PLEASE PRINT WITH BLACK INK

APPLICATION FOR HEALTH INSURANCE TO:

Allstate Life Insurance Company of New York
Home Office Hauppauge, NY

Workplace Division Service Center
PO Box 331429, Atlantic Beach, Florida 32233

Proposed Insured (Print) (Last, First, M.I.)	☐ Emp. ☐ Spouse ☐ Child	☐ M ☐ F	Age	Birthdate	Height	Weight	Social Security Number

Home Address	City	State	Zip	Home Phone Number

Employer (if not same as case)	Occupation	Date Hired

Payor (if other than Proposed Insured)	Social Security Number or Tax I.D. Number (Owner or Payor)	Employee ID

Owner's Name and Address (if different than Proposed Insured's)	City	State	Zip

Primary Beneficiary - Full Name Age Relationship	Contingent Beneficiary - Full Name Age Relationship

DEPENDENTS PROPOSED FOR COVERAGE

Last Name	First Name	M.I.	Relationship	Date of Birth	Age	Sex

INSURANCE PLANS

Disability _____
☐ Simplified Issue
☐ Select CGI
Occupation Class ☐ Preferred ☐ Standard

Monthly Salary $ _____
Monthly Benefit $ _____

Elimination Period _____ Days Acc. _____ Days Sick.
Benefit Period _____ Months

Accident Rider ☐ Yes ☐ No
Units _____
☐ Individual ☐ Family

Section 125 ☐ Yes ☐ No

Mode Premium $

Accident _____
(Units or Benefit Package)
☐ Simplified Issue ☐ Select CGI ☐ Individual ☐ Family
Proposed Insured Monthly Salary $ _____

Spouse Monthly Salary (for Spouse Disablity Rider) $ _____
Spouse Disability Rider Units _____

	Rider	Rider	Rider
Units	Units	Units	Units

Section 125 ☐ Yes ☐ No

Mode Premium $

Specified Disease Cancer _____
(Units or Benefit Package)
☐ Individual ☐ Family

Riders	Rider	Rider	Rider	Rider	Rider
Units/Amts.					

Section 125 ☐ Yes ☐ No

Mode Premium $

Specified Disease Critical Illness _____
☐ Individual ☐ Family
☐ Individual & Children
Basic Benefit Amount: _____
☐ without Cancer Benefit ☐ with Cancer Benefit

CI Riders	Rider	Rider	Rider	Rider	Rider
Units/Amts.					

Section 125 ☐ Yes ☐ No

Mode Premium $

Cash With Application _____
PAC Policies Transit Number _____
☐ Checking Account Number _____
☐ Savings Draft Date _____

Case Name
Case Number

Total Mode Premium: $

Premiums/Billing Mode ☐ Monthly ☐ Semi-Monthly ☐ Bi-weekly ☐ Weekly ☐ Other

Requested Issue Date _____ Date of First Deduction _____

Remarks

Home Office Use

Producer Number	Percentage Credit
	%
	%
	%
	%
	%

NON-MEDICAL QUESTIONNAIRE

All Coverages	1. Is the proposed insured actively at work now and has he/she worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No
Spouse Accident	2. Is the proposed insured's spouse actively at work now and has he/she worked at least 20 hours each week performing all duties at his/her regular occupation at his/her regular place of employment for the last 3 months except for minor illness or injury of 1 week or less, or normal pregnancy?	☐ Yes ☐ No

IF QUESTION 1-2 ABOVE ARE ANSWERED "NO" OR QUESTION 3-8 BELOW ARE ANSWERED "YES," PLEASE LIST THE REQUIRED HEALTH HISTORY IN QUESTION 10 BELOW.

All Coverages	3. Is any person to be insured now being treated, or ever been treated or diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No
All Select CGI	4. Has any person to be insured been disabled or hospitalized in the last 6 months?	☐ Yes ☐ No
Specified Disease Cancer & Specified Disease Critical Illness with Cancer	5. Is any person to be insured currently undergoing any diagnostic test for, now being treated for, or ever been treated for, cancer or any malignancy which includes: carcinoma; sarcoma; Hodgkin's Disease; leukemia; lymphoma; or any malignant tumor?	☐ Yes ☐ No
Simplified Issue Disability	6. a) Has any person to be insured, in the last 2 years, had, been treated for, or been told by a member of the medical profession that he/she has: diabetes, emphysema, asthma, epilepsy, hepatitis, mental or nervous illness, ulcers, any disorder of the central nervous system (to include muscular dystrophy or multiple sclerosis); Parkinson's disease; lupus; rheumatoid arthritis; fibromyalgia; chronic fatigue syndrome; any disorder of the heart, kidneys, liver, lungs, pancreas, or back (including neck); paralysis; optic neuritis; cancer (except basal cell skin cancer), malignant tumor, leukemia, Hodgkin's Disease; or stroke? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to 6b is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? d) Has any person to be insured, in the last 2 years, been treated for or counseled for alcohol or drug abuse? e) Has any person to be insured had any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but not done at this time? f) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
All Specified Disease Critical Illness	7. Has any person to be insured used tobacco in any form in the last 12 months? If so, who and what type? _____	☐ Yes ☐ No
All Specified Disease Critical Illness	8. a) Is any person to be insured now being treated for, or in the last 10 years, been treated for, stroke or Transient Ischemic Attacks; a heart attack; a heart condition; heart trouble; any abnormality of the heart; or any artery disease; or diabetes? b) Has any person to be insured ever been diagnosed with hypertension or high blood pressure? c) If the answer to the above is yes, in the last year has that person had a systolic blood pressure reading higher than 150 more than once or a diastolic blood pressure reading higher than 100 more than once? d) Has any person to be insured received any advice, treatment, or consultation for Alzheimer's disease, dementia, senility, or organic brain syndrome? e) Has any person to be insured received any advice, treatment or consultation for any disease or disorder of the kidneys, liver or lungs; hepatitis, emphysema; or any medical or surgical procedures (including major organ transplant) advised or recommended by a doctor but not done at this time?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
All SI Accident policies and riders	9. Has any person to be insured, in the last 3 years, had his/her driver's license suspended or revoked or been convicted of driving under the influence of drugs or alcohol and/or been involved in 3 or more motor vehicle accidents? If yes, provide additional details below.	☐ Yes ☐ No
Required Health History	10. Name / Nature of Illness/Injury or Medical Attention/ Reason Last Consulted / Date and/or Duration / Name and Address of Physician or Hospital/Clinic _____ **Use additional paper if needed**	
All Coverages	11. **Replacement.** Is this insurance to replace or change any existing health coverage? If yes, indicate product being replaced or changed and complete replacement form provided by your producer if required by your state. _____	☐ Yes ☐ No
All Coverages	12. **Existing Insurance.** Is there any other specified disease, disability, or accident insurance in force or applied for on proposed insured? If yes, list company name, policy number, year issued, type of coverage, number and type of specified diseases covered and amount of benefit. _____	☐ Yes ☐ No
Specified Disease Cancer or All Specified Disease Critical Illness	13. I have received an Outline of Coverage for Specified Disease coverage.	☐ Yes ☐ No
Specified Disease Cancer or All Specified Disease Critical Illness	14. Does each person to be insured have either major medical insurance or basic hospital insurance and basic medical insurance?	☐ Yes ☐ No

REPRESENTATION. I have read or had read to me the completed application. I represent that statements and answers given on this application are true, complete, and correctly recorded to the best of my knowledge and belief. • **UNDERSTANDING.** I understand that the "effective date" of the policy will be the date assigned by Allstate Life Insurance Company of New York in accordance with the policy dating rules in effect at the time the policy is issued. I also understand that, if premiums for the policy(ies) is (are) to be paid by payroll deduction, these deductions may start before the "effective date" of the policy(ies) and that this does not change the effective date of coverage. If the policy(ies) is (are) not issued, Allstate Life Insurance Company of New York will refund any deductions it receives. I also understand that no producer (agent) has authority to waive any answer or otherwise modify this application, or to bind this company in any way by making any promise or representation that is not set out in writing in this application. • **AUTHORIZATION.** I authorize any physician, medical practitioner, hospital, clinic or other medical facility, insurance company, the Medical Information Bureau or other organization, institution or person, that has records or knowledge of me or my health to give to Allstate Life Insurance Company of New York or its reinsurers any information. I acknowledge receipt of the Important Notice Under the Fair Credit Reporting Act and MIB Notice form. A copy of this authorization is as valid as the original. This authorization applies to any dependent on whom insurance is requested. This authorization is valid for a period of 24 months from the date signed. I understand that I may revoke this authorization at any time by notifying Allstate Life Insurance Company of New York in writing of my desire to do so.

FRAUD WARNING: **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.**

Signed at: City/State: _____ Date Signed: _____

Signature of Proposed Insured _____ Signature of Owner, if other than Insured _____

Signature of Spouse, if to be covered _____

Producer's Statement. I certify that to the best of my knowledge and belief the information in this application is complete, accurate and correctly recorded.

Signature of Producer _____ Print Producer's Name _____

Important Notice Under the Fair Credit Reporting Act:

In processing your application, an investigative report may be made. Information is obtained through interviews with third parties, such as family members, business associates, friends, neighbors, or others with whom you are acquainted. This inquiry includes information as to your character, general information and personal characteristics. You have the right to make a written request within a reasonable period of time for a complete and accurate disclosure of additional information concerning the nature and scope of the investigation. In addition, upon your request, you will be informed whether or not an Investigative Consumer Report was requested in connection with your application. If one was requested, you will receive the name and address of the consumer reporting agency to which the request was made. You may inspect and review a copy of the Investigative Consumer Report by contacting the consumer reporting agency. You may obtain a written summary of your rights under the Fair Credit Reporting Act. To do so, contact Allstate Life Insurance Company of New York, 100 Motor Parkway, Hauppauge, NY 11788. You have the right to correct any erroneous information in an Investigative Consumer Report.

IN/MIBNY-1 (03/07)

MIB Notice:

Information regarding your insurability is treated as confidential. We or our reinsurers may, however, make a brief report to the Medical Information Bureau (Bureau), a non-profit membership organization of life insurance companies, which operates an information exchange for its members. If you apply to another Bureau member company for life or health insurance coverage or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request from you, the Bureau arranges disclosure of any information it may have in your file. (Medical information is disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, contact the Bureau and seek a correction in accordance with the procedure set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, PH. #866-692-6901 (TTY 866-346-3642 for hearing impaired). Allstate Life Insurance Company of New York or its reinsurers may release information in its file to other insurance companies that you apply to for life or health insurance, or submit a claim to for benefits. However, no specific information pertaining to Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) will be disclosed to anyone outside the company or its employees, insurance affiliates or reinsurers. Such information will only be disclosed to the applicant and a physician designated by the applicant, in writing.

IN/MIBNY-1 (03/07)

ALLSTATE LIFE INSURANCE COMPANY OF NEW YORK
100 Motor Parkway, Hauppauge, New York 11788

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- Hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays:

- hospital or medical expenses up to the maximum stated in the policy

Medicare generally pays for most or all of these expenses.

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

- hospitalization
- physician services
- hospice
- outpatient prescription drugs if you are enrolled in Medicare Part D
- other approved items and services

Before You Buy This Insurance

- ✓ Check the coverage in **all** health insurance policies you already have.
- ✓ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.
- ✓ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).