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Pennsylvania Veterinary Medical Association

American General Assurance Company

A member company of American International Group, Inc.

APPLICATION FOR GROUP DISABILITY INCOME INSURANCE

For members of the Pennsylvania Veterinary Medical Association

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.)

MEMBER DATA *Please print or type all information requested.*

Your Full Name ______________________ ☐ Male ☐ Female

Birth Date ____/____/____ Birth Place ______________________

Height ____ ft. ____ in. Weight ____ lbs. Social Security No. ______________________

Billing Address ______________________
Street

____
City *State* *ZIP*

( ) ______________ ( ) ______________
Work Phone Number *Home Phone Number*

____
E-mail Address

PERSONAL DATA

Employer Name ______________________
Company Name

Employer Address ______________________ ( ) ______________
Street *Phone Number*

____
City *State* *ZIP*

Occupation (Specialty) ______________ Annual Salary $ ______________

Are you now working at least 30 hours per week with your present employer? ☐ Yes ☐ No

INSURANCE PLAN DESIRED

Waiting period (in days)

☐ 30 ☐ 60 ☐ 90 ☐ 180 ☐ 365

Monthly benefit desired

$ ______________

(in $100 increments)

The maximum benefit is $10,000 per month if under age 50; $6,000 per month if age 50-54; and $3,000 per month if age 55-59.

Maximum benefit period

To age 65

Premium to be paid

☐ Annually

☐ Semi-annually

$1,000 accidental death and dismemberment benefit

(included in plan)

____

Name of beneficiary

____

Relationship to you

Optional Riders

(Check all desired)

☐ Residual Benefits

☐ Cost of Living Adjustment

☐ Guaranteed Purchase Option *(available if under age 40)*

☐ Recovery Benefit

INSURABILITY QUESTIONS

Name, address and telephone number of your physician: ______________________

______________________ Date last consulted: ______________

What treatment or medication was prescribed:

Answer each question by checking the "Yes" or "No" box, as it applies.

	Yes	No
1. DURING THE PAST FIVE YEARS, HAVE YOU EVER HAD OR BEEN TREATED FOR: (Circle specific disorders experienced)		
a. Disease or disorder of the heart or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke?	☐	☐
b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury?	☐	☐
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?	☐	☐
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears?	☐	☐
e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder?	☐	☐
f. Diabetes or elevated glucose? Sugar, albumin or pus in urine? Thyroid or other glandular disorder?	☐	☐
g. Duodenal or stomach ulcer, or other disorder of stomach, liver (including hepatitis), gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine?	☐	☐
h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection?	☐	☐
i. Menstrual, uterine or ovarian disorder? Disorder of the breast?	☐	☐
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose?	☐	☐
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect?	☐	☐
l. Mental or emotional problem requiring help of a physician or psychologist?	☐	☐
m. A surgical operation? A surgical operation advised but not performed?	☐	☐
n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system?	☐	☐
o. Alcohol or drug abuse?	☐	☐
2. Have you consulted any hospital, institution, physician or practitioner within the past five years for any disease, disorder, injury or other routine visit (including pregnancy) other than stated above? (This includes any self-diagnosis, treatment or medication)	☐	☐

PLEASE COMPLETE THE REVERSE SIDE OF THIS APPLICATION →

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

Information regarding your insurability will be treated as confidential. American General Assurance Company 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.

American General Assurance 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.

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CONTINUED FROM FRONT SIDE OF APPLICATION

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Please print or type all information

3. Do you take prescription or non-prescription drugs, use hormone replacement therapy or medications or any herbal remedies? .... Yes ☐ No ☐

If "Yes" to any part of questions 1 a-o, 2 or 3, please explain fully in the chart below.
Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question		Date		Degree of	Names, Addresses and Phone Numbers of Physicians

What other Disability Insurance do you now carry or have an application pending for? (Give full details)

Insurance Company	Amount of Monthly Benefit	How long are benefits payable? Accident	Sickness

4. Are you replacing any current disability income coverage you have? ☐ Yes ☐ No
   (If "Yes", provide name of Insurance Company and Policy Number):________________________

5. Have you ever applied for or been issued insurance that has been declined, rated up, modified, ☐ Yes ☐ No
   or had its renewal refused? (If "Yes", provide name of Insurance Company and details):____________________

DECLARATION OF MEMBER GIVING STATEMENT OF INSURABILITY

1. To the best of my knowledge and belief, all statements made on this application are true and complete.
2. I understand that my application for insurance will be accepted or declined on the basis of these statements.

AUTHORIZATION

I authorize the sources stated on the MIB Disclosure to give to American General Assurance Company, or any consumer reporting agency acting on its behalf, information about me. Such information will pertain to my employment, other insurance coverage, and medical care, advice, treatment or supplies for any physical or mental condition. Authorized sources are: any physician or medical professional, any hospital, clinic or other medical care institution; any insurer, the Medical Information Bureau; any consumer reporting agency; any employer. I understand that this information will be used by American General Assurance Company 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 that American General Assurance Company has taken in reliance on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier. I know that I have the right to receive a copy of this authorization if I request one. I agree that a photocopy of this authorization is as valid as the original.

________________ ________________________________
(Date Signed) *(Signature of Proposed Insured)*

SIGNATURE OF AGENT: ________________________________

Form AG-43012 DI-PVMA AG5877 (02/08) Group Policy No. G-300,156 00306101-1225 R02/08

Just complete this application and return it today!

Mail your application to: USI AFFINITY, Eastern Pennsylvania – One International Plaza, Suite 400, Philadelphia, PA 19113, 1-800/265-2876, www.usiaffinity.com
Western Pennsylvania – The Stealth Technology Center, 333 Technology Drive, Suite 255, Canonsburg, PA 15317, 1-800/926-5287, 1-800/327-1550

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.