APPLICATION FOR GROUP TERM LIFE INSURANCE

To Apply:

Send this completed form with your premium check payable to:

ADMINISTRATOR
NSTA GROUP INSURANCE PROGRAM
P.O. Box 10374
Des Moines, IA 50306-8812

QUESTIONS?
1-800-503-9230
customerservice.service@mercer.com

Underwritten by
The United States Life Insurance Company
in the City of New York
(Herein called the Company)

1. Name of Association National Science Teachers Association

2. Member/Applicant's Name ______________________ Social Security #______________
First Middle Last

3. Member/Applicant's Address ____
Number Street City State Zip Code

4. Home Phone No. (_______)______________________ Work Phone No. (_______)______________________

5. Name and Address of Member/Applicant's Physician ____

6. Member/Applicant's Beneficiary ______________________ Relationship ______________

(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise your beneficiary will be your children, parents, siblings, or estate.)

7. ☐ Spouse ☐ Domestic Partner's* Name______________________ Social Security # ______________
First Middle Last

8. Spouse's Beneficiary ______________________ Relationship ______________

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

9. Name and Address of Spouse's Physician ____

10. Member/Applicant's Email Address ______________________ Spouse's Email Address ______________

11. Check Life Insurance plan(s) desired:

☐ Life Insurance for Member $ __________ (Amount) ☐ Life Insurance for Spouse $ __________ (Amount) ☐ Life Insurance for child(ren) $5,000

Up to $500,000 of coverage is available. Contact the Plan Administrator for more information and rates. Unmarried dependent children are eligible for $5,000 of coverage. One economical premium covers all eligible dependent children (subject to state variations), no matter how many are being covered.

12. I wish to Pay: ☐ Semiannually ☐ Quarterly ☐ Automatic Monthly Check Withdrawal
(If you select Automatic Monthly Check Withdrawal, please complete Automatic Check Withdrawal Request)

13. Complete the following for the applicant/member, spouse and children** for whom coverage is requested.

Insured	Name	Age	Date of Birth (MM/DD/YR)	Place of Birth	Height Ft. In.	Weight Lbs.	Sex M F
Member					ft. in.	lbs	
Spouse					ft. in.	lbs	
Child					ft. in.	lbs	
Child					ft. in.	lbs	
Child					ft. in.	lbs	

G-19430 ME

Group Policy No. G-201,230 10/14
AG-10862

14332/15228/ 1018/51857

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NSTA National Science Teachers Association

Please answer these brief questions.

	Member	Spouse
1. Has the applicant/member or spouse, if applying, ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor (EXCEPT FOR HIV)?	❑ Yes ❑ No	❑ Yes ❑ No
2. Has the applicant/member or spouse, if applying, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above (EXCEPT FOR HIV)?	❑ Yes ❑ No	❑ Yes ❑ No
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	❑ Yes ❑ No	❑ Yes ❑ No

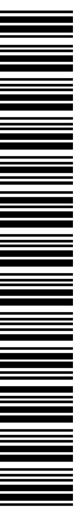
For "Yes" answers to questions 1-4 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated.

If additional information is attached, check "Yes" in the box at the right ❑ Yes ❑ No

Question #	Member	Spouse	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

EXISTING AND PENDING INSURANCE SECTION Life Insurance in Force and/or Pending on Proposed Insured's Life, including Business Insurance: (If none, check "None".) ❑ None

Please Check		Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?	
Member	Spouse					Yes	No



National Science Teachers Association

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give to The United States Life Insurance Company in the City of New York or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. To facilitate the rapid submission of such information, I authorize all said sources, except the MIB Medical Information Bureau, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 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. I understand that failure to sign this authorization may impair the ability of the Company to evaluate claims and process this application and may be a basis for denying this application or claim for benefits.

*Wherever the term spouse appears will read as Domestic Partner throughout the application.

**Dependent Child must be unmarried, up to 23 years of age if a full-time student (subject to state variations). All dependents must be dependent in accordance with IRS guidelines.

Important Notice: *It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.*

Date __________________ **Member/Applicant's Signature** ____

Date __________________ **Spouse/Domestic Partner's Signature** ____________________________________

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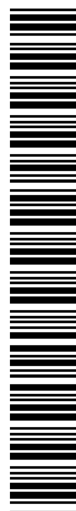

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These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

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, Inc., formerly known as Medical Information Bureau, 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 about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the 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 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

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.

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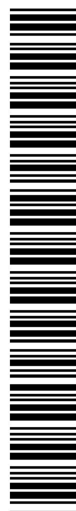

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AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #: ____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: ____ **Date:**____________________________

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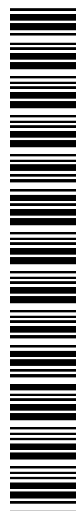

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Domestic Partnership Declaration

Name of Applicant ____

Name of Domestic Partner ____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.

2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).

3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):

- ❏ Common ownership of a motor vehicle.
- ❏ Joint bank or credit accounts.
- ❏ Assignment of durable power of attorney in favor of one another.
- ❏ Common ownership of real estate or common leasehold interest in property.
- ❏ Joint ownership or holding of stocks, bonds or other investments.
- ❏ Execution of will naming each other as executor and/or beneficiary.
- ❏ Designation as beneficiary under the other's retirement or pension benefits account.

4. That the undersigned member and domestic partner (check one):

- ❏ have filed a domestic partner declaration with the (City/Council/Borough) of______________ and that such domestic partner declaration remains in effect (attach copy of declaration).
- ❏ do not reside in a jurisdiction that provides for the registration of domestic partnership declarations.

5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.

6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.

7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability that would prevent them from making this affidavit.

8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.

9. That the undersigned member and domestic partner are not related by blood in any degree that would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature______________________________ **Date**______________

Soc. Sec. No.____

Domestic Partner's Signature______________________________ **Date**______________

Soc. Sec. No.____

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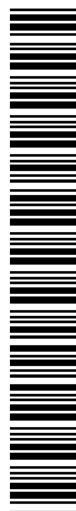

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National Science Teachers Association

Group Term Life Insurance Plan

FOR NSTA MEMBERS AND THEIR FAMILIES

LIFE INSURANCE PROVIDES SECURITY FOR FAMILIES

The last thing you want your family to have to worry about, at a time when they have so much on their minds, is where they will turn for financial security. Group Term Life Insurance is an economical way to help make sure they are provided for.

WHO CAN APPLY FOR UP TO $500,000 OF COVERAGE?

All members in good standing and their spouses/domestic partners under age 60 may apply. In addition, unmarried, dependent children typically ages 6 months to 19 years (19 to 23 if a full-time student) are eligible for $5,000 of coverage. Children ages 15 days to 6 months may be insured for $1,000 each. (Subject to state variation.) You and your spouse/domestic partner, if applying, must be 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.

Dependent children must not be hospitalized on the date insurance is to take effect. If so, insurance will take effect on the day after discharge.

KEY PLAN FEATURES

Continuation of Insurance Without Premium Payment During Disability

If you or your spouse/domestic partner become totally disabled, as defined by the group policy, before age 60 and the disability continues for at least six months with no interruption, your Group Term Life Insurance may continue without premium payment. Continuation of insurance will end on the date total disability ends, proof of total disability is not given by you when due, you are not examined when required, or you attain age 60.

YOU SELECT YOUR BENEFICIARY

You may name anyone as your beneficiary. You may change your beneficiary (unless irrevocable) by contacting the Insurance Administrator in writing.

ACCELERATED BENEFITS

If you and/or your spouse are diagnosed with a terminal illness (which is defined as a medical condition which is expected to result in the insured's death within 6 months and from which the person is not expected to recover), the Accelerated Benefits rider allows you to elect to receive up to 60% of your Life Insurance, not to exceed $250,000 (less discount), prior to death.

The remaining benefit then becomes payable to your beneficiary after your death. Accelerated death benefits are not payable if the insured person has made an absolute assignment of his life insurance under the group policy, all or part of the insured person's life insurance under the group is to be paid to his child(ren) or former spouse as part of a court approved divorce agreement, is not received written consent by any irrevocable beneficiary, or if the terminal illness is a result of intentional self-inflicted injury or attempted suicide. Receipt of Accelerated Benefits may be taxable. Consult your personal tax advisor for specific details.

There is a 180-day waiting period that begins on the date your insurance goes into effect. Note: the minimum Accelerated Benefit is $10,000, less the discount. After age 70, coverage does not include the Accelerated Benefit.

There is no additional premium charged for the Accelerated Benefit.

CONVERSION RIGHTS

If your insurance ends for a reason other than non-payment of premium, you may buy an individual life insurance policy from United States Life during the conversion period without providing evidence of insurability. The amount of the new policy may be limited depending on the reason your insurance ends.

ECONOMICAL PREMIUMS

Receive Volume Discount Premium Rates when you apply for $250,000 or more of coverage. There are also discounted rates for non-smokers.

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HOW TO APPLY:

1. Complete, sign and date the enclosed application.
2. Remember to select your payment option. If you select Automatic Monthly Check Withdrawal, please include a blank voided check and a check for your first monthly premium. If you select Semi-Annual Direct Bill, just include a check for your first semi-annual premium.
3. Make checks payable to: Mercer Consumer. Send to:

   Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
   P.O. Box 10374
   Des Moines, IA 50306-8812

EXCLUSIONS AND TERMINATIONS

The only exclusion is suicide within the first two years of coverage. If a person commits suicide within 2 years from the date his insurance takes effect, the insurance company's liability will be limited to the premiums paid, plus interest. If a person's age, sex or any other data is misstated, the correct data will be used to determine if insurance is in force. If insurance is in force, the premium and/or benefits will be adjusted according to the facts. Your coverage will end if you fail to pay your premiums when due, the Group Policy is terminated, you reach age 80, or insurance ends for your class.

Administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
P.O. Box 10374
Des Moines, IA 50306-8812

Questions?
1-800-503-9230
http://www.personal-plans.com/nsta

AR Ins. Lic. #100102691
CA Ins. Lic. #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC
TX Ins. Lic. #1850385
MN #40291395
OK #100100336

Underwritten By:
The United States Life Insurance Company
in the City of New York

The most prominent independent ratings agencies continue to recognize The United States Life Insurance Company in the City of New York in terms of insurer financial strength. For current insurer financial strength ratings, please consult the Web site at www.americangeneral.com/ratings.

Policies are issued by The United States Life Insurance Company in the City of New York (all states). The United States Life Insurance Company in the City of New York is responsible for the financial obligations of insurance products it issues and is a member of American International Group, Inc. (AIG)

This brochure is a brief summary of benefits only and is subject to terms, conditions, limitations and exclusions of Group Policy Number G-201,230, Form No. G-19000. Coverage may vary or may not be available in all states.

YOUR MONTHLY RATE PER $10,000 UNIT

Less than $250,000 coverage

	Non-Smoker		Smoker	
Age	Male	Female	Male	Female
Under 30	$0.65	$0.51	$0.75	$0.59
30–34	0.76	0.57	0.88	0.65
35–39	1.04	0.73	1.20	0.84
40–44	1.63	1.08	1.88	1.25
45–49	2.63	1.66	3.04	1.91
50–54	4.10	2.58	4.73	2.98
55–59	6.34	3.99	7.31	4.60
60–79*	6.83	4.76	7.88	5.49

$250,000 coverage or more
(Volume Discount Premium Rates)

	Non-Smoker		Smoker	
Age	Male	Female	Male	Female
Under 30	$0.59	$0.46	$0.68	$0.53
30–34	0.68	0.51	0.79	0.59
35–39	0.94	0.66	1.08	0.76
40–44	1.46	0.97	1.69	1.12
45–49	2.37	1.49	2.74	1.72
50–54	3.69	2.32	4.25	2.68
55–59	5.71	3.59	6.58	4.14
60–79*	6.14	4.28	7.09	4.94

Eligible child(ren): $0.83 monthly insures all.
($5.00 semi-annually)

*Renewal only. Coverage reduces by 50% at the next renewal date following ages 65, 70 and 75. Coverage terminates at age 80. All premiums are based on applicant's attained age at the date of issue and on renewal dates. Premiums will increase as the applicant enters a new 5 year age bracket.

COMPUTING YOUR PREMIUM IF PAYING THROUGH AUTOMATIC MONTHLY CHECK WITHDRAWAL: Find the appropriate monthly rate above based on the amount of coverage you are applying for, your sex, age, and smoker/non-smoker status. Multiply that rate by the number of $10,000 units you are applying for. **EXAMPLE**: Let's say you are a 35-year-old male non-smoker and wish to apply for $200,000. Take $1.04 x 20 units ($200,00 divided by $10,000 unit) = $20.80. This is your monthly premium.

COMPUTING YOUR PREMIUM IF PAYING THROUGH SEMI-ANNUAL DIRECT BILL: Follow the same steps described above, then multiply the total monthly premium by 6. EXAMPLE: Take $20.80 (the total monthly premium figured above) x 6 = $124.80.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

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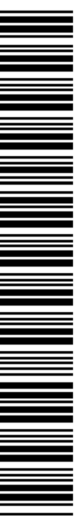

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