APPLICATION FOR
GROUP DISABILITY INSURANCE

Underwritten by The United States Life Insurance Company in the City of New York
Home Office: 175 Water Street, New York, NY 10038
(Herein called the Company)
Administrative Office: P.O. Box 10374, Des Moines, IA 50306-8812

1. Name of Association Nebraska State Bar Association

2. Member/Applicant's Name ______________________ ❑ Male ❑ Female
First Middle Last

3. Membership Number (if any) ____________ 4. E-mail address ______________

5. Member/Applicant's Address ______________________
Number Street City State Zip Code

6. Name and Address of Member/Applicant's Physician ______________________

7. Home Phone No. (_______)______________ Work Phone No. (_______)______________

8. **PERSONAL DATA**

Age	Date of Birth (MM/DD/YR)	Place of Birth	Height Ft. In.	Weight Lbs.
			ft. in.	Lbs

9. Are you now, and have you been for the last 90 days, performing all of the duties of your regular occupation for at least 25 hours per week for your present employer? ❑ Yes ❑ No

10. Occupation ______________ 11. Annual Earned Income (after business expenses) $________

12. Date of Hire ______________

13. Employer Name and Address ______________________

INSURANCE REQUESTED

14. **Disability Insurance**

Waiting Period: ❑ 30 days ❑ 90 days (Long-Term Plan Only) (Plan II)

Monthly Benefit: ______________ (not to exceed 70% of your monthly income)

Note: The monthly benefit amount is based upon your Annual Earned Income (after business expenses)

Benefit Period: ❑ Short-Term Plan (Plan I) ❑ Long-Term Plan (Plan II)

15. I wish to pay: ❑ Direct Bill ❑ Monthly ❑ Semiannually ❑ Annually
❑ Automatic Check Withdrawal (If you select Automatic Check Withdrawal, please complete the request form.)

PLEASE COMPLETE AND SIGN APPLICATION

Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had or been treated for (Circle specific disorders experienced):

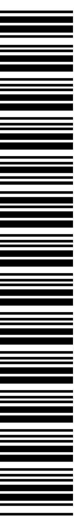
a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? ❑ Yes ❑ No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? ❑ Yes ❑ No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? ❑ Yes ❑ No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? ❑ Yes ❑ No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? ❑ Yes ❑ No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? ❑ Yes ❑ No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? ❑ Yes ❑ No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? ❑ Yes ❑ No
e. Disease or disorder of the rectum? Vascular or blood disorder? ❑ Yes ❑ No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? ❑ Yes ❑ No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? ❑ Yes ❑ No	m. A surgical operation? Or a surgical operation advised but not performed? ❑ Yes ❑ No
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? ❑ Yes ❑ No	n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? ❑ Yes ❑ No
	o. Alcohol or drug abuse? ❑ Yes ❑ No

2. Have you 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? ❑ Yes ❑ No

3. Are you now taking prescription medication or receiving medical attention? ❑ Yes ❑ No

For "Yes" answers to questions 1-3 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".
❑ Yes ❑ No

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



PLEASE COMPLETE AND SIGN APPLICATION

EXISTING AND PENDING INSURANCE SECTION

4. Do you have any disability insurance in force or pending? (including group coverage) ❑ Yes ❑ No
   (If "Yes", please indicate companies and amounts) ______________________________

5. Will this coverage applied for replace any insurance now in force? ❑ Yes ❑ No
   (If "Yes", please indicate which insurance and the amount being replaced) ____________________

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 Company 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 MIB, 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, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

A copy of this application will be attached to and made a part of your certificate.

Date____________________ Member/Applicant's Signature ______________________________

PLEASE COMPLETE AND SIGN THIS PAGE OF APPLICATION

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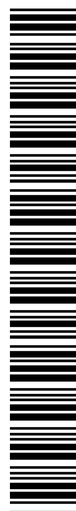

These Notices must be detached and retained by the applicant

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.

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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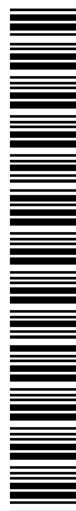

AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

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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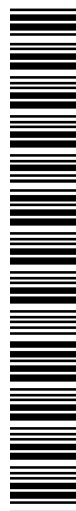

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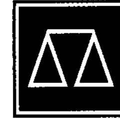
Group Disability Income Insurance Plan

DEVELOPED FOR MEMBERS



THIS PLAN REPLACES A PORTION OF YOUR INCOME WHEN YOU CAN'T WORK

If a disabling accident or illness suddenly took away your ability to work and as a result also took away your ability to earn a paycheck ... how would you continue to afford the living expenses you must now pay? With the Group Disability Income Insurance Plan sponsored by your association, your income would continue in the form of a monthly benefit that you select. You can select short-term or long-term insurance protection. Don't let a disability rob you of your income. Rely on the security provided by the Group Disability Income Insurance Plan.

WHO CAN APPLY

All actively working (at least 25 hours per week) members in good standing who are practicing attorneys, dentists or physicians and/or their lawful spouses also actively working (at least 25 hours per week), under age 60, may apply for this coverage.

HOW THIS PLAN WORKS

SHORT-TERM PLAN (PLAN I): Under this coverage, you may receive a monthly benefit beginning on the 31st day of total disability for up to one full year if totally disabled due to a covered injury or sickness.

LONG-TERM PLAN (PLAN II): Under this coverage, you may receive a monthly benefit beginning on either the 31st or 91st day of total disability up to age 65, if total disability begins prior to age 65, or for two years but not beyond age 70 if disability occurs on or after age 65 but prior to age 70. Total Total benefits you receive from this plan and from any other income replacement plan (as defined by the group policy) may not exceed 70% of your basic monthly pay. See Certificate of Insurance for complete details.

Monthly benefits will be paid up to the maximum benefit period selected. Monthly benefits under either plan will end on the date proof of continuing disability is not provided, you are no longer disabled, the maximum benefit period ends, or you die.

YOU CAN SELECT YOUR MONTHLY BENEFITS

SHORT-TERM PLAN (PLAN I): Your monthly benefit can range from $500 to $3,000 (in $100 increments). Your selected benefit cannot exceed 70% of your basic monthly pay.

LONG-TERM PLAN (PLAN II): Your monthly benefit can range from $500 to $10,000 (in $100 increments). Your selected benefit cannot exceed 70% of your monthly salary.

IMPORTANT PLAN FEATURES

Waiver of Premium Benefit

After a covered total disability has continued for six continuous months for which benefits are payable and while the program is in force, premiums will be waived and it will not be necessary to continue premium payments for as long as the insured is continuously disabled and receiving benefits. When the insured stops receiving monthly benefits, premiums must again be paid when due.

Rehabilitation Benefit

Insurance benefits will be reduced by 50% of the wages the insured earns during rehabilitation when participating in an an approved vocational rehabilitation program. This benefit is payable up to the earlier of 12 months after the date rehabilitation benefit begins or to age 65.

Related Disability Benefits

The insured will receive their selected benefit for disabilities which are recurrent in nature. Successive periods of disability due to the same or related cause, when separated by a return to full-time work for less than 6 continuous months, shall be considered one period of total disability.

TAX-FREE BENEFITS

The benefits you receive under this Plan are usually tax-free and you may use them for any purpose you wish, just like your regular income. Consult your personal tax advisor for details.

30 Day Free Look

Once approved, you will be sent your Certificate of Insurance. When you receive your Certificate, review it carefully If you are not completely satisfied with the terms of your coverage, simply return your Certificate within 30 days and any premiums that have been paid will be promptly refunded in full.

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IMPORTANT DEFINITION

Basic Monthly Pay

BASIC MONTHLY PAY means the insured person's monthly rate of pay from his employer. Such rate will be that in effect on the day before total disability begins. "Basic monthly pay" includes commissions but not bonuses, overtime pay, or other extra compensation. Commissions will be averaged for the lesser of: the 24 month period of employment before the date total disability begins; or the period of employment.

For persons who are self-employed, basic monthly pay means the average Net Monthly Income from the personal practice of his profession. The average is based on the 24 month period of self-employment before total disability begins. For a person self-employed less than 24 months, the average is based on the entire time the person was self-employed. "Net income" excludes investment returns, rents, royalties, and similar income not directly produced by the person's occupation.

Total Disability

Being totally disabled means the insured is completely unable, due to sickness or injury, to perform the material duties of: his/her regular profession for the waiting period and the next 24 months (12 months for the short-term plan) Thereafter, total disability is defined as the complete inability, due to sickness or injury, of the insured to perform the material duties of any gainful job for which he/she is reasonably fit by education, training or experience. The insured must also be under the regular care of a licensed physician and must not be performing the duties of any gainful job.

ADDITIONAL BENEFITS

Partial Disability Benefits

A benefit is payable for partial disabilities (following a total disability) based on the income received from employment. The maximum monthly partial disability benefit is the monthly benefit that would be payable for total disability less the wages earned while partially disabled. Benefits will be paid until the earlier of the end of the maximum benefit period described for total disability or the date the insured person earns 80% or more of their monthly income. Partial disability means that an insured is not able to perform the material duties of his regular profession but is able to perform at least one of these duties on a part-time basis, or at least one, but not all, of these duties on a full-time basis. The partial disability must be a result of the injury or sickness that caused the total disability. Partial disability benefits will not be paid to an insured who is receiving, or entitled to receive to receive rehabilitation benefits.

Survivor Benefits

If the insured dies while receiving benefits, an eligible survivor will receive a one-time benefit payment equal to three times the last net monthly benefit paid to the insured. Eligible survivors include the insured's spouse and dependent children under age 19, or age 23 if a full-time student. Only one such benefit is payable.

Benefits for Specific Disorders under the Long-Term Plan (Plan II)

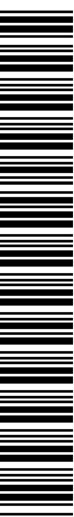
If total disability is due to a mental, nervous or emotional disorder, alcoholism or drug addiction, a maximum of 24 monthly benefits will be paid while such disability continues. This benefit is only applicable to Plan II.

Plan II Reduction on Account of Other Income Benefits

If the monthly benefit paid under this plan plus income benefits you received from other sources (as listed in the group policy) exceeds 70% of the insured's basic monthly pay, then the monthly benefits to be paid under this plan will be reduced by the amount by which the total income benefit exceeds 70%. This limited reduction is only applicable to Plan II.

SEMI-ANNUAL PREMIUMS PER $100 MONTHLY BENEFIT — **Rates as of 03/2017**

SHORT-TERM PLAN (PLAN I)		LONG-TERM PLAN (PLAN II)		
	Benefits on the 31st day		**Benefits on the 31st day**	**Benefits on the 91st day**
Under 30	$2.28	Under 30	$6.24	$4.32
30–34	3.24	30–34	9.90	6.84
35–39	4.50	35–39	13.56	9.36
40–44	5.58	40–44	17.22	11.88
45–49	9.48	45–49	25.38	17.52
50–54	13.98	50–54	35.64	24.60
55–59	20.46	55–59	39.30	27.12
60–69*	30.00	60–69*	42.96	29.64



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TERMS OF COVERAGE

Pre-Existing Conditions

No benefits will be paid for any disability which is a result of a pre-existing condition. A pre-existing condition is an injury or sickness for which a person incurred charges, received medical treatment, consulted a physician or took prescribed drugs during the 12 months immediately before the insured's Effective Date of Insurance. If disability is due to a pre-existing condition and it begins within 24 months of the insured's Effective Date of Insurance, no benefits will be paid unless the person has not incurred charges, received medical treatment, consulted a physician, or taken prescribed drugs for such condition, or any complication of it, for 12 continuous months, while insured.

Effective Date of Insurance

Insurance becomes effective on the first of the month after the date the application is approved, provided the first premium has been paid. You and your spouse, if applying, must be actively at work on the date insurance is to take effect. If not, insurance will take effect on the day you resume such work.

Date Insurance Ends

A person's insurance will end at the earliest of the date the group policy ends; the date insurance ends for his/her class; the end of the period for which the last premium has been paid by him/her; the date the person ceases full-time employment for reasons other than total disability; the premium due date coinciding with or next following the date the person ceases to be a member of this association or the association ceases to be a Participating Association, or the premium due date coinciding with or next following the date the person attains age 70.

Exclusions

No benefits are payable for any period of disability during which the insured person is not under the direct care and treatment of a licensed physician; intentionally self-inflicted injury; war or act of war; normal pregnancy or childbirth or voluntary abortion (complications of pregnacy are covered); committing a crime or an attempt to do so.

TAKE THIS TIME NOW TO COMPLETE THE APPLICATION THAT HAS BEEN ENCLOSED FOR YOUR USE.

TO COMPUTE YOUR PREMIUM: Select Short-Term or Long-Term coverage. Multiply the premium listed for your age group by the number of $100 units of monthly coverage you select. The monthly benefit amount you select may not exceed 70% of your basic monthly pay, exclusive of bonuses, dividends and overtime pay.

SEND NO MONEY NOW! YOU WILL BE BILLED WHEN YOUR APPLICATION IS APPROVED.

HOW TO APPLY

1. Complete the application included in this package.
2. Return your completed application to the Insurance Administrator for your Association:

Administered By:

MAKE TOMORROW, TODAY

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

1-866-236-6582
https://www.personal-plans.com/nebar

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

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

3600 Route 66
P.O. Box 1580
Neptune, NJ 07754-1580

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 issued by The United States Life Insurance Company in the City of New York (US Life). Issuing company US Life is responsible for financial obligations of insurance products and is a member of American International Group, Inc. (AIG). Products may not be available in all states and product features may vary by state. Policy # G-199,137, Form # G-19000.

This brochure is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of the Group Policy.

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Policy #G-199,137
AG-11879
March 2017

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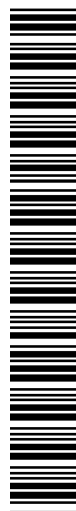

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