AIG

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

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

OLA

Applicant

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

_____ _____
Mailing Address *Home Phone*

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

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

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

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

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

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

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

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

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

1. Name and Address of Applicant's Physician _____

2. Height _____*Ft* _____*In* Weight _____ *Lbs.*

		Yes	No
3.	Have you ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood, or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder?	☐	☐
4.	Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	☐	☐
5.	Are you now taking prescription medication or receiving medical attention?	☐	☐

For "Yes" answers to questions 3-5 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper signed and dated. If additional information is attached, check this box. ☐

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

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

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

2. _____% _____ _____

3. _____% _____ _____

EXISTING AND PENDING INSURANCE

Life insurance in force and/or pending on proposed insured's life, including business insurance: (If none, check "None".) ☐ None

Name of Company	Type of Coverage	Life Amount	Accidental Death	Year Issued	Do you plan to replace this coverage?
					☐ Yes ☐ No
					☐ Yes ☐ No

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc. or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time by giving written notice to the Company. I agree that such revocation will not affect any action that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. (For state specific variations, see below.)*

SIGN & DATE

Applicant's Signature X_____ Date _____

G-19430 Group Policy No. G-610,477 6/17 AG-11944

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

SIGN & DATE

Applicant's Signature X_____ Date _____

M&A 6/2017 - GEN

Important Notice: For residents of Alabama: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof. **For residents of Alaska, Arizona, Arkansas, California, Connecticut, Delaware, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Louisiana, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, North Carolina, North Dakota, Puerto Rico, Rhode Island, South Carolina, South Dakota, Texas, Utah, Vermont, West Virginia, Wisconsin, and Wyoming:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **For residents of District of Columbia:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **For residents of Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime. **For residents of Maine, Tennessee, and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **For residents of Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. **For residents of New York:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **For residents of Oklahoma:** Warning: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.**For residents of Oregon:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud and may be subject to fines and confinement in prison. **For residents of Pennsylvania:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties. **For residents of Virginia:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against any insurance company, submits an application or files a claim containing a false or deceptive statement may be in violation of state law.

Applicant signs two areas indicated above and mails this request to the Administrator:

Meyer and Associates ◆ 18 Washington Avenue ◆ Chatham, NJ 07928 ◆ 800-635-7801 Weekdays 8:30AM-6:00PM ET ◆ www.AlumLifeTo95.com