



THE UNITED STATES LIFE Insurance Company
 in the City of New York (Called United States Life)
APPLICATION FOR INSURANCE

For office use only:
 DB/11476/11477/1001/37872
 PRD 32740/32741/1001/37872

Please print or type all information requested.

1. Name of Association Uniformed Firefighters Association of Greater New York

2. Member's Full Name _____ Social Security # _____

3. Spouse/Domestic Partner's Full Name _____ Social Security # _____

4. Home Address _____
Number Street City State Zip Code

Cash Deductible \$10,000

5. Complete the following for member, spouse and/or children, if applying for insurance. Use a separate sheet of paper if more space is needed for answers.

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

6. Have you, your spouse, or your children, if applying for insurance, ever had chest pains, heart trouble, liver trouble, high blood pressure, albumin or sugar in the urine, tuberculosis, diabetes, cancer, tumors or ulcers?
 Member: Yes No Spouse: Yes No Child: Yes No

7. Have you, your spouse, or your children, if applying for insurance, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution?
 Yes No Yes No Yes No

If "Yes" to any part of questions 6 or 7, give details below. Use a separate sheet of paper if more space is needed for answers.

Question Number	Does Question apply to Member, Spouse or Child (if child, give name)	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY

1. I authorize the sources stated below to give to United States Life, or any consumer reporting agency acting on its behalf, information about me and my children, if applying for insurance. 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.
2. I understand that this information will be used by United States Life to determine eligibility for insurance.
3. 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 on the authorization. I understand that this authorization will not be valid after 30 months, if not revoked earlier.
4. I know that I have the right to receive a copy of this authorization if I request one.
5. I agree that a photocopy of this authorization is as valid as the original.
6. To the best of my knowledge and belief, all the statements made above are true and complete.
7. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance shall 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 and health of all such persons from that stated in this application.
8. I understand that this plan will not pay benefits during the first 12 months after the effective date for any injury or sickness any proposed insured has now, or has had in the past 6 months.

Important Notice – Any person who knowingly and 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date _____ Signature of Member _____

Date _____ Signature of Spouse _____
(if applying)

G-19027(EM)

Page 2

Policy Number E-160,668 AG-6617 11/08

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

Do you, and your dependents if applying, have a basic major medical plan? Yes No

If "yes", name of insurance carrier _____

If "no", you do not qualify for coverage.

ADMINISTRATOR

UFA Group Insurance Program
P.O. BOX 10374
Des Moines, IA 50306-0374

QUESTIONS?

1-800-503-9230
<http://www.personal-plans.com/ufa>

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

CT385E-NY



These Notices must be detached and retained by the applicant

MEDICAL INFORMATION BUREAU (MIB) DISCLOSURE NOTICE

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted. Information regarding your insurability will be treated as confidential except that the Company may, however, make a brief report thereon to the Medical Information Bureau, Inc., a non-profit membership organization of life insurance companies which operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the Medical Information Bureau, Inc., will supply such company with the information it may have in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone number (866) 692-6901 [TTY (866) 346-3642]. The Company may also release information in its file to other life insurance companies to whom you may apply for life or health insurance or to whom a claim for benefits may be submitted.

MIB-19431

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.

FCRA-19432

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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. **Remember to include your first premium and a blank voided check with your application.**

Bank Name: _____

Bank Address: _____

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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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 which 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 which 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 which 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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\$2,000,000 Group Catastrophe Major Medical Insurance Plan



A Plan designed for the Uniformed Firefighters Association of Greater New York

Includes: Private Duty Nursing • Convalescent Home & Home Health Care Benefits

This plan can help PREVENT financial disaster as a result of a serious non-job related sickness or injury

Today, the cost of a serious non-job related injury or sickness may be far beyond the benefits provided by the average hospitalization or major medical insurance policy. Rising hospital and convalescent home costs, escalating doctor's fees, expensive medicine, specialized surgical procedures and new equipment can push your expenses far over the limit your basic insurance was ever designed to handle.

What if you were suddenly stricken by a non-job related injury or sickness requiring major surgery or even an extensive recuperation period? In addition to a hospital stay, you may need to enter a convalescent home for the injury or sickness which caused the hospitalization. Who would pay THOSE bills?

Even though your basic health insurance policy may have a large LIFETIME maximum benefit, benefits may be limited PER YEAR as to what will and won't be covered.

That's exactly why you need the \$2,000,000 Catastrophe Major Medical Insurance Plan ... to help take over when your basic insurance falls short. And, that's exactly how the Plan has been designed — as extended coverage. For this reason, the Plan includes a \$10,000 deductible (or the amount paid by your basic health insurance, whichever is greater) ... important also in keeping your costs as economical as possible. When a covered non-job related injury or sickness strikes, you have 12 months to satisfy your deductible. But once this deductible is reached, the Catastrophe Major Medical Insurance Plan pays up to 100% of all eligible, reasonable and customary expenses in excess of your basic health plan to a maximum of \$2,000,000 in lifetime benefits for up to 3 full years (each benefit period) from the date the first covered expense used to satisfy the deductible is incurred. Some benefits are subject to other limits as described in this brochure and defined by the group policy.

The UFA Catastrophe Major Medical Plan is offering an easy and direct way for you to pay your premium. The Payroll Deduction Option is a convenient way to pay without ever writing another check. The money is simply deducted from your paycheck. (Please note: payroll deduction is only payroll system.)

Important Features

Extended Coverage

The Catastrophe Major Medical Insurance Plan is DESIGNED TO HELP PAY beyond the limits of the various City of New York Employee Benefit Programs, any other major medical or hospitalization plan, Blue Cross/Blue Shield or even Medicare.

Convalescent Home Benefits

Anyone at any age can require convalescent or custodial care. That's why this is an important benefit. After the deductible has been satisfied, should ANY insured family member be confined as an inpatient in a convalescent home or custodial care facility for custodial or convalescent care due to a non-job related injury or sickness, the Plan will pay the eligible confinement expenses made by a convalescent home for convalescent or custodial care, up to \$600 per week — up to 2 full years (lifetime benefit). Confinement must begin within 14 days following a covered hospitalization of at least three days and must be due to the injury or sickness which required the hospitalization.

Convalescent Home means a licensed institution that has on its premises — organized facilities to care for and treat its patients; a staff of physicians to supervise such care and treatment; and a registered nurse on duty at all times.

Custodial Care Facility means a facility which provides care made up of services and supplies which an insured person needs to assist him in the activities of daily living.

Convalescent Home or Custodial Care Facility DOES NOT mean a place, or part of one, which is used mainly for — the aged; alcoholics; drug addicts; or persons with mental, nervous or emotional disorders.

Home Health Care Benefits

After the deductible has been satisfied, the Plan will pay the reasonable and customary charges for covered home health care treatment up to 100 visits in any one calendar year. These services must be set up and approved by a physician and a certified home health care agency. Each visit by a member of a home health care team will be considered as one home health care visit. Four hours of home health aide services will be considered one home health care visit. Home health care is in lieu of confinement in a hospital or skilled nursing facility.

Common Disaster Provision

If more than one insured family member is injured in the same accident ... or contracts the same contagious disease within 30 days ... only one deductible needs to be satisfied and each insured family member will still be eligible for up to \$2,000,000 in benefits for up to 3 years from the date the covered expenses were first incurred against the deductible.

Survivor's Coverage

Coverage continues for eligible insured dependents of a deceased member as long as the dependents meet normal eligibility requirements, premiums continue to be paid at the adjusted rates depending on the survivor's age, and the group policy remains in force.

Effective Date Of Coverage

Your insurance will become effective on the date specified by United States Life and only if your premium is paid. The effective date for insurance will be delayed if the insured is unable to perform the normal activities of a person of like age and sex, with like occupation or status. Insurance will be effective upon the date the insured resumes such normal activities.

Simplified Acceptance Regardless Of Age

All Uniformed Firefighters Association members in good standing and including retired members, are eligible to apply for coverage for themselves and their lawful spouses regardless of age as long as statements made on the application are true. Unmarried dependent children from birth to 21 years of age (27 if attending school full-time) can also be covered. Certified Domestic Partner coverage is available when the member applies. When applying, please complete the domestic partner affidavit on the reverse side of the application. All applicants must be covered under a basic medical plan or by Medicare Parts A and B. See the back of this brochure for a description of a basic medical plan. (Subject to state variations.)

Your Deductible

The \$2,000,000 Catastrophe Major Medical Insurance Plan is designed to help provide coverage beyond the limits of your basic hospitalization, major medical insurance, Blue Cross/Blue Shield, Worker's Compensation ... or even Medicare.

For this reason, the Plan includes a deductible of either \$10,000 or the amount paid by your basic health insurance (whichever is higher). Eligible reasonable and customary expenses count towards your deductible in full. Even those eligible expenses paid for out of your own pocket count towards meeting your deductible.

You have up to 12 months to satisfy your deductible beginning with the date the first eligible expense is incurred for a covered non-job related injury or sickness and used to satisfy the deductible.

And, since this deductible is based on the total accumulation of eligible hospital-surgical-medical-convalescent expenses, you may include all eligible expenses regardless of whether or not the claims are related.

Termination Of Coverage

Your coverage will terminate if the group policy is terminated; the premium is not paid when due; or the date your membership with the association ends. A dependent's insurance will end at the earliest of the date your insurance ends; the date dependents' insurance ends under the group policy; the date the person ceases to be a dependent, the premium is not paid for the dependent when due.

Termination Of Benefit Period

A benefit period for a covered injury or sickness will cease at the earlier of: completion of 3 years from the day eligible expenses were first incurred and used to satisfy the deductible; two million dollars have been paid, except as stated for Convalescent Home Benefits or psychiatric, mental, nervous or emotional disorders, ailments or illness or alcoholism or alcohol abuse and substance abuse or substance dependence; the end of 12 consecutive months during which no charge is incurred for the injury or sickness; or after 24 months pass from the date the first eligible expense is incurred if 90 consecutive days pass without at least \$150 of eligible expenses have incurred, whichever comes first.

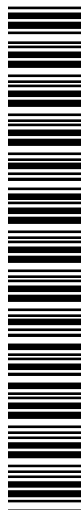
Pre-existing Conditions Limitation

Pre-existing conditions will not be covered until the insured has been covered under the group policy for 12 continuous months. All covered accidents and sicknesses which originate after the effective date of insurance are covered immediately. An injury or sickness for which an ordinarily prudent person would have sought medical advice, diagnosis, care or treatment within 6 months prior to the effective date of coverage, or any injury or sickness for which medical advice, diagnosis, care or treatment was recommended or received within 6 months prior to the effective date is a pre-existing condition. A pregnancy that exists on the effective date is also a pre-existing condition.

NOTE: If you are a resident of New York, you will receive credit for the requirements mentioned above if you have been insured under a previous plan and coverage under the previous plan ended no more than 63 days prior to the effective date of the group policy, as required by law.

Charges incurred for diagnosis and treatment of alcoholism, alcohol abuse, substance abuse or substance dependency will be covered — while hospitalized; for in-patient rehabilitation in a certified or accredited alcohol or substance abuse treatment center, up to 30 days per calendar year; for out-patient diagnosis and treatment in a certified or accredited alcohol or substance abuse treatment center, up to 60 visits per calendar year. Up to 20 of such visits may be for family members of the alcoholic or substance abuser.

Charges incurred for diagnosis and treatment for psychiatric, mental, nervous or emotional disorders, ailments or illnesses will be covered — while hospitalized, up to 30 days per calendar year, for out-patient visits, up to 30 visits per calendar year; subject to a maximum benefit of \$50 per visit (the facility for such visits must have been issued an operating certificate by the commissioner of mental health pursuant to the mental hygiene law, or be operated by the office of mental health, a licensed psychiatrist or psychologist licensed to practice



in New York, or a professional corporation of such psychiatrists or psychologists); for up to three (3) psychiatric emergency visits per calendar year, subject to a benefit of \$60 per visit. Benefits provided for emergency visits will reduce benefits otherwise payable for in-patient or out-patient care as described above.

What's Not Covered

The following is representative of the losses that are not covered under this Plan: intentionally self-inflicted injuries; war or acts of war; dental care, treatment or surgery except to the extent that it is necessary to treat a non-job related injury to natural teeth, the injury is caused by an accident which occurs while insured and such services are rendered within 12 months of the accident or they are made by a hospital while the person is insured; treatment for temporomandibular joint dysfunction (TMJ) will be covered except for those charges for crowns or bridgework; eye exams to prescribe or fit corrective lenses for eye glasses except to the extent that it is necessary to treat a non-job related injury and the injury is caused by an accident which occurs while insured; cosmetic treatment or surgery (except to the extent that it is necessary to treat a non-job related injury or sickness or a congenital disease or anomaly of a dependent child resulting in a functional defect); treatment given by a person's spouse or his or his spouse's father, mother, son, daughter, brother or sister; treatment given by an employer, or employee of the employer; treatment which would be given free if the person was not insured; treatment is not essential for the necessary care or treatment of the injury or sickness involved; treatment given after a person's insurance ends, regardless of when the injury or sickness occurred; treatment for psychiatric, mental, nervous or emotional disorders, ailments or illness, alcoholism, alcohol abuse, substance abuse or substance dependence, except as provided herein. Charges to buy or rent air conditioners, air purifiers, motorized transportation equipment, escalators or elevators in private homes, eye glass frames or lenses, hearing aids, swimming pools or supplies for them, general exercise equipment, and charges for a routine physical exam, except charges for preventive mammography and cytologic screening will not be covered. For persons who are not covered under a basic plan at time of claim, the following charges will not be covered: hospital charges incurred during the first 70 days of each confinement; the first \$10,000 of charges for chemotherapy, radiation therapy, physical therapy or speech therapy that would otherwise be covered; the first \$25,000 of charges for physician services that would otherwise be covered; and the first \$2,500 of charges for prescription drugs while not hospitalized that would otherwise be covered.

A complete listing of all exclusions is detailed in the Certificate of Insurance.

Pays Up To 100% of Eligible Reasonable and Customary Expenses After Your Deductible

- Hospital charges including daily semi-private room and board or intensive care.

- Miscellaneous hospital services and operating room charges.
- Treatment by a currently licensed physician, surgeon or physiotherapist whether in a hospital, at home or in the office.
- Medically necessary private duty nursing services by a registered or licensed practical nurse while in a hospital, or at home — \$120 maximum per 8-hour shift (\$360 maximum per day) up to a lifetime maximum of \$35,000 per insured.
- Dental care, treatment or surgery if natural teeth are injured by a non-job related covered accident which occurs while insured and such services are rendered within 12 months of the accident or they are made by a hospital while hospitalized.
- X-ray, physiotherapy (by a licensed physiotherapist) or laboratory services for diagnosis and treatment.
- Anesthesia and its administration.
- Ambulance service to and from a hospital if prescribed by a licensed physician ... up to \$2,000 lifetime maximum per insured.
- Drugs and medicines requiring written prescriptions, casts, splints, braces, trusses or crutches both in and out of the hospital.
- Oxygen and rental of equipment for its administration and rental of wheelchairs or hospital beds.
- Rental of mechanical equipment for the treatment of respiratory paralysis; rental of other mechanical equipment for medical or surgical treatment.
- Plus ... expenses for room and board, general nursing care services and supplies for convalescent or custodial care confinement as an inpatient in a convalescent home or custodial care facility due to a non-job related injury or sickness ... up to \$600 per week for up to 2 full years (lifetime maximum).

Consider the advantages ... and you'll choose Payroll Deduction!

- No checks to write
- No payment due dates to remember
- No invoices

Consider taking advantage of this easy, convenient payment method.

Just return your completed application ... it's that easy.

30-Day Free Look

When you receive your Certificate of Insurance, read it over carefully ... show it to a trusted advisor or friend. If the \$2,000,000 Group Catastrophe Major Medical Insurance Plan is less than what you had expected, just mail your Certificate back to the UFA Insurance Administrator within 30 days of receipt. Your coverage will be voided and your money will be promptly refunded. No questions asked!

GROUP CATASTROPHE MAJOR MEDICAL INSURANCE

Economical Group Premium Rates

Note: Your initial premium and all renewal premiums are based on your age as of the group policy anniversary date. All changes in premium and coverage will also be calculated as of this policy anniversary date. Although this is a group plan, rising trends in medical costs could result in a future increase on a group basis. You, however, will never be singled out for an increase in cost.

PAYROLL DEDUCTION PREMIUMS (Based on 26 Pay Periods)				
\$10,000 DEDUCTIBLE				
Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	\$1.83	\$3.67	\$6.39	\$4.56
40-49	3.67	7.35	10.07	6.40
50-59	6.10	12.20	14.92	8.82
60-64	9.18	18.36	21.08	11.90
65 & Over	10.30	20.60	23.32	13.02

MONTHLY PREMIUMS for Automatic Check Withdrawal				
\$10,000 DEDUCTIBLE				
Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	\$3.97	\$7.94	\$13.84	\$9.87
40-49	7.96	15.92	21.82	13.86
50-59	13.22	26.44	32.34	19.12
60-64	19.89	39.78	45.68	25.79
65 & Over	22.32	44.64	50.54	28.22

DIRECT BILLING SEMI-ANNUAL PREMIUMS				
\$10,000 DEDUCTIBLE				
Applicant's Age	Applicant Only	Applicant & Spouse/ Domestic Partner	Applicant & Spouse/ Domestic Partner & Child(ren)	Applicant & Child(ren)
Under 40	\$23.82	\$47.64	\$83.04	\$59.22
40-49	47.76	95.52	130.92	83.16
50-59	79.32	158.64	194.04	114.72
60-64	119.34	238.68	274.08	154.74
65 & Over	133.92	267.84	303.24	169.32



Applying is Easy!

1. Complete, date and sign the short application enclosed.
2. Make sure you list any eligible dependents you wish to insure.
3. Mail your completed application to:
Marsh Affinity Group Services
a service of Seabury & Smith
P.O. Box 10374
Des Moines, IA 50306-0374
4. If choosing Direct Billing as your payment option, include your first semi-annual premium check made payable to the UFA Plan Administrator.

NOTE: PRD is only available to those active members on city payroll. If you have any questions at all, please call the Plan Administrator's Customer Service Department Toll-Free: 1-800-503-9230.

Another Service of the:



Administered by:

MARSH

Affinity Group Services
A service of Seabury & Smith
P.O. Box 10374
Des Moines, IA 50306-0374
Call Toll-Free: 1-800-503-9230
<http://www.personal-plans.com/ufa>

Underwritten By:

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

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.

The insurance described in this brochure meets the minimum standards for limited benefit health insurance as defined by the New York State Insurance Department. It does NOT provide basic hospital, basic medical, major medical, nursing home and/or home health care, or long term care insurance as defined by the New York State Insurance Department.

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.aigag.com/ratings.

This brochure is a summary of benefits only and is subject to the terms, conditions and limitations of Group Policy Number E-160,668, form number G-19000.

All applicants must be covered under a basic medical plan which provides benefits at least as great as the following: semi-private room and board of \$300 per day for 70 days; \$25,000 for extra services; a \$5,000 surgical schedule; and a lifetime maximum benefit of \$1,000,000. In order to be eligible for this Catastrophe Major Medical Plan, you must have a basic medical plan (or Medicare Parts A and B) providing at least these benefits.

For persons who are not covered under a basic plan at time of claim, the following charges will not be covered: hospital charges incurred during the first 70 days of each confinement; the first \$10,000 of charges for chemotherapy, radiation therapy, physical therapy or speech therapy that would otherwise be covered; the first \$25,000 of charges for physician services that would otherwise be covered; and the first \$2,500 of charges for prescription drugs while not hospitalized that would otherwise be covered.

IMPORTANT NOTICE ABOUT THE MEDICAL INFORMATION BUREAU

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 MIB, a non-profit membership organization of life 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 files.

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 files, 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 Hill, MA 02184-8734.

The United States Life Insurance Company in the City of New York may also release information in its file to other life 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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Payroll Deduction Authorization (Please Print)

Member's Last Name	First Name	Middle Initial	Member's Social Security No.	
Street Address	City	State	Zip	Daytime Telephone No.

For Active Members on the New York City Payroll only
Note: Your deductions for the \$2,000,000 Catastrophe Major Medical Insurance Plan will be made on a 26-week schedule.

To the Employer:

I hereby authorize you to deduct from each of my salary checks the deduction necessary for the purpose of the Uniformed Firefighters Association \$2,000,000 Group Catastrophe Major Medical Insurance Plan, underwritten by The United States Life Insurance Company in the City of New York.

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.

I understand that this authorization may be revoked at any time by written notice to you.

Signature _____ Date _____

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Important Notice to Persons on Medicare This Insurance Duplicates Some Medicare Benefits

This is not Medicare Supplement Insurance

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement Insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare.
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- hospice care
- other approved items and services.

BEFORE YOU BUY THIS INSURANCE

1. Check the coverage in **all** health insurance policies you already have.
2. For more information about Medicare and Medicare Supplement Insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
3. For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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