

# Application for Group Long Term Disability Income Insurance

The United States Life Insurance Company in the City of New York,  
A subsidiary of American International Group, Inc. (AIG)



## To Apply:

Simply complete and return to:

**ADMINISTRATOR**  
APTA GROUP INSURANCE PROGRAM  
P.O. Box 14464  
Des Moines, IA 50306-9468

## QUESTIONS?

Call: 1-800-543-8819  
E-Mail: APTA@marshpm.com

Our hearing-impaired or voice-impaired members may call the  
Relay Line at 1-800-855-2881.

Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

**Please print in INK. Do not erase or use correction fluid. To correct, cross out, and initial and date changes. Answer all questions before signing.**

### Step 1: Membership in APTA is Required for Participation in this Plan

Are you now a member of the American Physical Therapy Association (APTA)?  Yes  No

### Step 2: Select Coverage for Both You and Your Spouse/Domestic Partner

Member monthly benefit:  \$1,000  \$5,000  \$10,000  Other \$ \_\_\_\_\_

Spouse/Domestic Partner monthly benefit:  \$1,000  \$5,000  \$10,000  Other \$ \_\_\_\_\_

Optional benefits (choose one):  COLA  Catastrophic Disability

Waiting period (choose one):  60-day  90-day  180-day

Note: Member coverage must be in force to request dependent spouse/domestic partner coverage. Dependent spouse/domestic partner monthly benefit amount can not exceed member's monthly benefit amount.

### Step 3: Complete the Information Below

#### Member Information

Name, if different from above \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_ Height \_\_\_\_ft. \_\_\_\_in Weight \_\_\_\_lbs

Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Fax Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Occupation/Specialty \_\_\_\_\_

Net Annual Earned Income (After Business Expenses) \_\_\_\_\_

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

#### Spouse/Domestic Partner Information

Name, if different from above \_\_\_\_\_  Male  Female

Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Place of Birth \_\_\_\_\_ Height \_\_\_\_ft. \_\_\_\_in Weight \_\_\_\_lbs

Home Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Work Phone \_\_\_\_ - \_\_\_\_ - \_\_\_\_ Fax Number \_\_\_\_ - \_\_\_\_ - \_\_\_\_

Occupation/Specialty \_\_\_\_\_

Net Annual Earned Income (After Business Expenses) \_\_\_\_\_

Name of Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

**Step 4: Select Your Preferred Payment Mode (Choose only one)**  
**(Send no money now – we'll send you a premium notice upon approval)**

**Option 1:** I prefer:  Quarterly Direct Bill  Semiannual Direct Bill  Annual Direct Bill

If a billing option is not selected, you will be billed quarterly.

**Option 2: Electronic Funds Transfer (EFT):** I request and authorize the APTA Group Insurance Program to make monthly withdrawals against the account specified on the attached voided check and for such bank to process these withdrawals, for the purpose of collecting premium contributions due under this Group Long Term Disability Insurance Plan. (Enclose a VOIDED check and sign below.)

**X**

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

**X**

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

**Step 5: Health Questions**

	Member		Spouse/ Domestic Partner	
	Yes	No	Yes	No
1. Are you now, and have you been for the last 20 days, performing all duties of your occupation for 20 or more hours per week at your place of business? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. 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? ...	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Disease or disorder of the rectum or anus? Varicose veins or other vascular disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Diabetes or elevated glucose? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Prostrate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorder? Urinary infection? ..	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Menstrual, uterine or ovarian disorder? Disorder of the breast? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of the lung or nose? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Mental or emotional problem requiring help of a physician or psychologist? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. A surgical operation? A surgical operation advised but not performed? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 5 years, other than stated above? (This includes any self-diagnosis, treatment or medication) .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

If you answered "yes" to any part of question 2 a–m and 3, give details below. Use a separate sheet of paper, sign and date, if more space is needed for answers.

Please check whether you've attached a separate piece of paper.  Yes  No

Question Number	Member or Spouse/ Domestic Partner	Condition	Date Occurred	Duration	Degree of Recovery	Name and Addresses of Physicians, Hospital or Clinics Consulted

**Step 6: Please Answer the Following**

	Member		Spouse/ Domestic Partner	
	Yes	No	Yes	No
1. Do you have any disability insurance in force or pending? (If yes, please indicate companies and amounts.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Will this coverage applied for replace any insurance now in force? (If yes, please indicate which insurance.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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**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 (MIB), 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 I 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 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.)

**Member Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Spouse/Domestic Partner Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(if applying)

G-19025

Policy No.G-610,298  
AG-6408

Complete and return this application in the enclosed envelope or mail to:  
APTA Group Insurance Program  
P.O. Box 14464  
Des Moines, IA 50306-9468

# Group Long Term Disability Income Insurance Fact Sheet



## Insure Your Income – Your Most Valuable Asset

Your most important asset is your ability to earn income. Even if you are young and healthy, a serious injury or sickness could put you out of work for months or even years – jeopardizing your livelihood. A reliable source of disability income protection is this Group Long Term Disability Income Insurance Plan exclusively for APTA members.

Even if you have some disability insurance through your employer, it may not be enough. Many employers provide only a short-term salary continuation plan or short-term disability income plan. This Plan can be used to complement benefits provided by your employer plan or as primary insurance protection if you do not have other disability income coverage.

This Plan is designed to provide you with a regular monthly income when you are totally disabled and unable to work as the result of an injury or sickness.

## Who Is Eligible?

Members in good standing of the American Physical Therapy Association under age 65, residing in the United States and actively working full-time (defined as more than 20 hours per week) are eligible to apply for coverage.

You may request coverage for your lawful spouse or domestic partner, who also is under age 65, residing in the United States and working full-time.

## Pays If You Can't Work as a Physical Therapist –

As a physical therapist, your job is highly specialized. You'll receive insurance protection in your own occupation as a physical therapist for the first 60 months during which disability benefits are payable, and the total disability wholly and continuously prevents you from performing the material and substantial duties of your occupation. Thereafter, you'll continue to receive insurance protection if the total disability wholly and continuously prevents you from performing the material and substantial duties of any occupation. The total disability requires the regular care of a physician.

## How the Plan Works

### You Choose Your Monthly Benefit and Waiting Period

#### Choice of Monthly Benefit

You have a wide choice of Monthly Benefit Options – from \$100 to \$10,000 per month in \$100 increments. The option you choose, together with any other disability income insurance you may have, cannot exceed 66 2/3% of your pre-disability monthly earnings. (See chart below for a guideline of benefits you may qualify for.)

If you are self-employed, pre-disability earning means your average net monthly income (gross revenues less business expenses) from the personal practice of your occupation or personal conduct of your main business averaged over the most recent 12 month period or your period of employment, whichever period is less. For all other members, pre-disability earnings means your average monthly income received for the 12 month period just prior to the date of disability. Pre-disability earnings includes commissions averaged over the lesser of the most recent 12 month period or your period of employment. It also includes bonuses, fees and overtime pay.

#### Program Guidelines

If your Annual Income is:	Sample Monthly Benefit Amounts:
\$25,000	\$1,400
\$50,000	\$2,700
\$100,000	\$5,600
\$150,000	\$8,300
\$180,000	\$10,000

#### Choice of Waiting Period

You have a choice of three waiting periods before benefit payment begin: 60, 90, or 180 days. A Waiting Period is the number of consecutive days at the onset of a continuous period of disability during which you must be totally disabled, for which no benefits are payable and which must elapse before benefits start. To satisfy the waiting period, you must be continuously totally disabled by the same disability. If you have an employer-provided disability plan, you should choose one that will provide benefits when your employer-provided benefits plan runs out. Coverage with a longer waiting period is less expensive.

## Plan Features

### Waiver of Premium

If you become totally disabled following the waiting period and while covered under the policy, any further premiums becoming due for your coverage will be waived as long as benefits are payable for the disability. When benefits for that disability are no longer payable, you may continue coverage by resuming payment of premium provided you are still eligible for the coverage and your insurance would not then be ceasing under any termination provision (as described under *When Coverage Ends*).

### Partial Disability Benefit

While you are recovering from a Total Disability, you may be eligible to receive a partial disability benefit even though you return to work. If you return to work immediately following a period of Total Disability for which benefits were payable, you may continue to receive a partial monthly disability benefit until the earlier of the maximum benefit period payable for Total Disability, or when you are able to earn 80% of your pre-disability earnings.

### Benefits for Recurring Disability

Successive periods of disability which are due to the same or related causes will be considered a single period of disability unless separated by return to active work for six continuous months or more.

### Rehabilitation Services

The costs of a vocational rehabilitation program to assist in returning to gainful occupation, approved by the insurance company in advance, could be paid after the onset of disability. Participation is voluntary and benefits will not be reduced due to participation in the program.

### Transplant Benefit

If you undergo one of the following surgical procedures to donate an organ for transplant (kidney, liver, lung, skin or bone marrow), and as a result, become totally or partially disabled, you will be considered to be disabled as a result of sickness. United States Life will waive the waiting period that would apply under the Total Disability Benefit.

However, such disability will have a maximum benefit period of 12 months. This benefit will be payable only once in your lifetime.

### Survivor Income Continuation Benefit

If you die – from any cause – while receiving benefits for Total Disability, and the disability has continued for 12 continuous months, a death benefit equal to three times the Monthly Benefit in force on the date of your death will be paid to the first of the following survivors: your beneficiary; if you have no surviving beneficiary, your spouse; if you have no surviving beneficiary or spouse, in equal shares to your child(ren) who were claimed as dependents on your federal income tax return for the last tax year prior to your death; or if there is no survivor in a category stated above, your estate.

### Tax-Free Benefits

Under current tax laws, if you pay your own disability premiums, your benefits are tax-free. If you own your own business, you may be able to claim your premiums as a business deduction; however, benefits would then be taxed.

Please consult with your tax advisor for more details.

### Deductible Sources Of Income

Benefits payable as the result of your total disability will be reduced by deductible sources of income to the extent that your total disability monthly benefit amount, when added to deductible sources of income, cannot exceed 66 2/3% of your pre-disability monthly earnings.

### Pre-Existing Conditions

Pre-Existing Conditions means an injury or sickness for which you incurred charges, received medical treatment, consulted a physician, or took prescribed drugs within 12 months before you became insured. If total disability is due to a pre-existing condition that begins within 24 months of the date you become insured, no benefits will be paid unless you have not incurred charges, received medical treatment, consulted a physician, or taken prescribed drugs for such a condition, or any complication of it, for 12 continuous months, while insured. If total disability is due to a pre-existing condition and that more than 24 months after the date you become insured, benefits will be paid as they accrue.

### When Coverage Begins

Your insurance will take effect on the date your application is approved by United States Life provided the initial premium payment is paid in a timely manner and any person to be insured is actively at work on the date insurance is to take effect. If not, such insurance will take effect on the day you resume such work.

Acceptance into this plan is subject to medical evidence of insurability as determined by United States Life. Depending on your age and the amount of coverage you request, a medical examination, medical tests or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

### Duration Of Benefits

Monthly benefits will be paid up to the maximum benefit periods. The duration of this period is based on your attained age when you become totally disabled. The benefit will end on the date you fail to give required proof of continuing total disability; your total disability ends; the maximum benefit period ends; or you die.

### When Coverage Ends

Once coverage is validly in force; it may be continued to the premium due date on or immediately after you reach age 70, unless; you retire or cease full-time work following a 60 day continuous period other than for reasons of disability, cease to be an APTA member, fail to pay premium contributions when due, you are no longer a resident of the United States

or the group plan is modified or terminated by the policyholder or United States Life Insurance Company to end insurance on the class of insureds to which you belong.

Total disability due to mental illness or substance abuse will reduce the maximum payment to two years during your lifetime unless you are confined to a hospital or other licensed institution for care and treatment for that disability.

## **Exclusions and Limitations**

The Plan will not pay a benefit for any loss or disability due to an act or accident of war or act of war, declared or undeclared whether civil or international, or due to any substantial armed conflict between organized forces of a military nature; due to suicide or intentionally self-inflicted injury; due to active participation in a riot; due to committing or attempting to commit a felony; due to your being engaged in an illegal occupation; due to pregnancy (except that complications of pregnancy are covered); while you are in the armed forces of any country or international authority for a period greater than 30 days (in such event the pro rata unearned premium shall be returned to you for any period of full-time active duty for more than 30 days provided you notify us within 12 months of entering the armed forces); or while incarcerated or under any house arrest that places restrictions on your movement outside of your home by a court of competent jurisdiction, including restrictions that are monitored by electronic or other means.

The Plan limits benefits for disabilities due to substance abuse, a mental, nervous or emotional disorder or any combination of these to a maximum of 24 monthly payments during your lifetime, unless hospitalized.

No benefits will be paid unless the disability occurs while you are insured under the Plan and you are under the regular care of a physician during the period of disability.

## Monthly Premium Chart

Cost is based on the Waiting Period and Monthly Benefit Option selected and on your age when coverage become effective. The cost increases on the premium due date on which or immediately after you reach a higher age bracket.

### Age 65 Benefit

\$1,000 Monthly Benefit			
<u>Member Age</u>	<u>60 Days</u>	<u>90 Days</u>	<u>180 Days</u>
Under 35	\$21.29	\$19.32	\$15.65
35-39	24.48	22.22	18.00
40-44	37.13	33.57	29.67
45-49	41.98	37.95	33.54
50-54	59.75	53.58	49.35
55-59	64.53	57.86	53.30
60-64	76.80	73.14	67.46
65-69	82.18	78.26	72.18

\$5,000 Monthly Benefit			
<u>Member Age</u>	<u>60 Days</u>	<u>90 Days</u>	<u>180 Days</u>
Under 35	\$106.45	\$96.60	\$78.25
35-39	122.40	111.10	90.00
40-44	185.65	167.85	148.35
45-49	209.90	189.75	167.70
50-54	298.75	267.90	246.75
55-59	363.60	289.30	266.50
60-64	384.00	365.70	337.30
65-69	410.90	391.30	360.90

\$10,000 Monthly Benefit			
<u>Member Age</u>	<u>60 Days</u>	<u>90 Days</u>	<u>180 Days</u>
Under 35	\$212.90	\$193.20	\$156.50
35-39	244.80	222.20	180.00
40-44	371.30	335.70	296.70
45-49	419.80	379.50	335.40
50-54	597.50	535.80	493.50
55-59	727.20	578.60	533.00
60-64	768.00	731.40	674.60
65-69	821.80	782.60	721.80

Please note: This rate chart illustrates monthly rates. Payment options are quarterly, semiannually or annually by direct bill, or monthly by bank draft. If you wish to request a Monthly Benefit Option (in \$100 units) other than those shown above, please contact Marsh for assistance at 1-800-543-8819. The minimum monthly benefit is \$500.

If total disability begins prior to age 63, benefits are payable to age 65. If total disability begins on or after age 63, but under age 70, benefits are payable for 2 years.

The premium contributions shown reflect the current rate and benefit structure. Benefits options and premiums may be changed by United States Life on any premium due date and any date on which benefits change. However, your rates may change only if they are changed for all others in the same class of insureds.

### Optional Benefits

United States Life will make a cost of living adjustment if: you are totally or residually disabled for 12 consecutive months; you are receiving benefits; your period of total or residual disability was caused by an injury that occurred, or a sickness that first manifested itself, after this benefit became effective; and your period of total or residual disability commenced prior to age 60. This adjustment is in addition to your monthly benefit. The increase will be the lesser of: 6%; or the annual percentage change in the Consumer Price Index (CPI-W) times the monthly benefit for total or residual disability then being received, but in no event less than 1%.

If you are disabled and meet 1 or more of the following requirements, certified by a doctor, you will receive a catastrophic disability benefit in addition to any other benefits payable under the group policy: you are continuously unable to perform 2 or more activities of daily living without stand-by help; you have a cognitive impairment, or you have a terminal illness.

#### COLA Adjustment

<u>Member Age</u>	<u>60 Days</u>	<u>90 Days</u>	<u>180 Days</u>
Under 35	\$0.050	\$0.045	\$0.037
35-39	0.058	0.052	0.042
40-44	0.087	0.079	0.070
45-49	0.099	0.089	0.079
50-54	0.140	0.126	0.116
55-59	0.152	0.136	0.125
60-64	0.180	0.172	0.159
65-69	0.193	0.184	0.170

#### Catastrophic Disability\*

<u>60 Days</u>	<u>90 Days</u>	<u>180 Days</u>
\$0.017	\$0.015	\$0.012
0.019	0.017	0.014
0.029	0.026	0.023
0.033	0.030	0.026
0.047	0.042	0.039
0.051	0.045	0.042
0.060	0.057	0.053
0.064	0.061	0.057

\*Rates are per \$100 of benefits. Multiply by 10 for \$1,000 benefit level; by 50 for \$5,000 benefit level; by 100 for \$10,000 benefit level.

## How To Apply

The Group Long Term Disability Income Insurance Plan is medically underwritten based on the information provided by you on the application. It is important that you complete the form truthfully and completely; failure to supply accurate information may invalidate coverage. Your application is subject to United States Life's approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the Plan.

1. Refer to the Plan description for benefits and premium costs as you fill out the application. Remember, only APTA members and spouses (as described under Who Is Eligible) may apply.
2. Be sure to include a voided check or deposit slip, as applicable, if you select the Electronic Funds Transfer (EFT) Option.
3. Mail the completed application with your voided check to:  
Administrator  
APTA Group Insurance Program  
P.O. Box 14464  
Des Moines, IA 50306-9468

If you have any questions about your eligibility or the features of this Plan, call a service representative toll-free at 1-800-543-8819, 7:30 am to 5:30 pm, CT, Monday through Friday.

### **30 DAY FREE LOOK**

There's no risk when you take advantage of your Disability Program benefit options.

You send no money with your application today. Then, as soon as your benefits are approved, you'll receive a Certificate of Insurance outlining the full details of your coverage. Look it over for a full 30 days.

If you're not fully satisfied, just mail back your certificate marked "Cancel." You'll owe nothing ... and your application will be cancelled – no questions asked.

## **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 the 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.

### **Administered by:**

## **MARSH**

Affinity Group Services  
a service of Seabury & Smith  
P.O. Box 14464  
Des Moines, IA 50306-9468

### **QUESTIONS?**

Call: 1-800-543-8819

E-Mail: [APTA@marshpm.com](mailto:APTA@marshpm.com)

Our hearing-impaired or voice-impaired members may call the Relay Line at 1-800-855-2881.

### **Underwritten by:**

The United States Life Insurance Company in the City of New York, a subsidiary of American International Group, Inc. (AIG)  
70 Pine Street  
New York, NY 10270

The underwriting risks, financial and contractual obligations and support functions associated with products issued by The United States Life Insurance Company in the City of New York (United States Life) are its responsibility. AIG does not underwrite any insurance policy referenced herein.

APTA and Marsh's Affinity Group Services are proud to offer you access to this high-quality, economical insurance plan. We remind members that there is no substitute for taking the time to be an educated consumer. Please read the Certificate of Insurance when it arrives and check to see how, if applicable, this plan will work with coverage you may already have. If you have questions or concerns, please call the program administrator at 1-800-543-8819.

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AG-6408