed premium scale	Ten years	Twenty years
Surrender cost index		
Net payment cost index		

An explanation of the intended use of these indexes is provided in the Buyer's Guide.

I acknowledge that I understand: 1) the Preliminary Information Statement and the options available in this policy form, including any riders; 2) that the policy has non-guaranteed elements, including premiums that increase following the level premium paying period and that any changes in the company's interest earnings, expenses or claim experience may result in lower or higher premium payments; 3) that I have reviewed this disclosure for the applied for policy and understand how the policy will perform during and after the level premium paying period; and 4) that the company will not accept my application for insurance without this properly completed, signed, and dated Preliminary Information Statement.

Applicant's Signature

X

Applicant's name (printed) ____________________

Applicant signed on (date) ____________________

Agent Signature **X** ____________________

Agent signed on (date) ____________________

Agent's name (printed) ____________________

Agent's address ____________________

AGENT INSTRUCTIONS – 2 copies of this form must be completed.
Copy 1 - Leave signed and dated copy with Applicant.
Copy 2 - Attach completed, signed, and dated original to application and submit to company.

Addendum to Application
Policy # (if known): ______________
New York Version

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

28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company named above. The Company is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)* : ____________________________

Primary Proposed Insured

First Name ____ MI ____ Last Name ________________________ SSN ________________

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

Primary Proposed Insured (PPI) Signature

X

PPI signed on (date) ______________________________

(If under age 14 ½, signature of parent or guardian)

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) ______________________________

(If under age 14 ½, signature of parent or guardian)

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) ______________________________

Preliminary Information Statement
Supplemental Information for the
Terminal Illness Accelerated
Death Benefit Rider
(for term policies)

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

Accelerated benefit means the payment, during the Insured's lifetime, of a benefit under the Terminal Illness Accelerated Death Benefit Rider. The Terminal Illness Accelerated Death Benefit Rider provides that the Owner may elect an accelerated benefit if the Insured is diagnosed with and is certified as having a Terminal Illness, subject to the provisions of the rider. Terminal Illness means an illness or condition which a physician has diagnosed and reasonably expects to result in death within 12 months or less from the date of diagnosis.

The maximum Accelerated Benefit amount that may be requested is the lesser of A or B where:

A equals the Face Amount multiplied by 50%; and
B equals $250,000.

The Accelerated Benefit amount payable is equal to:

1. The amount of the Accelerated Benefit requested; less
2. An administrative fee, not to exceed $250.00.

There is no charge for the rider. The Accelerated Benefit plus accrued interest on the Accelerated Benefit will be treated as a lien against the policy's death benefit amount to be satisfied at the time of a death claim unless the policy was previously terminated.

IMPORTANT NOTICES:

Receipt of a benefit under a Terminal Illness Accelerated Death Benefit Rider will reduce any death benefit that may become payable under the policy to which the rider is attached.

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income. Receipt of accelerated death benefits in periodic payments may be treated differently than receipt in a lump sum. Prior to applying for accelerated death benefits, policyowners should consult with the appropriate social services agency concerning how receipt will affect the eligibility of the recipient and/or the recipient's spouse or dependents.

Receipt of accelerated death benefits may be taxable. Prior to applying for such benefits, policyowners should seek assistance from a qualified tax advisor.

Generic Illustration

The following is a generic illustration demonstrating the manner in which the rider operates. The hypothetical example shown assumes that the policy is issued with a life insurance benefit of $100,000 on a male, age 45, Standard Non-tobacco and that an accelerated benefit is paid at age 55. The example assumes that the administrative charge is $250.00.

Contract Values Immediately Before Payment of Accelerated Benefit	
Face Amount	$100,000.00
Death Benefit Proceeds	$100,000.00
Annual Premium	$1,000.00

Maximum Accelerated Benefit Amount = Lesser of $250,000 or 50% of Face Amount
= $50,000.00

Calculation of Accelerated Benefit Paid Assuming You Request to Receive $25,000.00	
(A) Accelerated Benefit Amount requested	$25,000.00
(B) Administrative Fee	$250.00
Accelerated Benefit Amount paid is equal to: (A) minus (B)	$24,750.00

Contract Values Immediately After Payment of Accelerated Benefit	
Lien*	$27,000.00
Face Amount	$100,000.00
Death Benefit Proceeds**	$73,000.00
Annual Premium	$1,000.00

* After payment of the Accelerated Benefit, interest will accrue daily on paid out benefits at an annual effective interest rate. Interest on the lien will be payable in advance on each policy anniversary. The lien amount shown in the example includes the initial lien amount of $25,000.00 and interest to the end of the current policy year. The interest rate assumed in the hypothetical calculation above is 8.0%. This rate is not guaranteed. The actual interest used to calculate accrued lien interest will not be known until an Accelerated Benefit is paid and may be higher or lower than the rate assumed in this example.

** The death benefit proceeds payable will be reduced by the amount of the Accelerated Benefit plus accrued interest on the Accelerated Benefit.

Addendum to Application
Policy # (if known): ____________
New York Version

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

175 Water St, New York, NY 10038

In this form, the "Company" refers to the insurance company named above. The Company is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

This addendum is part of the application to which it is attached. Addendum to *(Part A, Part B, etc.)* : ____________________

Primary Proposed Insured

First Name ____________________ MI ____ Last Name ____________________ SSN ______________

(Use the space below to provide explanations to any application questions or details to any "yes" answers where the space provided on the application is insufficient or to provide any additional required application information. Provide an appropriate reference to the specific questions for which answers and details are included below.)

Primary Proposed Insured (PPI) Signature

X

PPI signed on (date) ____________________

(If under age 14 ½, signature of parent or guardian)

Other Proposed Insured (OPI) Signature

X

OPI signed on (date) ____________________

(If under age 14 ½, signature of parent or guardian)

Owner Signature

X

(If other than Primary Proposed Insured)

Owner signed on (date) ____________________

Financial Questionnaire is required for face amounts over $3 Million.

Financial Questionnaire
Policy # (if known): ____________
New York Version

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

28 Liberty Street, 45th Floor, New York, New York 10005-1400

In this form, the "Company" refers to the insurance company named above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

First Name ____ MI ____ Last Name ____ Date of Birth ____ Social Security # ____

1. Your income (before Income Tax):

	Current fiscal year (Date / / thru / /)	Previous fiscal year
A. Salary or wages		
B. Bonuses and/or commissions		
C. Net business or professional income (i.e., Gross income less business expenses, but not before personal income)		
D. Other earned income (give details in "Remarks" below)		
E. Unearned income (interest and dividends, net real estate income, etc.) give details in "Remarks" below		
F. TOTAL		

2. What is your approximate net worth, i.e., assets minus liabilities? (if necessary, give details in "Remarks" below)

	Current fiscal year (Date / / thru / /)	Previous fiscal year
A. Personal Assets		
B. Business Assets		
C. Liabilities		
D. Net worth		

3. Estimated tax liabilities at death (include potential estate taxes, inheritance taxes and capital gains taxes, both federal and state).

4. How was the need for this new amount of coverage determined?

Remarks (questions 1-4)

Financial Questionnaire is required for face amounts over $3 Million.

If applying for personal insurance, please skip questions 5 - 12 and complete the Signature and Agreement section at the bottom of this page. If applying for business insurance, please complete questions 5 - 12 and the Signature and Agreement section on this page.

5. Purpose of business insurance

☐ Key Person ☐ Deferred Compensation ☐ Buy-Sell/Cross Purchase Agreement ☐ Stock Repurchase ☐ Creditor

☐ Other (explain):______________________________

6. Is a written buy/sell agreement in effect? (if yes, attach copy)........ ☐ yes ☐ no

Is a buy/sell agreement contemplated? .... ☐ yes ☐ no

7. Creditor: Name of lender ______________________________

Is insurance requested by lender? .... ☐ yes ☐ no

Coverage amount required by creditor: $ ______________________________

Purpose of loan: ______________________________

____

(Use "Remarks" below for further details.)

8. Are other key persons or partners being insured? .... ☐ yes ☐ no

If yes, provide amount of inforce and/or applied for coverage with us or another insurance company. If no, explain:

____

9. What percentage of the business do you own? ___________%

10. Date business started? ______________________________

11. Estimated fair market value of business:_______________ *(In "Remarks" state how this value was determined)*

12. Financial details of business:

	Current fiscal year (Date / / thru / /)	Previous fiscal year
A. Total assets		
B. Total liabilities		
C. Gross sales or revenue		
D. Net income (before taxes)		

Please submit a copy of the most recent balance sheet and income statement (year or quarter).

Remarks (questions 5 - 12)

____

____

____

____

Agreement: I hereby declare that all statements and answers to the above questions are complete and true to the best of my knowledge and belief. I agree that they and this questionnaire shall form a part of my application for insurance. I agree that any material misrepresentation of fact by me may invalidate the contract. The Company will rely on my answers to determine the appropriate amount of insurance.

Owner Signature

X

Owner signed on (date) ______________________________

Owner signed at (city, state) ______________________________

Proposed Insured (PI) Signature

X

PI signed on (date) ______________________________

(If under age 14 1/2, signature of parent or guardian)

Enhanced REG 60 Processing Request Form

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

Only complete and submit this form with the application if USL is to request the values needed to complete the Disclosure Statement from the existing insurer on your behalf. If you have already requested the values from the existing insurer do not submit this form.

Applicant Name ______________________ Policy # (if known) ______________________

REQUIRED DOCUMENTS

The following documents must be submitted before a request for values will be made to the existing insurer. Please confirm all documents have been submitted by checking the boxes below:

☐ Completed and signed Definition of Replacement (USL1002N Rev0515)
Must be signed and dated by both applicant and agent on or before the application date.

☐ Completed and signed Request for Policy Information (USL1003N Rev0114)

☐ Signed Important Notice Regarding Replacement (USL1004N Rev0515)
Must be signed and dated by applicant on or before the application date.

☐ Illustration/Quotation for desired product

☐ Completed and signed Application Part A
Must be signed and dated by both applicant and agent on or after the Definition of Replacement and the Important Notice Regarding Replacement.

CONTACT INFORMATION FOR FOLLOW UP

Name ______________________

Phone ______________________ Ext. ______________________

Fax ______________________

Email ______________________

OTHER SPECIAL INSTRUCTIONS

By providing complete and accurate information, processing time can be reduced.

Index Universal Life
Supplemental Application
Policy # (if known): _______________
New York Version

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

28 Liberty Street, 45th Floor, New York, NY 10005-1400

In this form, the "Company" refers to the insurance company named above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Proposed Insured

______________________	____	______________________	______________	______________________
First Name	MI	Last Name	Date of Birth	Social Security #

This supplement must accompany the appropriate application for life insurance. This supplement and the application will be attached to and made a part of the policy.

Dollar Cost Averaging (DCA)

☐ **Please check this box if you are choosing to use DCA.**

Directions: Please check the box to select either Option A or Option B below:

☐ **Option A:** Deposit all premiums into DCA Account (not available for monthly or quarterly mode). If desired, you may allocate a portion of your premium to the Declared Interest Account below. The remainder will be deposited into the DCA Account which is allocated to Index Accounts available on the product(s) being applied for.

DCA Account (%)	________ %	Enter % allocated to DCA Account. Premiums in DCA Account are transferred on a monthly basis based on the mode (6 transfers for semiannual and 12 transfers for annual) using the DCA Allocation percentages selected.
Declared Interest Account (%)	________ %	Enter % allocated to the Declared Interest Account. The Declared Interest Account is not eligible to receive transfers from the DCA Account.
Total	**100%**	Note: Total allocation must equal 100%.

☐ **Option B:** Deposit only Lump Sum premium and/or 1035 exchange premiums (Internal and External) into DCA Account. Lump Sum premium is a single, non-recurring premium payment that is not a 1035 exchange premium. By checking this box, 100% of the Lump Sum and/or 1035 exchange premiums will be allocated to the DCA Account and 12 monthly transfers will be made.

Product Selection and Premium/DCA Account Allocation

Directions: Please complete the section below for the product being applied for.
If you have not chosen to use DCA, please indicate how each premium received should be allocated in the "Premium Allocation (%)" column.

If you have chosen to use DCA:
For Option A, please only complete the "DCA Allocation (%)" column. The "Premium Allocation (%)" column should remain blank.
For Option B, please complete the "Premium Allocation (%)" for premium not being deposited into the DCA Account and the "DCA Allocation (%)" column for all Lump Sum premium and 1035 exchange premium. Lump Sum premium and 1035 exchange premium cannot be allocated to the Declared Interest Account.

Total allocations in each column must equal 100%. Use whole percentages only.

Max Accumulator+ II

	Premium Allocation (%)	**DCA Allocation (%)**
Cap Rate Account *(1-Year, No. II, utilizing S&P 500® Index)*	__________	__________
Participation Rate Account *(1-Year, utilizing S&P 500® Index)*	__________	__________
Declared Interest Account	__________	N/A
	100%	**100%**

Value+ Protector III

	Premium Allocation (%)	DCA Allocation (%)
Cap Rate Account *(1-Year, No. II, utilizing S&P 500® Index)*	___________	__________
Participation Rate Account *(1-Year, utilizing S&P 500® Index)*	___________	__________
Declared Interest Account	___________	N/A
	100%	**100%**

Other

(Use for products not listed above unless otherwise instructed.)

Product Name: ____

Directions: Please complete the section below for the product being applied for.
If you have not chosen to use DCA, please indicate how each premium received should be allocated in the "Premium Allocation (%)" column.

If you have chosen to use DCA:
For Option A, please only complete the "DCA Allocation (%)" column. The "Premium Allocation (%)" column should remain blank.
For Option B, please complete the "Premium Allocation (%)" for premium not being deposited into the DCA Account and the "DCA Allocation (%)" column for all Lump Sum premium and 1035 exchange premium. Lump Sum premium and 1035 exchange premium cannot be allocated to the Declared Interest Account.

Total allocations in each column must equal 100%. Use whole percentages only.

	Premium Allocation	DCA Allocation
____	__________%	__________%
____	__________%	__________%
____	__________%	__________%

Agreement: I acknowledge that I have read this supplemental application or that it has been read to me. The completed supplemental application is true and complete to the best of my knowledge and belief. I agree that this supplemental application shall form a part of my application for insurance.

AGENT INSTRUCTIONS: Submit this form with the policy application packet.

Owner Signature

X

Owner signed on (date)______________________________

Supplemental Application for Chronic Illness Accelerated Death Benefit Rider

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

This is a supplement to the application for the Life Insurance for the Primary Proposed Insured. Please complete if the Chronic Illness Accelerated Death Benefit Rider is being elected.

(Check the box that applies)

☐ New Application ☐ Reinstatement ☐ Base Policy Specified Amount Increase

1. Primary Proposed Insured

First Name ________________________ MI____ Last Name ___________________________ Date of Birth ___________

Owner

First Name ________________________ MI____ Last Name ___________________________ Date of Birth ___________

2. Benefits (Complete for New Application Only)

A. Maximum Monthly Benefit: ☐ **2% of Lifetime Maximum Benefit** ☐ **4% of Lifetime Maximum Benefit** ☐ **Maximum Per Diem Allowable**

B. Lifetime Maximum Benefit Percentage: ____________%

C. The initial yearly cost of insurance is $____________ .

Note: If the Chronic Illness Accelerated Death Benefit Rider is approved and added to your policy, the policy will also include, at no additional charge, a Terminal Illness Accelerated Death Benefit Rider.

3. Existing Coverage and Replacements

A. Does any Proposed Insured have an existing life insurance policy including a chronic illness accelerated death benefit rider, any other similar life insurance policy or annuity contract providing an accelerated death benefit; any long term care insurance contract qualified under IRC section 7702B; or any other long term care insurance, nursing home insurance, home care insurance policy or coverage or long term care insurance policy or coverage provided under the partnership for long term care program? If "Yes,' provide details below .... ☐ Yes ☐ No

No.	Policy Number	Year of Issue	Coverage (see below)	Benefit Period	Type (see below)	Coverage Being Replaced?
1						☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________					
	Primary Insured Name: ______________					
2						☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________					
	Primary Insured Name: ______________					
3						☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________					
	Primary Insured Name: ______________					
4						☐Y ☐N
	Company Name: ______________ Amount of Coverage $ __________					
	Primary Insured Name: ______________					

Coverage: LI=Life, H=Health, A=Annuity, LT=LTC **Type:** i=individual, g=group, p=pending

4. Health Questions – In this section, "you" refers to the Primary Proposed Insured.

A. During the last 12 months, have you:

1. Required assistance or supervision of any kind to perform an activity of daily living, such as mobility (including the use of a pronged cane), taking medications, dressing, eating, walking, bathing or toileting? ☐ Yes ☐ No
2. Used a catheter, chair lift, dialysis, motorized scooter, oxygen equipment, quad or three-pronged cane, respirator, walker, or wheelchair? ☐ Yes ☐ No
3. Been advised to enter or reside in a nursing home, assisted living facility, long term care facility, Continuing Care Retirement Community (CCRC), residential care facility, rehabilitation facility, Skilled Nursing Facility (SNF) or an adult day care, or required home health care? ☐ Yes ☐ No

B. During the last 3 years, have you used insulin to treat Diabetes? ☐ Yes ☐ No

Have you ever been diagnosed or treated by a licensed health care provider for:

1. Diabetes WITH COMPLICATIONS (such as eye, kidney, or nerve damage)? ☐ Yes ☐ No
2. Diabetes AND Heart Disease, Stroke, or Peripheral Vascular Disease? ☐ Yes ☐ No

C. Have you EVER been diagnosed with, been treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Alzheimer's disease, Dementia, Mild Cognitive Impairment (MCI), or Organic Brain Syndrome (OBS) ☐ Yes ☐ No
2. Amputation due to disease ☐ Yes ☐ No
3. ALS (Lou Gehrig's disease) ☐ Yes ☐ No
4. Stroke, Cerebral Vascular Accident (CVA), or Transient Ischemic Attack (TIA) ☐ Yes ☐ No
5. Organ Transplant (other than cornea) ☐ Yes ☐ No
6. Multiple Sclerosis ☐ Yes ☐ No
7. Huntington's Chorea ☐ Yes ☐ No
8. Muscular Dystrophy ☐ Yes ☐ No
9. Myasthenia Gravis ☐ Yes ☐ No
10. Macular Degeneration ☐ Yes ☐ No
11. Blindness ☐ Yes ☐ No
12. Optic Neuritis ☐ Yes ☐ No
13. Osteoporosis with fractures ☐ Yes ☐ No
14. Parkinson's disease ☐ Yes ☐ No
15. Post-Polio Paralytic Syndrome ☐ Yes ☐ No
16. Polymyositis ☐ Yes ☐ No
17. Scleroderma ☐ Yes ☐ No
18. Memory loss ☐ Yes ☐ No
19. Unplanned weight loss greater than 15 pounds within the last 2 years ☐ Yes ☐ No
20. Arthritis with narcotic pain medication within the past 12 months ☐ Yes ☐ No

D. Do you have a parent or sibling diagnosed or treated by a licensed health care provider for Huntington's chorea or Polycystic Kidney Disease? ☐ Yes ☐ No

If any question in 4. A-D was answered yes, the rider is not available for the Primary Proposed Insured and this supplemental application should not be completed or submitted.

E. In the last 5 years, have you been diagnosed with, treated for, tested positive for, or received medical advice from a licensed health care provider for any of the following conditions:

1. Disorientation ☐ Yes ☐ No
2. Multiple falls or injury due to a fall ☐ Yes ☐ No
3. Chest Pain ☐ Yes ☐ No
4. Loss of balance ☐ Yes ☐ No
5. Loss of strength ☐ Yes ☐ No
6. Tremors ☐ Yes ☐ No
7. Dizziness ☐ Yes ☐ No

F. Do you have a handicap sticker, handicap placard, or handicap license plate? (If yes, give reason below) ☐ Yes ☐ No

G. In the last 24 months, have you had to limit or been advised by a licensed health care provider to limit, reduce, discontinue or restrict any activities or hobbies? (If yes, give reason below) ☐ Yes ☐ No

H. In the past 24 months, have you required assistance with shopping, arranging transportation, housekeeping, cooking, laundry, meal preparation, managing finances, managing medications, using the telephone or used a straight cane? (If yes, give reason below) ☐ Yes ☐ No

Give details to all yes answers to questions 4. E-H.

Question #	Nature of Condition/Date of diagnosis	Date of last treatment or last medication taken	Name & address of Physician seen

I. Within the past 5 years, have you received any long term care benefits, disability income benefits or Social Security Disability Income Benefits? (If yes, please provide details in **Section 5, Remarks**.)............................... ☐ Yes ☐ No

J. Within the past 5 years, have you been declined for long term care insurance, including long term care or chronic illness insurance provided by rider to a life insurance or other policy including annuities? (If yes, please provide the name of the company, date and the reason in **Section 5, Remarks**.)..................................... ☐ Yes ☐ No

5. Remarks

____

____

____

____

I, the Primary Proposed Insured and Proposed Owner signing below, agree that I have read the statements contained in this application supplement and that all statements and answers given in this application supplement are true and complete to the best of my knowledge and belief. I understand that any misrepresentation contained in this application and relied on by the Company may be used to reduce or deny a claim or void the rider if: (1) such misrepresentation materially affects the acceptance of the risk; and (2) the rider is within the contestable period.

I understand that benefits under the Chronic Illness Accelerated Death Benefit Rider are provided through an accelerated death benefit option, and that, if I exercise the accelerated benefit option, the policy's remaining death benefit, if any, payable to the beneficiary will be reduced.

I understand that:

- **The rider is not intended to qualify as a Qualified Long Term Care Insurance Contract for federal tax purposes.**
- The rider is intended to provide only benefit amounts subject to favorable tax treatment under section 101(g) of the Internal Revenue Code.
- When determining whether the benefit payments will receive favorable tax treatment, the payment of benefits from all insurance policies or programs providing chronic illness benefits must be considered.
- Certain limitations may apply with regard to benefits receivable under this rider if the Insured has alternative life insurance policies with accelerated death benefits or a stand-alone long term care insurance contract subject to section 7702B of the Internal Revenue Code, or if the Insured is entitled to the payment of certain similar benefits from some other source and receive benefits associated with those policies or such source.
- **Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.**
- It is possible that the Insured may be chronically ill and no benefit will be payable.

Check one box:

☐ I elect to designate person(s) to receive notice in the event of lapse or termination of the rider for nonpayment of premium:
Name and home address of person(s) designated ______________________________

____

☐ I elect NOT to designate person(s) to receive notice in the event of lapse or termination of the rider for nonpayment of premium.

Protection against unintended lapse. I understand that I have the right to designate at least one person other than myself to receive notice of lapse or termination of the rider for nonpayment of premium. I understand that notice will not be given until thirty (30) days after a premium is due and unpaid. I elect NOT to designate any person to receive such notice.

Receipt of accelerated death benefits may affect eligibility for public assistance programs such as medical assistance (Medicaid), Aid to Families with Dependent Children and Supplemental Security Income.

Caution: If your answers on this application fail to include all material information requested, The United States Life Insurance Company In The City Of New York has the right to deny benefits or rescind your rider.

Primary Proposed Insured Signature

X ______________________________

Date ______________________________

Proposed Owner Signature

X ______________________________

Date ______________________________

Licensed Writing Agent

X ______________________________

Date ______________________________

Writing Agent Name ______________________________

____

Writing Agent Number ______________________________

Agency Number ______________________________

STATE OF NEW YORK
COMPENSATION DISCLOSURE

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

Mailing Address: The United States Life Insurance Company in the City of New York • P.O. Box 650857 • Dallas, TX 75265-0857
Overnight Mailing Address: The United States Life Insurance Company in the City of New York • ATTN: Lockbox # 650857 • JPM TX1-0029 • 14800 Frye Rd, 2nd Floor • Fort Worth, TX 75265-0857

Contract No. ____________________

The following disclosure is provided pursuant to Section 30.3 of New York Comp. Codes R. & Reg., tit. 11, Pt. 30 (Regulation 194):

____ ("the producer") is an insurance producer licensed by the State of New York. Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.

Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In some cases, other factors such as the volume of business a producer provides to an insurer or the profitability of insurance contracts a producer provides to an insurer also may affect compensation.

The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and (if applicable) compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by requesting such information from the producer.

____
Insurance Producer Name (Print)

____ ____________________
Insurance Producer (Signature) Date

I ACKNOWLEDGE THAT I RECEIVED THIS DISCLOSURE FORM.

____
Client Name (Print)

____ ____________________
Client (Signature) Date

CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER OUTLINE OF COVERAGE

The United States Life Insurance Company in the City of New York
28 Liberty Street, 45th Floor, New York, NY 10005-1400

NOTICE TO BUYER: THIS RIDER MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH LONG TERM CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL RIDER LIMITATIONS. THE RIDER IS NOT A TAX QUALIFIED LONG-TERM CARE CONTRACT. IT IS A CHRONIC ILLNESS ACCELERATED DEATH BENEFIT RIDER AND IS NOT INTENDED TO PROVIDE LONG-TERM CARE COVERAGE.

Benefit payments may only be made if the payments are subject to favorable tax treatment by the federal government. When determining whether the benefit payments will receive favorable tax treatment, the payment of benefits from all insurance policies and similar sources must be considered. It is possible that the Insured may be Chronically Ill and no benefit will be payable. Prior to applying for such accelerated death benefits, policyowners should seek assistance from a qualified tax advisor.

1. **The rider is an individual chronic illness accelerated death benefit rider.**

2. **PURPOSE OF OUTLINE OF COVERAGE.**

   This outline of coverage provides a very brief description of the important features of the rider. You (the Owner) should compare this Outline of Coverage to outlines of coverage for other policies available to you. This is not an insurance contract, but only a summary of coverage. Only the individual rider and the policy to which it is attached contain governing contractual provisions. This means that the rider and policy set forth in detail the rights and obligations of both you and the insurance company. Therefore, if you purchase this coverage, or any other coverage, it is important that you READ YOUR RIDER AND POLICY CAREFULLY!

3. **TERMS UNDER WHICH THE RIDER MAY BE RETURNED.**

   You may return the rider within 30 days after delivery if you are not satisfied with it for any reason. The rider may be returned to us or to the agent through whom it was purchased. Upon surrender of the rider within the 30-day period, it will be void from the beginning.

4. **THIS IS NOT MEDICARE SUPPLEMENT COVERAGE.**

   Neither The United States Life Insurance Company In The City Of New York nor its agents represent Medicare, the federal government or any state government.

5. **BENEFITS PROVIDED BY THE RIDER.**

   What is a Chronic Illness Accelerated Death Benefit Rider?

   The Chronic Illness Accelerated Death Benefit Rider provides that you may elect an accelerated death benefit if the Insured is certified as being Chronically Ill, subject to the provisions of the rider.

   What is Chronically Ill?

   The term "Chronically Ill" means that the Insured has been Certified or Re-certified by a Licensed Health Care Practitioner within the preceding 12-month period as:

   (a) Being unable to perform, without Substantial Assistance from another person, at least two Activities of Daily Living for a period of at least 90 consecutive days due to a loss of functional capacity; or

   (b) Requiring Substantial Supervision to protect the Insured from threats to health and safety due to Severe Cognitive Impairment.

The 90 consecutive day requirement above is not a waiting period. The Licensed Health Care Practitioner, in determining the effective date of the Insured's Chronic Illness, shall identify the earliest date the Insured satisfied the requirements above.

What are the Activities of Daily Living?

The term "Activities of Daily Living" means the following self-care functions:

(a) Bathing: Washing oneself by sponge bath, or in either a tub or shower, including the task of getting into or out of the tub or shower.

(b) Continence: The ability to maintain control of bowel and bladder functions; or, when unable to maintain control of bowel or bladder functions, the ability to perform the associated personal hygiene (including caring for catheter or colostomy bag).

(c) Dressing: Putting on and taking off all items of clothing and any necessary braces, fasteners or artificial limbs.

(d) Eating: Feeding oneself by getting food into the body from a receptacle (such as a plate, cup or table), or by feeding tube, or intravenously.

(e) Toileting: Getting to and from the toilet, getting on and off the toilet and performing associated personal hygiene.

(f) Transferring: Moving into or out of a bed, chair, or wheelchair.

What is Severe Cognitive Impairment?

The term "Severe Cognitive Impairment" means a loss or deterioration in intellectual capacity that is comparable to (and includes) Alzheimer's disease and similar forms of irreversible dementia and is measured by clinical evidence and standardized tests that reliably measure impairment in the person's:

(a) Short-term or long-term memory; and

(b) Orientation as to people, places or time; and

(c) Deductive or abstract reasoning.

What benefit amount may be paid?

Accelerated Benefit means the amount paid to you during the Insured's lifetime if the Insured is Certified as being Chronically Ill. You may choose monthly benefit payments or the lump sum option. In the event that the Monthly Benefit would be less than the Minimum Monthly Benefit shown on the Rider Schedule, any benefit payable will be paid as a lump sum as described in the Lump Sum Option provision. We may pay as a lump sum any Accelerated Benefit that reflects the 90 consecutive day period considered by the Licensed Health Care Practitioner that is immediately before the date of execution of a Certification submitted to us pursuant to a claim.

The Monthly Benefit is the amount paid each month beginning on the first monthly deduction day following the date that the Insured becomes eligible for Monthly Benefits.

For each 12-month benefit period, you may select the Monthly Benefit amount. Such amount must not be less than the Minimum Monthly Benefit, shown in the rider, or more than the Maximum Monthly Benefit.

Subject to the Limitation of Benefits Based on Favorable Tax Treatment provision of the rider, the Maximum Monthly Benefit that you selected is shown on the Rider Schedule. If you selected the monthly equivalent of the per diem limitations declared by the Internal Revenue Service, the Maximum Monthly Benefit is the lesser of:

(a) The monthly equivalent of the per diem limitations declared by the Internal Revenue Service at the time all of the conditions in the Eligibility for Benefits provision are first satisfied; and

(b) The monthly equivalent of the per diem limitations declared by the Internal Revenue Service on the Rider Date of Issue, increased annually by the Annual Increase Percentage shown on the Rider Schedule.

If you selected a percentage of the Lifetime Maximum Benefit, the Maximum Monthly Benefit amount is the least of:

(a) The Maximum Monthly Benefit percentage, shown on the Rider Schedule, multiplied by the Lifetime Maximum Benefit at the time all of the conditions in the Eligibility for Benefits provision are first satisfied; and

(b) The monthly equivalent of the per diem limitations declared by the Internal Revenue Service at the time all of the conditions in the Eligibility for Benefits provision are first satisfied; and

(c) The monthly equivalent of the per diem limitations declared by the Internal Revenue Service on the Rider Date of Issue, increased annually by the Annual Increase Percentage shown on the Rider Schedule.

Any Accelerated Benefit will reflect the 90 consecutive day period considered by the Licensed Health Care Practitioner that is immediately before the date of execution of a Certification submitted to Us pursuant to a claim.

What is the effect of other coverages on my benefit amount?

Benefit payments under the rider may only be made if, based on the information provided to us by you or the Insured, if different, the payments would be subject to favorable tax treatment by the federal government under Section 101(g) of the Internal Revenue Code for the calendar year in which benefits will be paid.

The Accelerated Benefits in any calendar year cannot be greater than the per diem limitation declared for that calendar year by the Internal Revenue Service multiplied by the number of days for which the Insured is Certified or Re-certified as being Chronically Ill in that calendar year. When determining whether benefits will receive favorable tax treatment, the payment of benefits for chronic illness or long term care services under all insurance policies and other sources must be considered.

What is the Maximum Death Benefit You Can Accelerate in a Calendar Year?

The Maximum Death Benefit You Can Accelerate in a Calendar Year as to the Insured under this rider is the least of:

(a) The then-current Specified Amount; or

(b) The Lifetime Maximum Benefit; or

(c) The maximum portion of the Specified Amount that you may elect to accelerate, subject to the Limitation of Benefits Based on Favorable Tax Treatment provision to ensure that benefit amounts are subject to favorable tax treatment under Section 101(g) of the Internal Revenue Code.

The Maximum Death Benefit You Can Accelerate in a Calendar Year is affected, in part, by the chronic illness accelerated death benefits for all policies and riders under which the Insured is covered by us or by any other insurer as well as any long term care benefits, including reimbursements, payable from any source. The amount of the Maximum Death Benefit You Can Accelerate in a Calendar Year cannot result in a Accelerated Benefit that is greater than the IRS per diem limitation declared for a calendar year by the Internal Revenue Service, multiplied by the number of days for which the Insured is certified or re-certified as being Chronically Ill in that calendar year.

It is possible that the Maximum Death Benefit You Can Accelerate in a Calendar Year may be zero.

How do I elect a benefit?

If, after you have filed a claim under this Rider, we determine that the conditions for payment of an Accelerated Benefit have been met, we will notify you of the amount of such Accelerated Benefit potentially payable, if any, if the Insured is Chronically Ill and we will send you an election form for Accelerated Benefits. You must complete the election form and return it to us within the election period shown in the rider. The failure to provide the required election form within the election period may preclude payment of a benefit. You may choose either to elect or not to elect to receive an Accelerated Benefit if the Insured is Chronically Ill.

What waiver benefit does the rider provide?

During a benefit period, 100% of the policy's monthly deduction and the continuation guarantee account's monthly deduction, if any, will be waived. Such waiver will begin on the date Accelerated Benefits are payable under the Eligibility for Benefits provision of the rider, whether as Monthly Benefits or in a lump sum, and will continue while the policy remains in force during the period for which the Accelerated Benefits are paid. Payment of the waiver benefit under this rider does not guarantee that the policy will remain in force during or after a benefit period. Continuation of the policy while the waiver benefit is being paid under the rider will depend upon the amount of such waiver benefit and the payment of any premiums and will be subject to the grace period and termination provisions of the policy. The Owner may be required to pay premiums during and/or after a benefit period to keep the policy in force.

6. LIMITATIONS AND EXCLUSIONS.

Benefit payments under the Rider may only be made if, based on the information provided to us by the policy owner, the payments would be subject to favorable tax treatment by the federal government under Section 101(g) of the Internal Revenue Code for the calendar year in which benefits will be paid.

The Accelerated Benefit will be subject to the following limitations:

(a) We will pay no benefits if the Insured is Chronically Ill as a direct result of his or her attempted suicide or intentionally self-inflicted injury.

(b) If the Insured dies after a request for any Accelerated Benefit has been submitted and before you receive an Accelerated Benefit payment, such request will be voided and the policy's Death Benefit will be payable.

(c) If the Insured dies before all Accelerated Benefit payments have been received, all remaining payments will be voided and the policy's Death Benefit will be payable, subject to all other policy provisions.

7. PREMIUM.

There is a charge to include the Chronic Illness Accelerated Death Benefit Rider on a policy. The monthly cost of insurance for the rider will be added to the monthly deduction for the policy. The maximum rider cost of insurance rates per unit of coverage are shown in the rider.

REQUEST FOR POLICY INFORMATION IN CONNECTION WITH NEW YORK REPLACEMENT REGULATION 60

To the Existing Insurer:

In accordance with New York State Regulation 60, this notice is being furnished to you by a representative of The United States Life Insurance Company in the City of New York (USLife). Please take note that an existing life insurance or annuity policy(ies) issued by your Company may be replaced (as defined in this regulation) by life insurance or annuity policy(ies) issued by USLife.

Regulation 60 requires that replacing agents must request certain information from the existing insurer necessary to complete required "Disclosure Statements" relative to the life insurance or annuity policy(ies) to be replaced. A list of the policies issued by your company to be replaced is attached to this form and indicates the action proposed to be taken by with respect to each life insurance policy or annuity contract.

Please provide all necessary disclosures as required by New York insurance law within twenty (20) days of receipt of this correspondence. As required by law, please send this information to both the replacing agent and to USLife at the addresses indicated on the attached form.

Please note that Regulation 60 requires the agent to prepare Disclosure Statements that include your Company's policy values as they would exist after the proposed replacement transaction and also as they would exist if the proposed change did not occur. This information is therefore requested from your Company.

Also, please note that if this requested response is not received by the replacing agent within 20 days of your receipt of this communication, the agent may estimate values when completing the Disclosure Statements and USLife is required by law to report your lack of response to the Department of Financial Services of the State of New York.

The policyowner's signed authorization appears on the attached form.

Thank you,

The United States Life Insurance Company

REQUEST FOR POLICY INFORMATION IN CONNECTION WITH NEW YORK REPLACEMENT REGULATION 60

	EXISTING INSURER	REPLACING INSURER	REPLACING AGENT
Name:		United States Life	
Attention:		New Business Department	
Street Address:		1050 North Western Street Amarillo, TX 79106	
P.O. Box:		P.O. Box 90503	
City, State, Zip:		Amarillo, Tx 79105-4003	
Telephone:		Telephone: (888) 436-4974	
Fax:		Fax: (800) 250-9245	

THE PROPOSED TRANSACTION WILL AFFECT EXISTING POLICY(IES) AS DESCRIBED BELOW:

	POLICY #1	POLICY #2
Policy Number		
Name of Insured(s)		
Name of Policyowner(s)		
Lapse or Surrender	☐ Yes ☐ No	☐ Yes ☐ No
Loan or Withdrawal: (Amount)	$	$
Death Benefit Reduction to: (Face)	$	$
Reduced Paid-Up For: (Face)	$	$
Cash released by change: (Amount)	$	$
Extended Term to: (Date)		
Other, including Amendments and Reissues (if Yes, explain. Use additional pages as necessary)	☐ Yes ☐ No	☐ Yes ☐ No

Policyowner's Authorization:

I hereby request and authorize the Existing Insurer to furnish the Replacing Agent and The United States Life Insurance Company with an in-force reprojection that complies with New York Insurance Regulation 60 disclosure requirements on the above policy(ies) within twenty (20) days of receipt of this notice.

Policyowner's Signature **Date**

Policyowner's Signature **Date**

DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK
IMPORTANT NOTICE REGARDING REPLACEMENT OR CHANGE OF LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY 11 NYCRR PART 51 (INSURANCE REGULATION 60)

YOU ARE CONTEMPLATING THE PURCHASE OF A LIFE INSURANCE POLICY OR ANNUITY CONTRACT IN CONNECTION WITH THE SURRENDER, LAPSE OR CHANGE OF EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS. THE AGENT OR BROKER IS REQUIRED TO GIVE YOU THIS NOTICE. A SIGNED DISCLOSURE STATEMENT WILL ALSO BE PROVIDED TO YOU CONTAINING THE SUMMARY RESULT COMPARISON FOR THE NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT AND ANY LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO BE CHANGED THAT SETS FORTH THE FACTS OF THE TRANSACTION AND ITS ADVANTAGES AND DISADVANTAGES TO YOU. YOUR DECISION COULD BE A GOOD ONE - OR A MISTAKE - SO MAKE SURE YOU UNDERSTAND THE FACTS. YOU SHOULD:

1. CAREFULLY STUDY THE DISCLOSURE STATEMENT, WHICH INCLUDES A SUMMARY RESULT COMPARISON, UNTIL YOU ARE SURE YOU UNDERSTAND FULLY THE EFFECT OF THE TRANSACTION. **THE DISCLOSURE STATEMENT IS REQUIRED TO BE PROVIDED TO YOU NO LATER THAN UPON DELIVERY OF THE POLICY OR CONTRACT.**

2. ASK THE COMPANY, AGENT OR BROKER FROM WHOM YOU BOUGHT YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS TO REVIEW WITH YOU THE TRANSACTION. YOU MAY BE ABLE TO EFFECT THE CHANGES YOU DESIRE MORE ADVANTAGEOUSLY WITH THEM.

3. CONSULT YOUR TAX ADVISOR. THERE MAY BE UNFAVORABLE TAX IMPLICATIONS ASSOCIATED WITH THE CONTEMPLATED CHANGES TO YOUR EXISTING LIFE INSURANCE POLICIES OR ANNUITY CONTRACTS.

As a general rule, it is often not advantageous to drop or change existing coverage in favor of new coverage, whether issued by the same or a different insurance company. Some of the reasons it may be disadvantageous are:

1. The amount of the annual premium under an existing life insurance policy may be lower than that called for by a new life insurance policy having the same or similar benefits. Any replacement of the same type of policy will normally be at a higher premium rate based upon the insured's then attained age.

2. Since the initial costs of a life insurance policy are charged against the cash value increases in the earlier life insurance policy years, the replacement of an old life insurance policy by a new one results in the policyholder sustaining the burden of these costs twice. Annuity contracts usually contain provision for surrender charges, therefore a replacement involving annuity contracts may result in the imposition of surrender charges.

3. The incontestable and suicide clauses begin anew in a new life insurance policy. This could result in a claim being denied under the new life insurance policy that would have been paid under the life insurance policy that was replaced.

4. An existing life insurance policy or annuity contract often has more favorable provisions than a new life insurance policy or annuity contract in areas such as loan interest rate, settlement options, disability benefits and tax treatment.

5. There may have been changes in your health since the purchase of the existing coverage.

6. The insurance company with which you have existing coverage can often make a desired change on terms that would be more favorable than if you replaced existing coverage with new coverage.

YOU HAVE THE RIGHT, WITHIN 60 DAYS FROM THE DATE OF DELIVERY OF A NEW LIFE INSURANCE POLICY OR ANNUITY CONTRACT, TO RETURN IT TO THE INSURER AND RECEIVE AN UNCONDITIONAL FULL REFUND OF ALL PREMIUMS OR CONSIDERATIONS PAID ON IT, OR IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, A PAYMENT OF THE CASH SURRENDER BENEFITS PROVIDED UNDER THE POLICY OR CONTRACT, PLUS THE AMOUNT OF ALL FEES AND OTHER CHARGES DEDUCTED FROM GROSS CONSIDERATIONS OR IMPOSED UNDER THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT, AND MAY HAVE THE RIGHT TO REINSTATE OR RESTORE ANY LIFE INSURANCE POLICIES AND ANNUITY CONTRACTS THAT WERE SURRENDERED, LAPSED OR CHANGED IN THE TRANSACTION TO THEIR FORMER STATUS TO THE EXTENT POSSIBLE AND IN ACCORDANCE WITH THE INSURER'S PUBLISHED REINSTATEMENT RULES TO THE EXTENT SUCH RULES ARE NOT INCONSISTENT WITH THE PROVISIONS OF 11 NYCRR PART 51 (INSURANCE REGULATION 60).

IMPORTANT: THIS RIGHT SHOULD NOT BE VIEWED AS REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT TO THE SAME CONDITION AS IF IT HAD NEVER BEEN REPLACED. THERE MAY BE CONSEQUENCES IN REINSTATING OR RESTORING YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT, INCLUDING BUT NOT LIMITED TO:

- THE RIGHT TO REINSTATE OR RESTORE YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT APPLIES ONLY TO COMPANIES SUBJECT TO NEW YORK INSURANCE LAWS;

- YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT IS SUBJECT TO YOUR SPECIFIC COMPANY’S REINSTATEMENT RULES, WHICH MAY VARY FROM COMPANY TO COMPANY. THESE RULES MAY REQUIRE PAYMENT OF BOTH PREMIUM AND INTEREST; HOWEVER, YOU WILL NOT BE SUBJECT TO EVIDENCE OF INSURABILITY, OR A NEW CONTESTABLE OR SUICIDE PERIOD;

- YOU MAY NOT RECEIVE THE INTEREST OR INVESTMENT PERFORMANCE DURING THE PERIOD THE LIFE INSURANCE POLICY OR ANNUITY CONTRACT WAS REPLACED; AND

- THERE MAY BE UNFAVORABLE FEDERAL INCOME TAX CONSEQUENCES AS A RESULT OF THE REINSTATEMENT OF YOUR LIFE INSURANCE POLICY OR ANNUITY CONTRACT.

IMPORTANT: IN THE CASE OF A VARIABLE OR MARKET VALUE ADJUSTMENT POLICY OR CONTRACT, THE VALUE OF THE POLICY OR CONTRACT MAY INCREASE OR DECREASE DURING THE 60 DAY PERIOD DEPENDING ON THE PERFORMANCE OF THE UNDERLYING INVESTMENTS, WHICH MAY AFFECT THE VALUE OF THE REFUND YOU RECEIVE.

I HEREBY ACKNOWLEDGE THAT I READ THE ABOVE “IMPORTANT NOTICE” AND HAVE RECEIVED A COPY OF SAME.

Date: ______________________ **Signature of Applicant:** ___________________________________
Date: ______________________ **Signature of Applicant:** ___________________________________

AIG Life Insurance

New Business Bulletin

AIG

September 22, 2021 21-069

Tax transcript requests: Important update and reminder

IRS Form 4506-C is used to request tax return transcripts, and is required when:

- the insured's age is 18 and older, and
- the policy face amount is $5,000,001 and greater.

Effective October 1, 2021, the IRS will begin using Optical Character Recognition (OCR) software when processing the requests. The IRS has provided tips and guidance for these forms so they can be scanned by the software. The IRS has provided tips and guidance for these forms so they can be scanned by the software.

Please note: A pre-filled IRS Form 4506-C is available in Forms Depot that will help meet this new criteria. When submitting requests for tax transcripts, please use the Forms Depot version whenever possible.

Forms Depot link: Form 4506-C (IVES Request for Transcript of Tax Return)

IRS Guidance for use of Form 4506-C

- ✓ **The form must be free of editing marks, scratches, etc.** Do not edit or write over information. If the form 4506-C includes manual edits, the form will not pass OCR. Standard IRS rejections will apply.

- ✓ **List the data on the assigned lines**. The information needs to be on the appropriate line on the form; otherwise, it will be rejected.

- ✓ **Clearly identify the transcripts and tax years that need to be processed.**
  - Line 6 should contain a single transcript request only, i.e. 1040.
  - A single checkbox should be selected to match Line 6.
  - Line 8 should display only the year that is being requested.
  - The request should only be for the last two years.
  - ➢ **Please note ,the pre-filled IRS Form 4506-C in Forms Depot already has the transcript and tax year information.**

- ✓ **The form must include the taxpayer's printed (or typed) name.**

See sample IRS Form 4506-C with notes and instructions on following pages.

HOW TO FILL OUT **IRS FORM 4506-C**

NCS | TRV® SERVICES

TIPS FOR AVOIDING IRS REJECTS

Check for most recent form update

Form **4506-C** (September 2020)	Department of the Treasury - Internal Revenue Service **IVES Request for Transcript of Tax Return**	OMB Number 1545-1872

▶ **Do not sign this form unless all applicable lines have been completed.**
▶ **Request may be rejected if the form is incomplete or illegible.**
▶ **For more information about Form 4506-C, visit *www.irs.gov* and search IVES.**

1a. Name shown on tax return *(if a joint return, enter the name shown first)*
Primary Taxpayer Name

1b. First social security number on tax return, individual taxpayer identification number, or employer identification number *(see instructions)*
Primary Taxpayer Social Security

2a. If a joint return, enter spouse's name shown on tax return
Spouse Name (if applicable)

2b. Second social security number or individual taxpayer identification number if joint tax return
Spouse Social Security Number

#4 Address MUST match taxpayer's last return filed.

3. Current name, address (including apt., room, or suite no.), city, state, and ZIP code *(see instructions)*
Current Address (If PO Box, please include here)

4. Previous address shown on the last return filed if different from line 3 *(see instructions)*

#5a Use NCS/TRV Processing address, as shown here:

5a. IVES participant name, address, and SOR mailbox ID
NCS TRV Processing, P.O. BOX 321, EGG HARBOR CITY, NJ 08215 800-582-7066

#5b Do not fill in 5b. NCS will populate on your behalf prior to sending to the IRS.

5b. Customer file number *(if applicable) (see instructions)*

Caution: This tax transcript is being sent to the third party entered on Line 5a. Ensure that lines 5 through 8 are completed before signing. *(see instructions)*

6. **Transcript requested**. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request *more than one tax form is accepted by NCS

SELECT DESIRED REPORTS

a. **Return Transcript**, which includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-A, Form 1120-H, Form 1120-L, and Form 1120S. Return transcripts are available for the current year and returns processed during the prior 3 processing years ☐

b. **Account Transcript**, which contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns ☐

c. **Record of Account**, which provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years ☐

6b Does not provide original return information.

6c Will provide both original return information and any payments, penalty assessments & adjustments made to the account.

7. **Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript**. The IRS can provide a transcript that includes data from these information returns. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213 ☐

Caution: If you need a copy of Form W-2 or Form 1099, you should first contact the payer. To get a copy of the Form W-2 or Form 1099 filed with your return, you must use Form 4506 and request a copy of your return, which includes all attachments.

#8 Current year (posted on IRS site) + 3 prior consecutive years available.

8. Year or period requested. Enter the ending date of the tax year or period using the mm/dd/yyyy format *(see instructions)*
12 / 31 / 2016 12 / 31 / 2017 12 / 31 / 2018 12 / 31 / 2019

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-C on behalf of the taxpayer. **Note**: This form must be received by IRS within 120 days of the signature date.

MUST BE CHECKED HERE

☐ **Signatory attests that he/she has read the attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-C. See instructions.**

Sign Here

Signature *(see instructions)*: Primary taxpayer signature
Date: Must be within 120 days
Phone number of taxpayer on line 1a or 2a: (555)555-5555

Print/Type name: Printed name (including signature and date above) must be the taxpayer listed on line 1a

Title *(if line 1a above is a corporation, partnership, estate, or trust)*

Spouse's signature: Spouse signature (if applicable)
Date: Must be within 120 days

Print/Type name: Printed name (including signature and date above) must be the taxpayer listed on line 2a

Catalog Number 72627P www.irs.gov Form **4506-C** (9-2020)
For Privacy Act and Paperwork Reduction Act Notice, see page 2.

IMPORTANT: Adjustments/ additions to the 4506-C should NOT be made once the taxpayer has signed. To clarify taxpayer information, you may write the information in the margins of the 4506-C.

Form **4506-C** (October 2022)	Department of the Treasury - Internal Revenue Service **IVES Request for Transcript of Tax Return**	OMB Number 1545-1872

Do not sign this form unless all applicable lines have been completed.

Request may be rejected if the form is incomplete or illegible.

For more information about Form 4506-C, visit *www.irs.gov* and search IVES.

1a. Current name			**2a**. Spouse's current name *(if joint return and transcripts are requested for both taxpayers)*		
i. First name	**ii**. Middle initial	**iii**. Last name/BMF company name	**i**. Spouse's first name	**ii**. Middle initial	**iii**. Spouse's last name
1b. First taxpayer identification number *(see instructions)*			**2b.** Spouse's taxpayer identification number *(if joint return and transcripts are requested for both taxpayers)*		
1c. Previous name shown on the last return filed if different from line 1a			**2c**. Spouse's previous name shown on the last return filed if different from line 2a		
i. First name	**ii**. Middle initial	**iii**. Last name	**i**. First name	**ii**. Middle initial	**iii**. Last name
3. Current address *(including apt., room, or suite no.)*, city, state, and ZIP code *(see instructions)*					
a. Street address *(including apt., room, or suite no.)*			**b**. City	**c**. State	**d**. ZIP code
4. Previous address shown on the last return filed if different from line 3 *(see instructions)*					
a. Street address *(including apt., room, or suite no.)*			**b**. City	**c**. State	**d**. ZIP code
5a. IVES participant name, ID number, SOR mailbox ID, and address					
i. IVES participant name NCS TRV Processing			**ii**. IVES participant ID number	**iii**. SOR mailbox ID	
iv. Street address *(including apt., room, or suite no.)* P.O. Box 1089			**v**. City Hammonton	**vi**. State NJ	**vii**. ZIP code 08037
5b. Customer file number *(if applicable) (see instructions)*			**5c**. Unique identifier *(if applicable) (see instructions)*		
5d. Client name, telephone number, and address *(this field cannot be blank or not applicable (NA))*					
i. Client name Parameds					**ii**. Telephone number 212-223-3228
iii. Street address *(including apt., room, or suite no.)* 120-10 Queen's Blvd			**iv**. City Kew Gardens	**v**. State NY	**vi**. ZIP code 11415

Caution: This tax transcript is being sent to the third party entered on Line 5a and/or 5d. Ensure that lines 5 through 8 are completed before signing. *(see instructions)*

6. **Transcript requested**. Enter the tax form number here (1040, 1065, 1120, etc.) and check the appropriate box below. Enter only one tax form number per request for line 6 transcripts

a. Return Transcript ☐ **b.** Account Transcript ☐ **c.** Record of Account ☐

7. Wage and Income transcript *(W-2, 1098-E, 1099-G, etc.)* ☐

a. Enter a max of three form numbers here; if no entry is made, all forms will be sent.

b. Mark the checkbox for taxpayer(s) requesting the wage and income transcripts. If no box is checked, transcripts will be provided for all listed taxpayers

Line 1a ☐ Line 2a ☐

8. Year or period requested. Enter the ending date of the tax year or period using the mm dd yyyy format *(see instructions)*

/ /   / /   / /   / /

Caution: Do not sign this form unless all applicable lines have been completed.

Signature of taxpayer(s). I declare that I am either the taxpayer whose name is shown on line 1a or, if applicable, line 2a, or a person authorized to obtain the tax information requested. If the request applies to a joint return, at least one spouse must sign; however, if both spouses' names and TINs are listed in lines 1a-1b and 2a-2b, both spouses must sign the request. If signed by a corporate officer, 1 percent or more shareholder, partner, managing member, guardian, tax matters partner, executor, receiver, administrator, trustee, or party other than the taxpayer, I certify that I have the authority to execute Form 4506-C on behalf of the taxpayer. **Note**: This form must be received by IRS within 120 days of the signature date.

☐ **Signatory attests that he/she has read the above attestation clause and upon so reading declares that he/she has the authority to sign the Form 4506-C. See instructions.**

Sign Here	**Signature for Line 1a** *(see instructions)*	Date	Phone number of taxpayer on line 1a or 2a
	☐ Form 4506-C was signed by an Authorized Representative	☐ Signatory confirms document was electronically signed	
	Print/Type name		
	Title *(if line 1a above is a corporation, partnership, estate, or trust)*		
	Spouse's signature *(required if listed on Line 2a)*		Date
	☐ Form 4506-C was signed by an Authorized Representative	☐ Signatory confirms document was electronically signed	
	Print/Type name		

For Privacy Act and Paperwork Reduction Act Notice, see page 2.

Instructions for Form 4506-C, IVES Request for Transcript of Tax Return

Section references are to the Internal Revenue Code unless otherwise noted.

Future Developments

For the latest information about Form 4506-C and its instructions, go to *www.irs.gov* and search IVES. Information about any recent developments affecting Form 4506-C (such as legislation enacted after we released it) will be posted on that page.

What's New. Form 4506-C includes the Client company requesting transcripts and increased the number of Wage and Income transcripts requests.

General Instructions

Caution: Do not sign this form unless all applicable lines have been completed.

Designated Recipient Notification. Section 6103(c) limits disclosure and use of return information received pursuant to the taxpayer's consent and holds the recipient subject to penalties for any unauthorized access, other use, or redisclosure without the taxpayer's express permission or request.

Taxpayer Notification. Section 6103(c) limits disclosure and use of return information provided pursuant to your consent and holds the recipient subject to penalties, brought by private right of action, for any unauthorized access, other use, or redisclosure without your express permission or request.

Purpose of form. Use Form 4506-C to request tax return information through an authorized IVES participant. You will designate an IVES participant to receive the information on line 5a.

Note: If you are unsure of which type of transcript you need, check with the party requesting your tax information.

Where to file. The IVES participant will fax Form 4506-C with the approved IVES cover sheet to their assigned Service Center.

Chart for ordering transcripts

If your assigned Service Center is:	Fax the requests with the approved coversheet to:
Austin Submission Processing Center	Austin IVES Team 844-249-6238
Kansas City Submission Processing Center	Kansas City IVES Team 844-249-8128
Ogden Submission Processing Center	Ogden IVES Team 844-249-8129

Specific Instructions

Line 1a/2a *(if spouse is also requested)*. For IMF Requests: Enter the First, Middle Intial, and Last Name in the indicated fields. If all characters will not fit, please enter up to 12 for First name and 22 for Last name. For BMF Requests: Enter the company name in the Last Name field. If all characters will not fit, please enter up to 22.

Line 1b/2b *(if spouse is also requested).* Enter the social security number (SSN) or individual taxpayer identification number (ITIN) for the individual listed on line 1a including the dashes in the correct format, or enter the employer identification number (EIN) for the business listed on line 1a including the dashes in the correct format.

Line 1c/2c *(if spouse is also requested)*. Enter your previous name as shown on your last filed tax return if different than line 1a.

Line 3. Enter your current address in the indicated fields. If you use a P.O. Box, include it and the number in the Current Address field.

Line 4. Enter the address shown on the last return filed if different from the address entered on line 3.

Note: If the addresses on lines 3 and 4 are different and you have not changed your address with the IRS, file Form 8822, Change of Address, or Form 8822-B, Change of Address or Responsible Party — Business, with Form 4506-C.

Line 5b. Enter up to 10 numeric characters to create a unique customer file number that will appear on the transcript. The customer file number cannot contain an SSN, ITIN or EIN. Completion of this line is not required.

Line 5c. Enter up to 10 alpha-numeric characters to create a unique identifier that will show in the mailbox file information. The unique identifier cannot contain an SSN, ITIN or EIN. Completion of this line is not required.

Note. If you use an SSN, we will not input the information and the customer file number or unique identifier will reflect a generic entry of "9999999999".

Line 5d. Enter the Client company name, address, and phone number in the indicated fields. A Client company receives the requested tax transcripts from the IVES participant. If the IVES participant is also the Client company, the IVES participant information should be entered on Line 5a and 5d. These fields cannot be blank or Not Applicable (NA).

Line 6. Enter only one tax form number (1040, 1065, 1120, etc.) per request for all line 6 transcripts request types.

Line 6a. Return Transcript includes most of the line items of a tax return as filed with the IRS. A tax return transcript does not reflect changes made to the account after the return is processed. Transcripts are only available for the following returns: Form 1040 series, Form 1065, Form 1120, Form 1120-H, Form 1120-L, and Form 1120-S. Return transcripts are available for the current year and returns processed during the prior 3 processing years.

Line 6b. Account Transcript contains information on the financial status of the account, such as payments made on the account, penalty assessments, and adjustments made by you or the IRS after the return was filed. Return information is limited to items such as tax liability and estimated tax payments. Account transcripts are available for most returns.

Line 6c. Record of Account provides the most detailed information as it is a combination of the Return Transcript and the Account Transcript. Available for current year and 3 prior tax years.

Line 7. The IRS can provide a transcript that includes data from these information returns: Form W-2, Form 1099 series, Form 1098 series, or Form 5498 series transcript. Enter up to three information return types. If no specific type is requested, all forms will be provided. State or local information is not included with the Form W-2 information. The IRS may be able to provide this transcript information for up to 10 years. Information for the current year is generally not available until the year after it is filed with the IRS. For example, Form W-2 information for 2016, filed in 2017, will likely not be available from the IRS until 2018. If you need Form W-2 information for retirement purposes, you should contact the Social Security Administration at 1-800-772-1213.

Line 8. Enter the end date of the tax year or period requested in mm dd yyyy format. This may be a calendar year, fiscal year or quarter. Enter each quarter requested for quarterly returns. Example: Enter 12 31 2018 for a calendar year 2018 Form 1040 transcript.

CAUTION *You must check the box in the signature area to acknowledge you have the authority to sign and request the information. The form will not be processed if unchecked.*

Signature and date. Form 4506-C must be signed and dated by the taxpayer listed on line 1a and, if listed, 2a. The IRS must receive Form 4506-C within 120 days of the date signed by the taxpayer or it will be rejected. Ensure that all applicable lines, including lines 5a through 8, are completed before signing.

Authorized Representative: A representative can sign Form 4506-C for a taxpayer if the taxpayer has specifically delegated this authority to the representative on Form 2848, line 5a, and Form 2848 is attached to the Form 4506-C request. If you are Heir at Law, Next of Kin, or Beneficiary, you must be able to establish a material interest in the estate or trust. If Form 4506-C is signed by a representative, the Authorized Representative check box must be marked.

Electronic Signature: Only IVES participants that opt in to the Electronic Signature usage can accept electronic signatures. Contact the IVES participant for approval and guidance for electronic signatures. If the Form 4506-C is signed electronically, the Electronic Signature check box must be marked.

Individuals. Transcripts listed on line 6 may be furnished to either spouse if jointly filed. Signatures are required for all taxpayers listed on Line 1a and 2a.

Corporations. Generally, Form 4506-C can be signed by:

(1) an officer having legal authority to bind the corporation, (2) any person designated by the board of directors or other governing body, or (3) any officer or employee on written request by any principal officer and attested to by the secretary or other officer. A bona fide shareholder of record owning 1 percent or more of the outstanding stock of the corporation may submit a Form 4506-C but must provide documentation to support the requester's right to receive the information.

Partnerships. Generally, Form 4506-C can be signed by any person who was a member of the partnership during any part of the tax period requested on line 8.

All others. See section 6103(e) if the taxpayer has died, is insolvent, is a dissolved corporation, or if a trustee, guardian, executor, receiver, or administrator is acting for the taxpayer.

Documentation. For entities other than individuals, you must attach the authorization document. For example, this could be the letter from the principal officer authorizing an employee of the corporation or the letters testamentary authorizing an individual to act for an estate.

Privacy Act and Paperwork Reduction Act Notice. We ask for the information on this form to establish your right to gain access to the requested tax information under the Internal Revenue Code. We need this information to properly identify the tax information and respond to your request. You are not required to request any transcript; if you do request a transcript, sections 6103 and 6109 and their regulations require you to provide this information, including your SSN or EIN. If you do not provide this information, we may not be able to process your request. Providing false or fraudulent information may subject you to penalties.

Routine uses of this information include giving it to the Department of Justice for civil and criminal litigation, and cities, states, the District of Columbia, and U.S. commonwealths and possessions for use in administering their tax laws. We may also disclose this information to other countries under a tax treaty, to federal and state agencies to enforce federal nontax criminal laws, or to federal law enforcement and intelligence agencies to combat terrorism.

You are not required to provide the information requested on a form that is subject to the Paperwork Reduction Act unless the form displays a valid OMB control number. Books or records relating to a form or its instructions must be retained as long as their contents may become material in the administration of any Internal Revenue law. Generally, tax returns and return information are confidential, as required by section 6103.

The time needed to complete and file Form 4506-C will vary depending on individual circumstances. The estimated average time is:

Learning about the law or the form . . . . . . 10 min.
Preparing the form . . . . 12 min.
Copying, assembling, and sending the form to the IRS . . . . 20 min.

If you have comments concerning the accuracy of these time estimates or suggestions for making Form 4506-C simpler, we would be happy to hear from you. You can write to:

Internal Revenue Service
Tax Forms and Publications Division
1111 Constitution Ave. NW, IR-6526
Washington, DC 20224

Do not send the form to this address. Instead, see Where to file on this page.

Use this form for age 67 and over.

Agent Certification Form

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of New York**

In this form, the "Company" refers to the insurance company whose name is checked above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

Insured's Social Security Number ______________________________ Policy Number ____________________________

Additional Insured's Social Security Number______________________________

This form must be completed prior to taking any application for life insurance on an individual age 67 or older. The Company may also request agents to complete this Form in other situations where it is deemed appropriate.

Carefully review this Form and Company Field Bulletins regarding Investor Owned Life Insurance and Stranger Owned Life Insurance, and complete the certification below that applies to the transaction; <u>except, however, if part or all of the premium paid toward this policy is being financed and you cannot sign the certification, you must not take the application.</u>

Non-Premium Financing Certification

None of the premiums for the policy sought with the application for (Insured) ______________________________ or for ______________________________________(Additional Insured) dated_____________________will be financed other than pursuant to a split dollar agreement, including a family's private split dollar agreement.

Agent's Signature X ___________________________________ **Agent signed on** (date) ______________________________

Premium Financing Certification

1) I have reviewed and am familiar with all aspects of the premium financing proposal.
2) Based upon my review of the financing proposal, I believe that the costs associated with this premium financing proposal are such that assuming no change in the insured/additional insured's health, it is more likely than not that the insured/additional insured will maintain the policy in force for the benefit of his/her beneficiaries and those beneficiaries will receive more than 50% of the policy death benefit.
3) The insured/additional insured is not receiving any cash payment, borrowing funds in excess of those required to pay the scheduled premiums and interest, or receiving any other consideration as an inducement to participate in this transaction.
4) Within the past 24 months has the insured/additional insured had a life expectancy calculation? ☐ Yes ☐ No
   All life expectancy calculations performed on any proposed insured during the past 24 months must be submitted with any application for review and consideration.
5) There is no prearranged agreement to transfer the policy nor will the policyholder have a prearranged option or right of first refusal to transfer the policy to a third party.
6) All sales materials used in connection with the solicitation and sale of this policy were either produced by the life insurance company or have been submitted and approved by the Company.
7) I have read the Field Bulletins regarding Investor Owned Life Insurance, Stranger Owned Life Insurance and Viatical Transactions, and believe this transaction is in compliance with the company policies as set forth in those Bulletins regardless of whether the lending program is a recourse or non-recourse transaction.

All or part of the premiums paid towards this policy are being financed. I have read the statements set forth above and hereby certify that the statements are all true with regard to the application for (Insured) __________ _____________________ and _________________________________ (Additional Insured) dated ________________ .

Agent's Signature X ___________________________________ **Agent signed on** (date) ______________________________

Use this form for age 67 and over.

Premium Financing Disclosure for Proposed Insureds

American General Life Insurance Company, 2727-A Allen Parkway, Houston, TX 77019

In this form, the "Company" refers to the insurance company name listed above. The Company shown above is **solely** responsible for the obligation and payment of benefits under any policy that it may issue. No other Company is responsible for such obligations or payments.

We are providing this notice to all insureds age 67 or older who have applied for life insurance policies, as we have seen unprecedented growth in premium financing for policies in this demographic.

Premium financing is a practice that has been used in connection with the sale of life insurance policies for many years. If you are contemplating financing the purchase of life insurance or participating in the acquisition of a life insurance policy acquired with funds from a source outside your control, please consider the following issues:

- All the questions on the life insurance application should have been answered accurately and completely. Misrepresentations about your health, your financial resources or the purpose for acquiring the policy may result in claims disputes rather than payment of insurance benefits.

- Be sure you understand the transaction. Some transactions are established with a trustee or other third party who obtains financing from a lender on terms that may not be to the insured's advantage. Ask yourself, are the parties involved looking out for your best interest?

- Will a significant portion of your policy death benefit reach your beneficiaries? If most of the death benefits are not going to your beneficiaries, perhaps you should consider acquiring a more affordable policy that you control for your beneficiaries.

IMPORTANT: Any payments received as an inducement for entering into a life insurance transaction are taxable as ordinary income. Also, if you have financed premiums to pay for a policy with the understanding that you can walk away after the initial term with no personal obligation to repay the loan or loan interest, it is possible that forgiveness of debt can also create taxable income for you. If you sell your policy the gain is taxable to you. You should consult with your personal tax advisor about any questions you may have regarding the tax consequences of this transaction.

- It is important to know the lender, the trustee or other parties participating in the transaction. Ask whether you are comfortable participating in a transaction where investors or entities you do not know may end up owning a large insurance policy on your life.

This is not a complete list of all the issues that you should consider when contemplating a new life insurance transaction. If you have any questions or concerns, you can contact your Agent or call our Company at 1-800-247-8837, prompt 1.

Please acknowledge that you have received this disclosure by signing a copy of this form and returning it to the Company. Retain a copy for your records.

Proposed Insured's Signature

X

Proposed Insured signed on (date) ____________________

Certification of Trust

☐ **American General Life Insurance Company**
☐ **The United States Life Insurance Company in the City of New York**

1. **Account Information** *(Indicate one of the following)*

This form is being completed for an:

☐ Existing life insurance policy ☐ Existing annuity contract ☐ Existing Mutual Fund Account

Existing Policy/Contract/Account Number(s) ____________________

☐ Application for life insurance policy ☐ Application for an annuity contract

2. **Trust Information**

Full legal name of Trust____________________

Date on which Trust was executed ____________________

Trust's tax identification number ____________________

State where Trust established ____________________ ☐ Revocable Trust ☐ Irrevocable Trust

3. **Grantor Trust Information** *(complete only for annuities and modified endowment contracts)*

Is this Trust a Grantor Trust pursuant to IRC Sections 671 to 678? ☐ Yes ☐ No

A grantor trust is a trust under which the Grantor or someone other than the Grantor is treated as the owner of the trust assets for tax purposes under IRC Sections 671-678.

If yes, provide the following:

Grantor Name ____________________ Social Security Number ____________________

Grantor Name ____________________ Social Security Number ____________________

Address____________________

City ____________________ State__________ Zip__________

4. **Trustee Authority**

Names of all Trustees authorized to act on behalf of the Trust ____________________

____

If more than one Trustee:

☐ Any Trustee is able to act independently ☐ All Trustees must act jointly ☐ Other (please specify) __________

5. **Trustee Declaration and Signature Information**

All currently acting trustees must sign. This form will supersede any previously provided certifications.

By signing below, each and all of the undersigned hereby:

(a) represent they constitute all of the currently acting trustees of the Trust and that the Trust authorizes the Trustee(s) to purchase, own, and administer life insurance policies and/or annuity contracts on the life of the Insured(s)/Annuitant(s);

(b) declare that the Trust has not been revoked, modified, or amended in any manner that would cause the representations contained herein to be incorrect and agree to provide a new Certification of Trust if the Trust is amended in any manner that changes any representations made in this Certificate, including any changes to the acting Trustees;

(c) understand and agree that the life insurance company named above ("Life Company") (i) does not review trust documents, (ii) will administer the policy or contract in accordance with its standard procedures and has no obligation to administer in accordance with any terms of the Trust, (iii) may rely on the instructions and representations of the Trustee(s), and (iv) will have no responsibility to determine whether any instructions or representations of the Trustee(s) are consistent with the authorities granted to the Trustee(s) by the Trust document;

5. **Trustee Declaration and Signature Information** *(con't)*

(d) agree to defend, indemnify and hold the Life Company, its parents, subsidiaries, and affiliates, and their directors, officers, employees and agents harmless for and against any and all claims, demands, liabilities, damages, costs or expenses, including, but not limited to, reasonable attorney's fees, which it may suffer or incur by reason of its reliance upon any statements contained herein;

(e) agree to provide additional information regarding the Trust if required by the Life Company;

(f) acknowledges that the Trustee(s) have had an opportunity to consult with its own legal and/or tax counsel in preparation of the Certification of Trust and that the Trustee(s) are solely responsible for the tax consequences arising from this Policy/Contract being held by a trust;

(g) represent that no trustee of the Trust is an agent of record, servicing agent, solicitor, insurance producer, financial representative, investment advisor or related financial institution, broker/dealer or insurance agency or any individual or entity acting in a similar capacity involved in the sale, solicitation or placement of this contract/policy (such individuals and entities collectively "Distributor"), unless such Distributor is a member of Insured's/Annuitant's immediate family;*

(h) represent and certify that (i) the Trust and each beneficiary under the Trust has an insurable interest** in the Insured(s)/Annuitant(s) listed on this form, (ii) is not aware of any agreement or arrangement whereby the Insured(s)/Annuitant(s) has received a payment or anything else of value in exchange for permission to use his/her life on the Policy/Contract, and (iii) understand that the Life Company reserves the right to terminate the contract consistent with applicable law if it discovers a misstatement with respect to the insurable interests between the Trust and the Insured(s)/Annuitant(s).

This paragraph (h) does not apply because:

☐ Trust was designated as beneficiary for an Individual Retirement Annuity and/or employer sponsored retirement plan or program (such as 401(a)/(k), 403(b), or 457(b)).

☐ Other ____________________

**If the distributor is NOT a member of the insured's immediate family, then such Distributor and the Insured/Annuitant must complete an Acknowledgment and Release Form and submit same to the Company.*

***Generally, an interest is insurable if a familial relationship and/or economic interest exists. A familial relationship can only exist between individuals, and the relationship generally includes those persons related by blood or by law. An economic interest exists when the contract owner has a lawful and substantial economic interest in having the life, health, or bodily safety of the life that triggers the death benefit preserved. Charitable and not-forprofit organizations are exempt from insurable interest requirements.*

Trustee #1

Name____________________ Signature ____________________

Date__________ Phone __________ State of__________ County of __________

Trustee #2

Name____________________ Signature ____________________

Date__________ Phone __________ State of__________ County of __________

Trustee #3

Name____________________ Signature ____________________

Date__________ Phone __________ State of__________ County of __________

6. **Insured/Annuitant Information** *(This section not required where annuitant designates a trust as beneficiary for an Individual Retirement Annuity and/or employer-sponsored retirement plan or program (such as 401(a)/(k), 403(b) or 457(b)) or (2) with a permissible explanation under Section 5(h) of this form.)*

By signing below, each and all of the undersigned hereby:

(a) certifies that his/her life is being used as the insured for the life insurance policy or measuring life for the annuity contract, as applicable, and consents to the use thereof;

(b) certifies that he/she has not entered into any agreement or arrangement whereby he/she has been paid, or received any other benefit, in exchange for permission to use his/her life for the life insurance policy or annuity contract, as applicable. Such an arrangement or agreement may be deemed a fraudulent act.

Insured/Annuitant's Signature

X

Insured/Annuitant Name (printed) ____________________

____

Insured/Annuitant signed on (date) ____________________

Illustration Acknowledgement and Certification

The United States Life Insurance Company in the City of New York, 28 Liberty Street, 45th Floor, New York, NY 10005-1400

Illustration Acknowledgement and Certification

Our company and a number of states require that you receive a basic life insurance illustration at the time of application for this life insurance policy. The basic illustration explains the policy's features, benefits and values, including its guaranteed and non-guaranteed elements. However, when a basic illustration is not available, an illustration acknowledgement and certification form is required to be presented in its place.

I acknowledge that this Illustration and Acknowledgement Certification is being used because:

I have viewed an illustration on a computer screen but did not received a printed copy.

The illustration was based on the following personal and policy information:

Gender: Male_____ Female_____; Age_____;

Underwriting/Rating _______________; Policy Type ______________________________;

Initial Death Benefit_________________; Dividend Option (if any) ____________________;

or I have not viewed any illustration regarding the policy for which I have applied.

I understand that the policy applied for has elements that are not guaranteed and I have been advised that if my application is approved, I will receive and be required to sign and return a printed basic illustration corresponding to the policy issued no later than at the time of policy delivery.

Applicant's Signature

X

Applicant signed on (date) ______________________________

I certify that no illustration for the policy as applied for was used. I also certify that I have explained to the applicant that the life insurance policy applied for has elements that are not guaranteed. I also certify that I have not represented any non-guaranteed elements as guaranteed.

Agent or Authorized Representative's Signature

X

Agent or Authorized Representative signed on (date) __________

____

Life insurance for income replacement

You are working hard to prepare for your family's future. In the event of your premature death, could your family afford to maintain the lifestyle that you are working so hard to achieve?

The foundation of your financial security is your income. The purchase of a life insurance policy creates a benefit at your death that can provide an income for your family.

Life insurance can help protect your family's financial future.

In the event of your premature death, could your family...

- Afford the mortgage payment?
- Send your children to the college of their choice?
- Remain in their home?
- Maintain their current standard of living?
- Pay the bills?

Fortunately, life insurance is available to help...

- Pay off the mortgage
- Replace lost income
- Establish an emergency fund
- Create an education fund

A review of your current financial picture and the following worksheet–with your representative–can help determine the amount of insurance needed to replace your income and provide for your family.

Policies issued by **American General Life Insurance Company** (AGL), Houston, TX except in New York, where issued by **The United States Life Insurance Company in the City of New York** (US Life).

Complete a family life insurance needs analysis in just 5 minutes

Name: ______________________________

Date of birth: ______________________ ○ Male ○ Female Monthly Income: $ ______________

Step 1

1. Final Expenses $____________
   [funeral, attorney fees, etc.;
   $15,000 minimum recommended]

2. Mortgage Balance $____________

3. Debts $____________
   [auto loans, credit card balances, etc.]

4. Children's Education[1]
   $____________ x ____________ = $____________
   total cost of degree   number of children

5. Living Expenses $____________

TOTAL **STEP 1** [Add nos. 1 through 5]: $____________

Step 2

6. Existing Life Insurance Coverage $____________

7. Cash and Savings Account Totals $____________

8. Retirement Assets (e.g. 401(k), IRA) $____________

9. Other Liquid Assets (e.g. mutual funds) $____________

TOTAL **STEP 2** [Add nos. 6 through 9]: $____________

Step 3

Additional life insurance you need:

TOTAL **STEP 1** minus TOTAL **STEP 2** $____________

Instructions:

- After the mortgage and other debts are paid off, how much does your family need to cover living expenses each month?
- Find the closest number in the monthly income column below and the corresponding number of years needed on the right. Enter the resulting number into no. 5, above.

Desired Monthly Income	Number of Years Needed[2]		
	10 years	15 years	20 years
$1,000	$100,000	$140,000	$170,000
$2,000	$200,000	$280,000	$340,000
$3,000	$300,000	$410,000	$500,000
$4,000	$400,000	$550,000	$670,000
$5,000	$500,000	$680,000	$830,000

[1] As a 2022-2023 estimate, the average annual cost of tuition, fees, and room and board for a 4-year in-state public university is approximately $23,250 and $53,430 for a private nonprofit university. [Source Trends in College Pricing, Annual Survey of Colleges 2022]

[2] Assumes 4% annual net interest earned combined with a systematic liquidation of principal to provide income for the stated period. 4% is not guaranteed and is used for illustrative purposes only. All amounts in the table have been rounded up to the next $10,000.

corebridge financial

For more information,
contact your financial professional.

corebridge financial

Differences Between Employer (Group) and Individual Life Insurance

If you need more life insurance, you may be faced with a question: Do I purchase an "Individual" life insurance policy? Or, do I just get it at work?

Nearly 60 percent of employees have access to life insurance through work[1] (commonly referred to as "group life insurance"). How does this coverage differ from an "Individual" life insurance policy (purchased separately from work)? When does it make sense to buy an individual policy?

41% of consumers agree they need life insurance or more coverage.[2]

4.1 YEARS is the median number of years employees have been with their current employer.[3]

57% of U.S. workers have life insurance through their workplace.[4]

27% of adults lost their life insurance coverage in 2020 due to an unplanned loss of employment.[4]

Understanding Employer (Group) Life Insurance

BASIC Term Life Insurance Policy:

For some, the policy coverage is a flat amount (e.g., $25K of coverage). For others, it is based on one's salary (e.g., coverage = 1 x salary).

- Advantages:
  - **Convenient**—Sign up at work, premiums get deducted from paycheck
  - **Guaranteed coverage**—No questions, no tests, no underwriting
  - **Free**—Generally free, regardless of age, health, etc.
- Disadvantages:
  - **Work-Related Restrictions**—Coverage typically requires "active" working status. If you become ill and unemployed before dying, the insurance may not pay.
  - **Not Portable**—Can't take policy with you if you leave the employer. Next employer may not offer life insurance.

SUPPLEMENTAL Term Life Insurance Policy:

Some employers offer the option to buy additional life insurance – which can be 2x salary, 3x salary, etc. This can be added to the "Basic" coverage.

- Advantages:
  - **Convenient**—Sign up at work, premiums get deducted from paycheck (if issued).
  - **Minimal Underwriting (if any)**—There may be some high-level medical questions (e.g., "Have you ever had a heart attack?") or a medical exam.
  - **Potentially Lower Costs for Unhealthy**—Have health issues? Your premiums may be lower than for an "Individual" policy because they are based on covering a group (the young, old, healthy and unhealthy).
- Disadvantages:
  - **Work-Related Restrictions**—Like the "Basic" coverage, typically requires you to be "actively" working.
  - **Not Portable**—Can't take policy with you if you leave the employer. If your next employer doesn't offer "Supplemental" insurance, then you may need to purchase an "Individual" policy to maintain the same level of coverage – paying higher premiums based on your age and health.
  - **Increasing Premiums**—Typically, costs increase each year as you age.
  - **No Options**—Employer coverage typically offers few or no bells and whistles that an "Individual" policy may include.

Policies issued by **American General Life Insurance Company** (AGL), Houston, TX except in New York, where issued by **The United States Life Insurance Company in the City of New York** (US Life).

Understanding Individual Life Insurance

INDIVIDUAL Term Life Insurance Policy

A policy purchased from an insurance company or a licensed agent – outside of the workplace.

- Advantages:
  - **Potentially Lower Costs for Healthy**—Coverage is dependent on your circumstances via underwriting. Healthy people will typically experience significantly lower premiums compared to "Supplemental" insurance.
  - **Level Premiums**—Term policies lock in the premium for a fixed period (e.g., 10 years, 20 years).
  - **Portable**—Since this policy is not connected to your employer, it is completely portable, providing you continuous coverage.
  - **No Work-Related Restrictions**—This means that an "Individual" insurance policy is more likely to pay out benefits than employer-provided coverage.
  - **Multiple Options**—Can choose from large selection of term policies which offer variety of special features and riders that provide flexibility.
- Disadvantages:
  - **Underwriting process**—Policies are, typically, fully underwritten, meaning that your policy will be based on your health and other factors. There will be more questions than for the "Supplemental" insurance, and may include some medical tests.

For more information, contact your financial professional.

How do I decide what to do?

1. Always take advantage of free "Basic" employer-provided coverage.
2. Determine how much insurance you'd like to have.
   - Online calculators can help determine the right amount. Or, you can work with a licensed insurance professional.
3. Get quotes for both "Individual" and "Supplemental" group life insurance for the coverage needed in addition to the "Basic" employer policy.
   - Get an "Individual" life insurance policy quote from a licensed insurance professional.
   - Get the price for "Supplemental" coverage from your employer benefits office.
4. When making your decision, consider the features/benefits that are important to you.

Feature/Benefit	SUPPLEMENTAL Employer Insurance Policy	INDIVIDUAL Insurance Policy
Convenient/ Least Underwriting	✔	
Best Price – Healthy		✔
Best Price – Less Healthy	✔	
Level Premiums		✔
Portable		✔
No Work-related Restrictions		✔
Multiple Options/ Features/Riders		✔

[1] Employee Benefits in the United States - March 2022, Bureau of Labor Statistics, September 22, 2022
[2] 2022 Insurance Barometer Study, Life Happens and LIMRA, 2022
[3] Employee Tenure in 2022, Bureau of Labor Statistics, September 22, 2022
[4] Facts About Life 2021, Workplace Benefits, LIMRA, 2021

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LIFE INSURANCE BUYER'S GUIDE

Prepared by the National Association of Insurance Commissioners

This Guide Does Not Endorse Any Company or Policy

Reprinted by THE UNITED STATES LIFE Insurance Company in the City of New York

This guide can help you when you shop for life insurance. It discusses how to:

- Find a Policy That Meets Your Needs and Fits Your Budget
- Decide How Much Insurance You Need
- Make Informed Decisions When You Buy a Policy

The National Association of Insurance Commissioners is an association of state insurance regulatory officials. This association helps the various insurance departments to coordinate insurance laws for the benefit of all consumers.

IMPORTANT THINGS TO CONSIDER

1. Review your own insurance needs and circumstances. Choose the kind of policy that has benefits that most closely fit your needs. Ask an agent or company to help you.
2. Be sure that you can handle premium payments. Can you afford the initial premium? If the premium increases later and you still need insurance, can you still afford it?
3. Don't sign an insurance application until you review it carefully to be sure all the answers are complete and accurate.
4. Don't buy life insurance unless you intend to stick with your plan. It may be very costly if you quit during the early years of the policy.
5. Don't drop one policy and buy another without a thorough study of the new policy and the one you have now. Replacing your insurance *may be costly.*
6. Read your policy carefully. Ask your agent or company about anything that is not clear to you.
7. Review your life insurance program with your agent or company every few years to keep up with changes in your income and your needs.

Buying Life Insurance

When you buy life insurance, you want coverage that fits your needs.

First, decide how much you need - and for how long - and what you can afford to pay. Keep in mind the major reason you buy life insurance is to cover the financial effects of unexpected or untimely death. Life insurance can also be one of many ways you plan for the future.

Next, learn what kinds of policies will meet your needs and pick the one that best suits you.

Then, choose the combination of policy premium and benefits that emphasize protection in case of early death, or benefits in case of long life, or a combination of both.

It makes good sense to ask a life insurance agent or company to help you. An agent can help you review your insurance needs and give you information about the available policies. If one kind of policy doesn't seem to fit your needs, ask about others.

This guide provides only basic information. You can get more facts from a life insurance agent or company or from your public library.

What About the Policy You Have Now?

If you are thinking about dropping a life insurance policy, here are some things you should consider:

- If you decide to replace your policy, don't cancel your old policy until you have received the new one. You then have a minimum period to review your new policy and decide if it is what you wanted.
- It may be costly to replace a policy. Much of what you paid in the early years of the policy you have now, paid for the company's cost of selling and issuing the policy. You may pay this type of cost again if you buy a new policy.
- Ask your tax advisor if dropping your policy could affect your income taxes.
- If you are older or your health has changed, premiums for the new policy will often be higher. You will not be able to buy a new policy if you are not insurable.
- You may have valuable rights and benefits in the policy you now have that are not in the new one.
- If the policy you have now no longer meets your needs, you may not have to replace it. You might be able to change your policy or add to it to get the coverage or benefits you now want.
- At least in the beginning, a policy may pay no benefits for some causes of death covered in the policy you have now.

In all cases, if you are thinking of buying a new policy, check with the agent or company that issued you the one you have now. When you bought your old policy, you may have seen an illustration of the benefits of your policy. Before replacing your policy, ask your agent or company for an updated illustration. Check to see how the policy has performed and what you might expect in the future, based on the amounts the company is paying now.

How Much Do You Need?

Here are some questions to ask yourself:

- How much of the family income do I provide? If I were to die early, how would my survivors, especially my children, get by? Does anyone else depend on me financially, such as a parent, grandparent, brother or sister?
- Do I have children for whom I'd like to set aside money to finish their education in the event of my death?
- How will my family pay final expenses and repay debts after my death?
- Do I have family members or organizations to whom I would like to leave money?
- Will there be estate taxes to pay after my death?
- How will inflation affect future needs?

As you figure out what you have to meet these needs, count the life insurance you have now, including any group insurance where you work or veteran's insurance. Don't forget Social Security and pension plan survivor's benefits. Add other assets you have: savings, investments, real estate and personal property. Which assets would your family sell or cash in to pay expenses after your death?

What Is the Right Kind of Life Insurance?

All policies are not the same. Some give coverage for your lifetime and others cover you for a specific number of years. Some build up cash values and others do not. Some policies combine different kinds of insurance, and others let you change from one kind of insurance to another. Some policies may offer other benefits while you are still living. Your choice should be based on your needs and what you can afford.

There are two basic types of life insurance: *term insurance* and *cash value insurance.* Term insurance generally has lower premiums in the early years, but does not build up cash values that you can use in the future. You may combine cash value life insurance with term insurance for the period of your greatest need for life insurance to replace income.

Term Insurance covers you for a term of one or more years. It pays a death benefit only if you die in that term. Term insurance generally offers the largest insurance protection for your premium dollar. It generally does not build up cash value.

You can renew most term insurance policies for one or more terms even if your health has changed. Each time you renew the policy for a new term, premiums may be higher. Ask what the premiums will be if you continue to renew the policy. Also ask if you will lose the right to renew the policy at some age. For a higher premium, some companies will give you the right to keep the policy in force for a guaranteed period at the same price each year. At the end of that time you may need to pass a physical examination to continue coverage, and premiums may increase.

You may be able to trade many term insurance policies for a cash value policy during a conversion period - even if you are not in good health. Premiums for the new policy will be higher than you have been paying for the term insurance.

Cash Value Life Insurance is a type of insurance where the premiums charged are higher at the beginning than they would be for the same amount of term insurance. The part of the premium that is not used for the cost of insurance is invested by the company and builds up a cash value that may be used in a variety of ways. You may borrow against a policy's cash value by taking a policy loan. If you don't pay back the loan and the interest on it, the amount you owe will be subtracted from the benefits when you die, or from the cash value if you stop paying premiums and take out the remaining cash value. You can also use your cash value to keep insurance protection for a limited time or to buy a reduced amount without having to pay more premiums. You also can use the cash value to increase your income in retirement or to help pay for needs such as a child's tuition without canceling the policy. However, to build up this cash value, you must pay higher premiums in the earlier years of the policy. Cash value life insurance may be one of several types; whole life, universal life and variable life are all types of cash value insurance.

Whole Life Insurance covers you for as long as you live if your premiums are paid. You generally pay the same amount in premiums for as long as you live. When you first take out the policy, premiums can be several times higher than you would pay initially for the same amount of term insurance. But they are smaller than the premiums you would eventually pay if you were to keep renewing a term policy until your later years.

Some whole life policies let you pay premiums for a shorter period such as 20 years, or until age 65. Premiums for these policies are higher since the premium payments are made during a shorter period.

Universal Life Insurance is a kind of flexible policy that lets you vary your premium payments. You can also adjust the face amount of your coverage. Increases may require proof that you qualify for the new death benefit. The premiums you pay (less expense charges) go into a policy account that earns interest. Charges are deducted from the account. If your yearly premium payment plus the interest your account earns is less than the charges, your account value will become lower. If it keeps dropping, eventually your coverage will end. To prevent that, you may need to start making premium payments, or increase your premium payments, or lower your death benefits. Even if there is enough in your account to pay the premiums, continuing to pay premiums yourself means that you build up more cash value.

Variable Life Insurance is a kind of insurance where the death benefits and cash values depend on the investment performance of one or more separate accounts, which may be invested in mutual funds or other investments allowed under the policy. Be sure to get the prospectus from the company when buying this kind of policy and STUDY IT CAREFULLY. You will have higher death benefits and cash value if the underlying investments do well. Your benefits and cash value will be lower or may disappear if the investments you chose didn't do as well as you expected. You may pay an extra premium for a guaranteed death benefit.

Life Insurance Illustrations

You may be thinking of buying a policy where cash values, death benefits, dividends or premiums may vary based on events or situations the company does not guarantee (such as interest rates). If so, you may get an illustration from the agent or company that helps explain how the policy works. The illustration will show how the benefits that are not guaranteed will change as interest rates and other factors change. The illustration will show you what the company guarantees. It will also show you what *could* happen in the future. Remember that nobody knows what will happen in the future. You should be ready to adjust your financial plans if the cash value doesn't increase as quickly as shown in the illustration. You will be asked to sign a statement that says you understand that some of the numbers in the illustration are not guaranteed.

Finding a Good Value in Life Insurance

After you have decided which kind of life insurance is best for you, compare similar policies from different companies to find which one is likely to give you the best value for your money. A simple comparison of the premiums is not enough. There are other things to consider. For example:

- Do premiums or benefits vary from year to year?
- How much do the benefits build up in the policy?
- What part of the premiums or benefits is not guaranteed?
- What is the effect of interest on money paid and received at different times on the policy?

Once you have decided which type of policy to buy, you can use a cost comparison index to help you compare similar policies. Life insurance agents or companies can give you information about several different kinds of indexes that each work a little differently. One type helps you compare the costs between two policies if you give up the policy and take out the cash value. Another helps you compare your costs if you don't give up your policy before its coverage ends. Some help you decide what kind of questions to ask the agent about the numbers used in an illustration. Each index is useful in some ways, but they all have shortcomings. Ask your agent which will be most helpful to you. Regardless of which index you use, compare index numbers only for similar policies - those that offer basically the same benefits, with premiums payable for the same length of time.

Remember that no one company offers the lowest cost at all ages for all kinds and amounts of insurance. You should also consider other factors:

- How quickly does the cash value grow? Some policies have low cash values in the early years that build quickly later on. Other policies have a more level cash value build-up. A year-by-year display of values and benefits can be very helpful. (The agent or company will give you a policy summary or an illustration that will show benefits and premiums for selected years.)
- Are there special policy features that particularly suit your needs?
- How are nonguaranteed values calculated? For example, interest rates are important in determining policy returns. In some companies increases reflect the average interest earnings on all of that company's policies regardless of when issued. In others, the return for policies issued in a recent year, or a group of years, reflects the interest earnings on that group of policies; in this case, amounts paid are likely to change more rapidly when interest rates change.

Addendum to Life Insurance Buyer's Guide

After you have decided which kind a life insurance fits your needs, look for a good buy. Your chances of finding a good buy are better if you use two types of index numbers that have been developed to aid in shopping for life insurance. One is called the "Surrender Cost Index" and the other is the "Net Payment Cost Index." It will be worth your time to try to understand how these indexes are used, but in any event, use them only for comparing the relative costs of similar policies. LOOK FOR POLICIES WITH LOW COST INDEX NUMBERS.

What Is Cost?

"Cost" is the difference between what you pay and what you get back. If you pay a premium for life insurance and get nothing back, your cost for the death protection is the premium. If you pay a premium and get something back later on, such as a cash value, your cost is smaller than the premium.

The cost of some policies can also be reduced by dividends; these are called "participating" policies. Companies may tell you what their current dividends are, but the size of future dividends is unknown today and cannot be guaranteed. Dividends actually paid are set each year by the company.

Some policies do not pay dividends. These are called "guaranteed cost" or "nonparticipating" policies. Every feature of a guaranteed cost policy is fixed so that you know in advance what your future cost will be.

The premiums and cash values of a participating policy are guaranteed, but the dividends are not. Premiums for participating policies are typically higher than for guaranteed cost policies, but the cost to you may be higher or lower, depending on the dividends actually paid.

What Are Cost Indexes?

In order to compare the cost of policies, you need to look at:

1. Premiums
2. Cash Values
3. Dividends

Cost indexes use one or more of these factors to give you a convenient way to compare relative costs of similar policies. When you compare costs, an adjustment must be made to take into account that money is paid and received at different times. It is not enough to just add up the premiums you will pay and to subtract the cash values and dividends you expect to get back. These indexes take care of the arithmetic for you. Instead of having to add, subtract, multiply and divide many numbers yourself, you just compare the index numbers which you can get from life insurance agents and companies:

1. LIFE INSURANCE SURRENDER COST INDEX. This index is useful if you consider the level of the cash values to be of primary importance to you. It helps you compare costs if at some future point in time, such as 10 or 20 years, you were to surrender the policy and take its cash value.
2. LIFE INSURANCE NET PAYMENT COST INDEX. This index is useful if your main concern is the benefits that are to be paid at your death and if the level of cash values is of secondary importance to you. It helps you compare costs at some future point in time, such as 10 or 20 years, if you continue paying premiums on your policy and do not take its cash value.

There is another number called the Equivalent Level Annual Dividend. It shows the part dividends play in determining the cost index of a participating policy. Adding a policy's

Equivalent Level Annual Dividend to its cost index allows you to compare total costs or similar policies before deducting dividends. However, if you make any cost comparisons of a participating policy with a nonparticipating policy, remember that the total cost of the participating policy will be reduced by dividends, but the cost of the nonparticipating policy will not change.

How do I Use Cost Indexes?

The most important thing to remember when using cost indexes is that a policy with a small index number is generally a better buy than a comparable policy with a larger index number. The following rules are also important:

(1) Cost comparisons should only be made between similar plans of life insurance. Similar plans are those which provide essentially the same basic benefits and require premium payments for approximately the same period of time. The closer policies are to being identical, the more reliable the cost comparison will be.

(2) Compare index numbers only for the kind of policy, for your age and for the amount you intend to buy. Since no one company offers the lowest cost for all types of insurance at all ages and for all amounts of insurance, it is important that you get the indexes for all actual policy, age and amount which you intend to buy. Just because a "shopper's guide" tells you that one company's policy is a good buy for a particular age and amount, you should not assume that all of that company's policies are equally good buys.

(3) Small differences in index numbers could be offset by other policy features, or differences in the quality of service you may expect from the company or its agent. Therefore, when you find small differences in cost indexes, your choice should be based on something other than cost.

(4) In any event, you will need other information on which to base your purchase decision. Be sure you can afford the premiums, and that you understand its cash values, dividends and death benefits. You should also make a judgment on how well the life insurance company or agent will provide service in the future, to you as a policyholder.

(5) These life insurance cost indexes apply to new policies and should not be used to determine whether you should drop a policy you have already owned for awhile, in favor of a new one. If such a replacement is suggested, you should ask for information from the company which issued the old policy before you take action.