



**ASSOCIATION LIFE INSURANCE
THROUGH THE
ISBA INSURANCE AGENCY**

Thank you for your interest in the ISBA's Group Term Life Insurance product. Per your request, please find enclosed the following:

- **A product brochure for Group Term Life insurance, including rates, and optional benefits**
- **An application**

If you wish to apply for coverage, please complete the application in full and return to: ISBA Insurance Agency, c/o Brown & Brown of Indiana, Attn. Katie Brockway, 11555 N. Meridian St. Ste., Carmel, IN 46032. If you prefer, you may fax the application to (317)471-1700.

Please DO NOT cancel any existing insurance coverage until you are notified of approval and given your effective date. If you have any questions or need assistance, please do not hesitate to contact Katie Brockway (317)396-1086 or toll-free (877) 647-2242.

APPLY TODAY FOR THIS ECONOMICAL GROUP PLAN

- You may apply for up to \$2,000,000
- Your spouse may apply for up to \$1,000,000
- Economical group rates
- Accelerated death benefit

30-day free look

If you change your mind, you can return your Certificate of Insurance within 30 days after receiving it and obtain a full refund of any premium paid.

Effective date

Coverage will begin on the first day of the month following the date your application is approved, provided the premium has been paid. All members in good standing, under the age of 65, are eligible to apply. You and your spouse under age 65 (if applying) must be able to perform the normal activities of a person of like age and sex, with like occupation or retired status, on the date insurance is to take effect. Otherwise, insurance will take effect on the day the insured resumes such activities.

Exclusions and limitations

If death is the result of suicide within two years from the date insurance takes effect, benefits are limited to return of 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.

A solid insurer

This plan is underwritten by The United States Life Insurance Company in the City of New York. This is only a brief summary of benefits and is subject to the terms, conditions, exclusions and limitations of group policy number G-610,367, Form No. G-19000. Coverage may vary and may not be available in all states.

Administered by:



11555 N. Meridian Street, Ste. 220
Carmel, IN 46032
1-877-647-2242
Fax: 317-471-1700

Underwritten by:

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

New York, 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.

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10-YEAR LEVEL TERM

LEVEL PREMIUM GROUP TERM LIFE INSURANCE

FOR YOU AND YOUR SPOUSE

APPLY FOR UP TO \$2,000,000
OF COVERAGE



INDIANA STATE BAR ASSOCIATION

IT'S EASY TO APPLY FOR THIS LIFE INSURANCE PROTECTION

This plan gives you a convenient, economical way to help give your family the insurance protection you want them to have.

Economical group rates

Group purchasing power means you receive quality coverage at competitive group rates.

Apply for up to \$2,000,000

As a member, you may apply for \$100,000 up to \$2,000,000, in \$10,000 increments. Your spouse may apply for up to \$1,000,000, and may apply even if you don't. You and your spouse must be under age 65 to apply.

Level premiums for up to 10 years

Your individual premium is scheduled to remain level for the initial 10-year term of the plan. Your premium will not increase during the initial term due to your age or health status. The insurance company does reserve the right to change premium rates, but may do so only once in a 12-month period for all insureds covered under the group policy and with 60 days written notice to the group policyholder.

After the initial 10-year period, you have the option of applying for a new level premium term life plan by providing satisfactory evidence of insurability at least three months prior to the end of the initial premium period if you are under age 65.

Accelerated death benefit

If you've been covered under this plan for at least 180 consecutive days, are under age 70, and you are diagnosed with a terminal illness (life expectancy of six months or less) from which you are not expected to recover, you may receive up to 60 percent of your benefit amount, with a minimum benefit of \$10,000, less the discount for early payment (amount may vary by state).

Living benefits are subject to certain exclusions, which are listed in your Certificate of Insurance.

Living benefits are not payable if there is an absolute assignment of your life insurance; there is an irrevocable beneficiary who does not give written consent; there is a court decree involving the life insurance in connection with a divorce agreement; or the terminal illness is due to intentionally self-inflicted injury or attempted suicide. Receipt of terminal illness (accelerated) benefits may be taxable (consult your tax advisor for details).

No medical exam typically required for amounts up to \$200,000*

Answers to the questions on the application are typically all that is needed for coverage amounts up to \$200,000, with no health exams or tests usually required.* Depending on the amount of coverage applied for, a paramedical exam may be required, which will be scheduled at your convenience and at no cost to you. Acceptance is subject to evidence of insurability as determined by the underwriting company.

* Issuance of a Certificate of Insurance or payment of benefits may depend upon the answers given in the application and the truthfulness of those answers.

Coverage termination

Coverage is renewable up to age 65 and ends when you reach age 75, at the end of the period for which the last premium has been paid, the group policy ends, or insurance ends for your class. If insurance ends for a reason other than non-payment of premium, you may buy an individual life insurance policy from the company during the conversion period, without providing evidence of insurability.

Level Premium Group Term Life Insurance

SEMI-ANNUAL RATES FOR MEMBERS AND SPOUSES

Age	Benefit Amount	Preferred Non-Smoker	
		Male	Female
25	\$250,000	\$ 68.75	\$ 60.00
	\$500,000	125.00	102.50
	\$1,000,000	210.00	160.00
30	\$250,000	68.75	60.00
	\$500,000	125.00	102.50
	\$1,000,000	210.00	165.00
35	\$250,000	70.00	60.00
	\$500,000	125.00	105.00
	\$1,000,000	210.00	165.00
40	\$250,000	86.25	83.75
	\$500,000	157.50	150.00
	\$1,000,000	265.00	245.00
45	\$250,000	142.50	126.25
	\$500,000	267.50	237.50
	\$1,000,000	460.00	410.00
50	\$250,000	220.00	175.00
	\$500,000	420.00	335.00
	\$1,000,000	760.00	605.00

If you qualify for Preferred rates, you will be notified when your application is approved. Preferred rates are for those who have not used tobacco in any form during the past 12 months, and whose lifestyle and health history meet the Preferred underwriting guidelines. The premium at which you enter the plan is projected to remain the same for the initial 10-year term and will not change due to your age or a change in your health status. While premiums are projected to remain level for the initial period, the company reserves the right to change rates for all insureds only once in a 12-month period, with 60 days written notice to the group policyholder. For annual rates, multiply the premium shown by 2. For smoker rates and rates for coverage amounts over \$1,000,000, please call the Plan Administrator at 1-877-647-2242. Coverage terminates at age 75. A \$3.00 administrative fee will be added to your premium bill.

DECIDE TODAY to add important financial security for those who depend on you.
Applying is easy - Simply complete and return the application today to:

ISBA INSURANCE AGENCY • 11555 N. MERIDIAN STREET • STE. 220 • CARMEL, IN 46032

CALL 1.877.647.2242 WITH ANY QUESTIONS, OR IF YOU WOULD LIKE ASSISTANCE WITH YOUR APPLICATION.



APPLICATION FOR GROUP TERM LIFE INSURANCE
Underwritten by The United States Life Insurance Company in the City of New York
(Herein called the Company)

Member information Please print or type

Name of Association		Name		
		First	Middle	Last
Address				
Number	Street	City	State	ZIP
Home Phone No. ()	Work Phone No. ()	E-mail Address		
Social Security #	Beneficiary		Relationship	
Name and Address of Member's Physician				

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

Spouse information Please print or type

Name			E-mail Address	
First	Middle	Last		
Social Security #	Beneficiary		Relationship	
Name and Address of Spouse's Physician				

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

Check Life Insurance plan(s) desired

Life Insurance for Member: \$ _____ (\$100,000–\$2,000,000, in \$10,000 increments)
 Life Insurance for Spouse: \$ _____ (\$100,000–\$1,000,000, in \$10,000 increments)
 Call the plan administrator for additional information and rates for coverage amounts over \$1,000,000.

Level Life period

10 years

Select your preferred payment mode

I wish to pay: Semi-annually Annually

Complete the following for the applicant /member and spouse for whom coverage is requested

Insured	Name	Age	Date of Birth (MM/DD/YY)	Place of Birth	Height	Weight	Sex (M/F)
Member					ft. in.	lbs.	
Spouse					ft. in.	lbs.	

G-19430 IN

10YR TL-ISBA

Group Policy No. G-610,367

AG8316 (12/10)

06673611-2057 R1/11

Please continue this application on the reverse side

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, 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 (TTY 866-346-3642). 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.

Note: Canadian Members should continue to use the following address: 330 University Avenue, Suite 501, Toronto, Ontario, Canada, M5G 1R7, tel. no. 416-597-0590.

Please answer these brief questions

	Member	Spouse
1. Has the applicant/member or spouse, if applying, during the past 5 years, 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; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder?	1. <input type="checkbox"/> YES <input type="checkbox"/> NO	1. <input type="checkbox"/> YES <input type="checkbox"/> 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?	2. <input type="checkbox"/> YES <input type="checkbox"/> NO	2. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	3. <input type="checkbox"/> YES <input type="checkbox"/> NO	3. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	4. <input type="checkbox"/> YES <input type="checkbox"/> NO	4. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. Has the applicant/member or spouse, if applying, ever had life or health insurance declined, modified or rated?	5. <input type="checkbox"/> YES <input type="checkbox"/> NO	5. <input type="checkbox"/> YES <input type="checkbox"/> NO
6. Is this insurance intended to replace or modify any insurance with this or any other company?	6. <input type="checkbox"/> YES <input type="checkbox"/> NO	6. <input type="checkbox"/> YES <input type="checkbox"/> NO

For "Yes" answers to questions 1-6 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

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

Please read the following, then sign and date below to apply

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 Medical Information Bureau, 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). To facilitate the rapid submission of such information, I authorize all said sources, except the 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.

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.

<input checked="" type="checkbox"/> Member's Signature	Date / /	<input checked="" type="checkbox"/> Spouse's Signature	Date / /
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G-19430 IN 10YR TL-ISBA Group Policy No. G-610,367 AG8316 (12/10) 06673611-2057 R1/11

PLEASE REPLY TODAY!

**It takes just minutes to give you and your family this solid life insurance protection.
A medical exam is typically not required for coverage amounts under \$200,000.
Send No Money Now! We'll send you a premium notice upon approval.**

Complete the application and return to:

ISBA Insurance Agency, 11555 N. Meridian Street, Ste. 220, Carmel, IN 46032 — Questions? Call 1-877-647-2242

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 a 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.