

# Welcome to Credit Union-Approved Group Term Life Insurance

**Print out this kit for everything you need  
to decide if this coverage is right for you:**

- Up to \$125,000 Group Term Life Insurance for credit union members
  - Rate tables, showing the economical costs for this coverage
- Your application, if you decide to apply, ready to complete and mail to:

**LifeHelp  
6724 Lockheed Drive, Suite 1  
Redding, CA 96002-9004**

**You have two options for completing your application:**

1. Print out the form, fill in your information, sign and mail
2. Fill in your information electronically, print out the form, sign and mail

*That's it. It's that easy.*

## Young Family Group Term Life Insurance

- ✓ Up to \$125,000 of coverage to help better protect your loved ones
- ✓ Members-only group rates keep your premiums economical
- ✓ Your spouse may apply even if you do not.
- ✓ Dependent children can also be covered for \$10,000<sup>1</sup>.
- ✓ Medical Exam typically not required
- ✓ Easy, automatic payment from your credit union account
- ✓ Renew up to age 75 – regardless of health questions
- ✓ Just complete and mail the application included in this kit

<sup>1</sup>Dependent children can include children up to age 23 if full-time student.  
(Subject to state variations)

## Consider the financial consequences for family left behind:

- **Many people in the U.S. overestimate what the government pays after death...** The current Social Security death benefit is only \$255 – and not everyone qualifies.<sup>1</sup>
- **34% of families admit they will immediately have trouble meeting everyday expenses** if a primary wage earner dies.<sup>2</sup>
- **7 in 10 households are dual-income households** – and yet one-third of wives own no life insurance at all despite the fact that nearly 30 percent of wives earn more than their husbands.<sup>3</sup>

<sup>1</sup>U.S. Social Security Administration Web site, 9/2012.

<sup>2</sup>Trillion Dollar Baby – Growing Up, “LIMRA Web site, 9/2011.

<sup>3</sup>Facts About Life, “LIMRA Web site, 9/2012.

California Insurance Producer License Number: Agency # 0449782 Agent # OA80713, Arkansas Insurance Producer License Number: Agency # 247784 Agent # 46641

If you have any questions, please call LifeHelp toll-free at  
1-800-340-7401

5 a.m. to 5 p.m. Pacific Time, Monday through Friday

# Monthly Rates Exclusively For Credit Union Members Group Term Life Insurance

## Act Now For These Affordable Group Rates:

Rates as of 2013

Non-Tobacco*	Male			Female		
	\$125,000	\$100,000	\$75,000	\$125,000	\$100,000	\$75,000
Age						
18-24	\$15.92	\$12.83	\$9.75	\$5.60	\$4.58	\$3.56
25-29	13.21	10.67	8.13	6.33	5.17	4.00
30-34	15.92	12.83	9.75	9.35	7.58	5.81
35-39	23.00	18.50	14.00	13.73	11.08	8.44
40-44	31.23	25.08	18.94	22.27	17.92	13.56
45-49	49.15	39.42	29.69	32.58	26.17	19.75
50-54	68.63	55.00	41.38	44.56	35.75	26.94

Tobacco	Male			Female		
	\$125,000	\$100,000	\$75,000	\$125,000	\$100,000	\$75,000
Age						
18-24	\$30.40	\$24.42	\$18.44	\$12.79	\$10.33	\$7.88
25-29	26.23	21.08	15.94	14.04	11.33	8.63
30-34	30.71	24.67	18.63	20.92	16.83	12.75
35-39	44.25	35.50	26.75	32.06	25.75	19.44
40-44	64.15	51.42	38.69	52.27	41.92	31.56
45-49	99.35	79.58	59.81	75.08	60.17	45.25
50-54	136.75	109.50	82.25	102.48	82.08	61.69

**Spouse Coverage:** Your spouse, if under age 56, may also apply even if you do not.

**Children's Coverage:** All dependent children can also be covered, for an additional premium of \$3.34 per month. Benefit is \$10,000 for children ages 6 months to 19 years (23 if full-time student), \$500 for ages 14 days to 6 months. (Subject to state variations)

Economical group rates are based on your age at time of application and will change when you enter a new age band. You may apply for up to \$125,000, typically with no medical exam. At age 65, coverage reduces to the lesser of 50% of the original benefit amount or \$20,000, with a corresponding reduction in your premiums. Insurance terminates at age 75. The insurance company does reserve the right to change premium rates, but may only do so for all insureds covered under the group policy and with 60 days written notice. Rates shown above include a \$.50 administrative fee. A \$1.00 monthly processing fee will be charged for the monthly billing option.

Insurance is available up to \$125,000 on a simplified underwriting basis, in increments of \$5,000. Montana residents: Male rates apply to all applicants, regardless of gender. Please contact LifeHelp, the plan administrator, toll-free at 1-800-340-7401, for renewal costs for ages 55 through 74.

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. This coverage is underwritten by American General Life Insurance Company. Group Policy Number G-500,068, Form Number G-20000 issued to the Trustee of the Financial Institution Group Insurance Trust.

\* To qualify as a non-smoker, the member/spouse must not have used tobacco or nicotine in any form, including nicotine patches or nicotine gum, for the past 12 months.

**Questions?** Please call LifeHelp toll-free at

1-800-340-7401

5 a.m. to 5 p.m. Pacific Time, Monday through Friday

# Affordable, reliable group term life insurance available exclusively for credit union members

This coverage has been reviewed and approved by your credit union.

## Q. Who is eligible to apply?

A. You are eligible for this offer if you are a member in good standing under age 56, not in active military duty, and are able to perform the normal activities of a person of like age and sex, with like occupation or retired status.

## Q. Can I apply for coverage for my spouse or children?

A. Yes. Your spouse or domestic partner, if under age 56, may also apply. If you or your spouse are insured, you can also insure your unmarried, dependent child(ren), age 15 days to under 19 years (23 if full-time student), for \$10,000 (\$500 if age 15 days to under 6 months). The Accidental Death benefit also applies to spouse and child coverage.

Please note, the amount of dependent child(ren) coverage may vary by state laws and is subject to the limits imposed by the individual states. Spouses and independent children must not be hospitalized on the date insurance is to take effect. If so, insurance will take effect on the day after discharge.

## Q. Will my cost go up if my health changes?

A. No. Premiums may be increased only on a class-wide basis\* — you can never be singled out for a rate increase due to your age or health status. Your premium will be based on your age as of the date your policy is effective, then normal increases will occur as you enter each new five-year age band.

## Q. I'm a smoker – can I still apply?

A. Yes. This plan allows smokers to apply. Premiums are adjusted to reflect different risk levels.

## Q. Should I send a payment with my application?

A. No. your premium will be deducted from the credit union account you specify on your application. That way, you'll never have to bother writing checks, or worry about forgetting to make a payment.

## Q. How long will my policy last?

A. Coverage ends when you reach age 75, when the group policy ends, if insurance ends for your class, if you enter active military duty, or at the end of the period for which the last premium has been paid. When you reach 75, or 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.

## Q. Will I need a medical exam?

A. Answers to the questions on the application are typically all that is needed for coverage up to \$125,000, with no health exams or tests usually required.\*\* Acceptance is subject to evidence of insurability as determined by the underwriting company. If a paramedical exam is required, it will be scheduled at your convenience and at no cost to you. Coverage will begin on the first day of the month following the date your application is approved, and your first premium is received.

## Q. What exclusions are there?

A. If death is the result of suicide during the first two years of coverage; benefits are limited to return of premiums paid. 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.

The accidental death double benefit is paid in the event of death occurring as a direct result of, and within 90 days of, an accidental bodily injury while insured under this plan.

This double benefit will not be paid for any loss that results from or is caused directly, indirectly, wholly or partly by any of the following: suicide, or intentionally self-inflicted injury; insurrection, war or an act of war; a physical or mental sickness, or treatment of that sickness; voluntary intake of poison, drugs, gas or fumes, unless taken as prescribed by a doctor; committing a crime, or an attempt to do so; being intoxicated or under the influence of any drug, unless taken as prescribed by a doctor; being in active military duty in the service of any country; flight in any type of aircraft, unless the insured is traveling as a fare-paying passenger, or on a pass, and if the aircraft is licensed to carry passengers; the carrier is licensed to fly such aircraft; the aircraft is flown by a licensed pilot and the flight is regularly scheduled between established airports.

## Q. When does my coverage begin?

A. Your coverage is effective on the first day of the month on or after the date the insurance company approves your application, provided the initial insurance premium is paid within 31 days of such date and persons to be insured are performing the normal activities of a person of good health and like age as of the effective date.

\*A class is a group of people with the same age or gender.

\*\* 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.

The sponsoring Credit Union incurs costs in connection with providing oversight and administrative support for this sponsored plan. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The sponsoring Credit Union, or its affiliate, also receives a fee in connection with the plan.

The Insurance Company is not an affiliate of the Credit Union. While the Credit Union endorses the product offered, the Credit Union does not accept any liability for the product offered. This is an offer for insurance. It is 1) not a deposit, 2) not an obligation of or guaranteed by any credit union, and 3) not insured by the NCUA. The purchase of insurance will not affect the extension of credit in any way.

This credit union-approved plan is underwritten by American General Life Insurance Company. This is a brief summary of benefits and is subject to the terms, conditions, exclusions and limitations of group policy number G-500,068, form number G-20000. Coverage may vary and may not be available in all states.

# APPLICATION FOR GROUP TERM LIFE INSURANCE

Underwritten by American General Assurance Company (Herein called the Company)

Please print or type

## Member information

Name of Credit Union				
Name First Middle Last			E-mail Address	
Address Number Street City State Zip				
Home Phone No. ( )	Work Phone No. ( )		Social Security # - -	
Beneficiary			Relationship	
Name and Address of Member's Physician				
Age	Date of Birth (MM/DD/YY) / /	Place of Birth	Height ft. in.	Weight lbs. Sex <input type="checkbox"/> M <input type="checkbox"/> F

(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/Domestic Partner\* information

Name First Middle Last			E-mail Address	
Home Phone No. ( )	Work Phone No. ( )		Social Security # - -	
Beneficiary			Relationship	
Name and Address of Spouse's Physician				
Age	Date of Birth (MM/DD/YY) / /	Place of Birth	Height ft. in.	Weight lbs. Sex <input type="checkbox"/> M <input type="checkbox"/> F

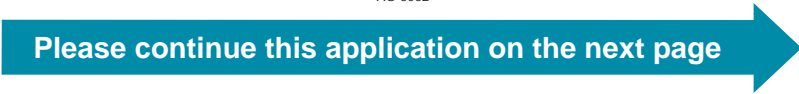
(Unless otherwise requested, the member will be the beneficiary of any spouse/domestic partner insurance applied for.)

## Select Life Insurance plan(s) desired

Amount:

Life Insurance for Member:	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$75,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> Other (specify): \$ _____
Life Insurance for Spouse:	<input type="checkbox"/> \$100,000	<input type="checkbox"/> \$75,000	<input type="checkbox"/> \$50,000	<input type="checkbox"/> Other (specify): \$ _____
Life Insurance for Children:	<input type="checkbox"/> \$10,000/child			Up to \$100,000 coverage in \$5,000 increments.

Unmarried dependent children are eligible for \$10,000 of coverage (\$500 if age 15 days to under 6 months). One economical premium covers all eligible dependent children, no matter how many are being covered.



Underwritten by American General Assurance Company (Herein called the Company)

## Select your payment mode

I wish to pay:  Quarterly  Monthly

Credit Union  
Account Number

Checking  Savings

As an account owner, I hereby authorize my Credit Union to deduct from my account such premium as may be required and to pay such amounts on my behalf to the Plan Administrator. I authorize the Plan Administrator to transmit my payments to the Insurance Company. I also authorize my Credit Union to provide or confirm my account number to the Plan Administrator to enable these deductions. This authorization shall continue until canceled by me in writing.

## Complete the child applicant information

Complete the following information for child(ren) for whom selecting coverage.

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

## Please answer these brief questions

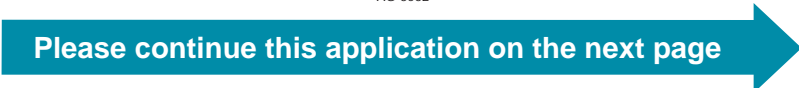
1. Has the member or spouse, if applying, ever had, been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder?
2. Has the 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?
3. Has the member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?
4. Is the member or spouse, if applying, now taking prescription medication or receiving medical attention?
5. Has the member or spouse, if applying, ever had life or health insurance declined, modified, or rated?

Member	Spouse
1. <input type="checkbox"/> YES <input type="checkbox"/> NO	1. <input type="checkbox"/> YES <input type="checkbox"/> NO
2. <input type="checkbox"/> YES <input type="checkbox"/> NO	2. <input type="checkbox"/> YES <input type="checkbox"/> NO
3. <input type="checkbox"/> YES <input type="checkbox"/> NO	3. <input type="checkbox"/> YES <input type="checkbox"/> NO
4. <input type="checkbox"/> YES <input type="checkbox"/> NO	4. <input type="checkbox"/> YES <input type="checkbox"/> NO
5. <input type="checkbox"/> YES <input type="checkbox"/> NO	5. <input type="checkbox"/> YES <input type="checkbox"/> NO

IMPORTANT: If you answered "Yes" to any questions above, your application cannot be processed without details on all "Yes" answers in the space below. If more space is needed, use a separate sheet of paper, signed and dated, and check "Yes" in the box at the right.

Additional Information Attached?  
 YES  NO

Question #	Member	Spouse	Condition	Date Occured	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					
	<input type="checkbox"/>	<input type="checkbox"/>					



Underwritten by American General Assurance Company (Herein called the Company)

## Existing and pending insurance section

Life Insurance In Force and/or Pending on Proposed Insured's Life, including any insurance through work: (If none, check "None").

If you have questions when completing this section, please call 1-800-340-7401.

None

Member	Spouse	Name of Company	Type of Coverage	Life Amount	Year Issued	Do you plan to replace this coverage?
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/>	<input type="checkbox"/>					<input type="checkbox"/> Yes <input type="checkbox"/> 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 MIB, Inc., formerly known as 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 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.

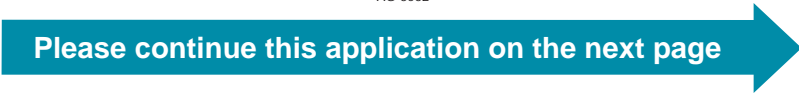
\*Wherever the term spouse appears will read as Domestic Partner throughout the application.

\*\*Dependent Child must be unmarried, up to 19 years of age (23 if a full-time student). All dependents must be dependent in accordance with IRS guidelines.

**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. (This notice does not apply in Virginia.) (For state specific variations, please see below.)

<input checked="" type="checkbox"/> Member/Applicant's Signature	Date	<input checked="" type="checkbox"/> Spouse/Domestic Partner's Signature	Date
------------------------------------------------------------------	------	-------------------------------------------------------------------------	------

**For residents of Arkansas, Louisiana and West Virginia:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **For residents of Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **For residents of the District of Columbia: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **For residents of Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **For residents of Tennessee and Washington:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits. **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **For residents of New Mexico:** ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO CIVIL FINES AND CRIMINAL PENALTIES. **For residents of New York:** 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. **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud. **For residents of Oklahoma: Warning:** Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony. **For residents of Pennsylvania:** 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 subjects such person to criminal and civil penalties.



## THESE NOTICES MUST BE RETAINED BY THE APPLICANT

### 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.

### MIB DISCLOSURE NOTICE

(Retain for your records)

Information regarding your insurability will be treated as confidential. American General Assurance Company 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 procedure 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.

American General Assurance Company, 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](http://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.

Complete and mail the first three pages of this application to:  
**LifeHelp, 6724 Lockheed Drive, Suite 1, Redding CA 96002-9004**

Send no money! Once your coverage is approved, your premiums will be conveniently deducted from your designated credit union account.

Questions?

**Call LifeHelp toll-free: 1-800-340-7401**

5 a.m. to 5 p.m. Pacific Time, Monday through Friday