AMERICAN GENERAL

Refusal of Insurance Card

The United States Life Insurance Company in the City of New York
New York, New York
Member of American International Group, Inc.
Attn: Client Services 3-A
PO Box 1583
Neptune, NJ 07754-1583

GROUP POLICY NO. ______________________ NAME OF EMPLOYER, ASSOCIATION OR UNION ______________________

EMPLOYEE'S NAME ______________________ (LAST, FIRST, MI) SOCIAL SECURITY NO. ______________________

MARITAL STATUS: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

NUMBER OF ELIGIBLE DEPENDENT CHILDREN: _______

I was given the opportunity to enroll in this plan or group insurance offered by my employer/association and insured by United States Life. I am refusing: **(Note: Benefits provided on a non-contributory basis cannot be refused)**

	Major Medical Refusal:	Dental Refusal:	Prescription Drug Refusal:
☐ All coverage Offered			
☐ Long Term Disability	☐ Employee & Dependents	☐ Employee & Dependents	☐ Employee & Dependents
☐ Short Term Disability	☐ Spouse	☐ Spouse	☐ Spouse
☐ Other: ☐ Vision	☐ Child(ren)	☐ Child(ren)	☐ Child(ren)

ANSWER IF YOU ARE REFUSING EMPLOYEE, SPOUSE AND/OR CHILD MAJOR MEDICAL OR DENTAL COVERAGE:

Are you or your dependents now covered by any other group plan? ☐ Yes ☐ No

If yes: Policyholder's Name ______________________ Carrier ______________________

(Your dependent(s) may be insured by this Plan although they are covered elsewhere.)

I understand that I must furnish, at my expense, evidence of insurability satisfactory to United States Life if I later wish to enroll for any of the coverage refused, except Dental, which may be subject to reduced benefits.

Signature of Employee ______________________ Date ______________________

Signature of Witness ______________________ Date ______________________