

DEPENDENTS INFORMATION AND BENEFICIARY DESIGNATION FORM

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

Member 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: University of Nevada School of Medicine

Group #: G189803 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: _____~~

~~Please complete, and sign this form if you are refusing coverage for any of the following insurance products.~~

~~Please check the appropriate box(es).~~

- ~~Life Dependent Life Long Term Disability Short Term Disability~~

~~NOTE: Enrollment/Refusal Form #00302101-1113 is required for each employee for Dental and Vision coverages.~~

Please Read and Sign:

~~I, the undersigned, hereby affirm that I have reviewed the insurance plan(s) from The United States Life Insurance Company in the City of New York being offered by my employer. With my signature, I certify that I have decided to refuse coverage. I understand that if I should later decide to enroll, I will be considered a late enrollee and may be subject to Evidence of Insurability and/or reduced benefits.~~

~~Signature: _____ Date: _____~~