

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

New York, New York

Administrative Office: P.O. Box 30066, Tampa, FL 33630-3066

Phone: 877-672-1648 Fax: 877-672-1650

GROUP POLICY NO. _____ NAME OF EMPLOYER, ASSOCIATION OR UNION _____

EMPLOYEE'S NAME _____ SOCIAL SECURITY NO. _____
(LAST, FIRST, MI)

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED

NUMBER OF ELIGIBLE DEPENDENT CHILDREN: _____

I was given the opportunity to enroll in this plan or group insurance offered by my employer/association and insured by The United States Life Insurance Company in the City of New York. I am refusing: **(Note: Benefits provided on a non-contributory basis cannot be refused)**

<input type="checkbox"/> All coverage Offered	Major Medical Refusal:	Dental Refusal:	Prescription Drug Refusal:
<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Employee & Dependents	<input type="checkbox"/> Employee & Dependents
<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse	<input type="checkbox"/> Spouse
<input type="checkbox"/> Other: <input type="checkbox"/> Vision	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)	<input type="checkbox"/> Child(ren)

ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD MAJOR MEDICAL OR DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? Yes No

If yes: Policyholder's Name _____ Carrier _____
(Your dependent(s) may be insured by this Plan although they are covered elsewhere.)

I understand that I must furnish, at my expense, evidence of insurability satisfactory to The United States Life Insurance Company in the City of New York if I later wish to enroll for any of the coverage refused, except Dental, which may be subject to reduced benefits.

Signature of Employee _____ Date _____

Signature of Witness _____ Date _____