

APPLICATION FOR GROUP TERM LIFE INSURANCE

The United States Life Insurance Company in the City of New York, A subsidiary of American International Group, Inc. (AIG)
For members of the Arkansas Bar Association and their spouses

PLEASE REPLY TODAY! *It takes just minutes to give you and your family this solid life insurance protection.*

Simply complete and return to
Regions Insurance, Inc., 1500 Riverfront Dr., Little Rock, AR 72202
If you have any questions, call 1-888-272-6656.

STEP 1 APPLICANT information Please print or type

Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address			
City	State	ZIP	
Age	Date of Birth / /	State of Birth	Height Ft. In. Weight Lbs.
Home Phone ()		Work Phone ()	
Social Security Number		E-mail Address	
Beneficiary		Relationship to you	

SPOUSE information (If applying) Please print or type

Name		Sex <input type="checkbox"/> Male <input type="checkbox"/> Female	
Street Address			
City	State	ZIP	
Age	Date of Birth / /	State of Birth	Height Ft. In. Weight Lbs.
Home Phone ()		Work Phone ()	
Social Security Number		E-mail Address	
Beneficiary		Relationship to you	

(Unless otherwise requested, the member will be the beneficiary of any spouse insurance applied for.)

STEP 2 You can select coverage for you, your spouse and children

- Applicant Coverage Amount Desired: \$ _____ (\$50,000 to \$1,000,000, in increments of \$25,000)
 Optional AD&D Coverage: Amount \$ _____ (\$50,000 to \$1,000,000, in increments of \$25,000)
 Spouse Coverage Amount Desired: \$ _____ (\$50,000 to \$1,000,000, in increments of \$25,000)
 Optional AD&D Coverage Amount: \$ _____ (\$50,000 to \$1,000,000, in increments of \$25,000)
 Dependent Child Coverage*: \$1,000/child - age 15 days to less than 6 months, \$5,000/child - age 6 months or more

* Amount of dependent child(ren) coverage available may vary by state law and is subject to limits imposed by individual states.

Child's Name	Age	Date of Birth / /	State of Birth	Height Ft. In.	Weight Lbs.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Child's Name	Age	Date of Birth / /	State of Birth	Height Ft. In.	Weight Lbs.	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female

STEP 3 Select your preferred payment mode *(Send no money now – we'll send you a premium notice upon approval)*

I prefer to pay: Semi-annual Direct Bill Annual Direct Bill

STEP 4 Answer these three questions

APPLICANT (If applying)

1. YES NO
 2. YES NO
 3. YES NO

Please answer these health questions and provide details below to any "Yes" answers. If more space is needed, provide details on a separate sheet of paper. Sign and date.

- Have you ever had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in your urine, diabetes, cancer, tumors or ulcers?
- Have you, during the past five years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?
- Have you used tobacco or nicotine in any form during the past 12 months?

SPOUSE (If applying)

1. YES NO
 2. YES NO
 3. YES NO

If you answered "YES" to any part of questions 1 or 2, give details below.
Please check whether you've attached a separate piece of paper. YES NO

Question Number	Condition		
Date Occurred	Duration	Degree of Recovery	
Names & Addresses of Physicians, Hospitals or Clinics Consulted			

If you answered "YES" to any part of questions 1 or 2, give details below.
Please check whether you've attached a separate piece of paper. YES NO

Question Number	Condition		
Date Occurred	Duration	Degree of Recovery	
Names & Addresses of Physicians, Hospitals or Clinics Consulted			

STEP 5 Please read the following, then sign and date below to apply

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY: I hereby authorize any licensed physician, medical practitioner, hospital, clinic, or other medical or medically related facility, insurance company, the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that 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 transmission of such information, I authorize all said sources, except the Medical Information Bureau, to give such records or knowledge to any agency employed by United States Life to collect and transmit such information. I understand that this information will be used by United States Life solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand that this authorization will not be valid after 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 and with intent to defraud any insurance company or other person files a 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 may be a crime. (Fraud provisions vary by state).

<input checked="" type="checkbox"/> Applicant Signature	Date / /	<input checked="" type="checkbox"/> Spouse Signature (If applying)	Date / /
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G-19027-L

Group Policy No. G-610,101

AG6093 (05/08)

06673611-1643 R05/08

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE (Retain for your records)

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to MIB, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. 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 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 (TTY 866-346-3642). 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

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