

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

A member company of American International Group, Inc.

**FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER GROUP POLICY FORM G-19000.**

Policy Holder:		<b>Value Benefits of America</b>						
Applicant:	Date of Birth:	Place of Birth:	Age:	Sex:	Ht	Wt	Social Security Number:	
Home Address: (Include number & street, city, state and zip code)				Mailing or Billing Address (if other than Home Address)				
Home Phone:	Work Phone:	Email Address:			Occupation:			

**DEPENDENT COVERAGE: I wish to apply for coverage for my following dependents:**

First, Middle and Last Name	Date of Birth	Age	Sex	Ht	Wt	Social Security No.	Relationship

**BENEFITS BEING APPLIED FOR:**

	(check one)	<input type="checkbox"/> Classic	<input type="checkbox"/> Silver	<input type="checkbox"/> Gold	<input type="checkbox"/> Platinum
Daily Hospital Confinement Benefits.....	\$250	\$500	\$750	\$1,000	\$1,000
Daily Intensive Care/Coronary Care Unit Confinement Benefits.....	\$1,000	\$2,000	\$3,000	\$4,000	\$4,000
Maximum Emergency Accident Treatment Benefits.....	\$62.50	\$125	\$187.50	\$250	\$250
Maximum Ambulance Transportation Benefits.....	\$125	\$250	\$375	\$500	\$500
Maximum Surgical Benefits Per Schedule.....	\$5,000	\$10,000	\$15,000	\$20,000	\$20,000

**QUALIFYING MEDICAL QUESTIONS:**

- In the past 24 months, have you or your dependents, if applying for insurance, had chest pains, disease or disorder of the heart, liver, kidneys or lungs, high blood pressure, albumin or sugar in the urine, diabetes, cancer, tumors or ulcers?.....  Yes  No
- Have you or your dependents, if applying for insurance, during the past 24 months, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution? .....  Yes  No
- Please give details to any "Yes" answers, specifying person, condition, dates, treatment received and/or recommended and current status: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_ (Attach additional signed & dated sheet if more room needed.)

**OTHER COVERAGE:**

- Are you now covered under, or awaiting issuance of, any accident or health insurance?.....  Yes  No  
 If "Yes", please list ALL accident and health coverages now in force or pending issuance (include coverage name and form number (if known), coverage type and benefit amount, and company name: \_\_\_\_\_  
 \_\_\_\_\_ (Attach additional signed & dated sheet if more room needed)  
**Please note: This coverage is not meant to be a replacement for comprehensive benefits under a health insurance plan or health maintenance organization (HMO) plan and this is not a comprehensive plan.**
- Will any existing coverage be replaced by the coverage you are applying for?.....  Yes  No  
 If "Yes", please give company name, type of coverage and policy number: \_\_\_\_\_

**PREMIUM:**

Insurance Premium \$ \_\_\_\_\_ plus \$15.00 Monthly Administrative Fee  
 Payment Mode:  Monthly Bank Draft  Monthly List Bill (2 or more)  Semi-Annual  Annual

**I HEREBY APPLY** for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the questions contained in this application are true and complete.

**I UNDERSTAND AND AGREE** that: (1) this coverage will be granted solely and entirely in reliance upon my answers to the questions contained in this application; (2) no coverage will exist until a Certificate of Coverage is issued, and will be in force only as of the Certificate Effective Date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a condition for which medical advice or treatment was received from a doctor during a twelve month period prior to the date of this application, will not be covered until my coverage has been in force for 12 months.

**WARNING:** Any person who, 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 may subject such person to criminal and civil penalties.

Dated at \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20 \_\_\_\_\_

Signature of Applicant: **X** \_\_\_\_\_ date signed \_\_\_\_\_

I hereby certify that I personally saw the applicant and truly and accurately recorded the above information.

Agent's Signature: **X** \_\_\_\_\_ date signed \_\_\_\_\_

Print Agent's Name David Neighbors Agent's Number(s) 94835

