AIG AMERICAN GENERAL

For H.O. use only: Group Number: _____
Class _____ Division _____

DEPENDENTS INFORMATION AND BENEFICIARY DESIGNATION FORM

The United States Life Insurance Company in the City of New York
New York, New York
A member company of American International Group, Inc.
Administrative Office: 3600 Route 66, P.O. Box 1591, MSN 3D, Neptune, NJ 07754-1591

This form may be used only in conjunction with a Group Enrollment Census form for initial enrollment. This form is not an employee application and should not be used for the addition of new employees.

Employee Information — To be completed by each employee

Employee's Name: _____
LAST *FIRST* *MI*

Name of Employer: _____

Group #: _____ Social Security # _____

Dependent Information for Life Coverage

To insure your dependents, please complete the following: (Employee is the beneficiary for all insured dependents)

Spouse's Name _____ Birthdate _____/ _____/ _____
LAST *FIRST* *MI*

Social Security No. _____ ☐ Male ☐ Female

Applicant's Signature: _____ Date: _____

Beneficiary Designation

If applying for Life Coverage, enter the Beneficiary information.

Beneficiary Name: _____ Relationship _____
LAST *FIRST* *MI*

Contingent Beneficiary: _____ Relationship _____
LAST *FIRST* *MI*

Applicant's Signature: _____ Date: _____

REFUSAL OF COVERAGE

Employee Information (Please Print)

Employee's Name: _____
LAST *FIRST* *MI*

Name of Employer: _____

I was given the opportunity to enroll in this plan for group insurance offered by my employer and insured by United States Life. I am refusing:

	Dental	**Vision**
☐ LTD	☐ Employee & Dependents	☐ Employee & Dependents
☐ STD	☐ Spouse	☐ Spouse
☐ Life/AD&D	☐ Child(ren)	☐ Child(ren)
☐ Dependent Life	☐ All Dependents	☐ All Dependents
☐ Supplemental Life/AD&D		
☐ All Coverages Offered		

MUST ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD COVERAGE:
Are you or your dependents now covered by another group plan? ☐ YES ☐ NO
(Your dependent(s) may be insured by this plan even if they are insured elsewhere.)
If Yes: Policyholder's Name _____ Carrier _____

I understand that if I am refusing insurance because I am insured under another applicable insurance plan, I may be added to this plan under the same terms and conditions with respect to pre-existing conditions and their limitations as if I enrolled when initially eligible. I understand that I must request enrollment within 31 days following the termination of other applicable insurance plan. If Dental coverage is refused, I understand that my benefits may be reduced if later wish to enroll for this coverage. I must furnish, at my expense, evidence of insurability satisfactory to United States Life if I wish to enroll in any other coverage that is now being refused.

____/____/____ _____
DATE OF REFUSAL APPLICANT'S SIGNATURE