

BUY \$30,000 LIFE INSURANCE FOR ONLY \$8.70 MONTHLY

(Age 30, 5-Year Renewable Term)

Apply the easy way - by mail today!

Just complete and mail this application to: Life Insurance Department, Genesee Savings Division of The New York Bank For Savings, Culver Ridge Plaza, 2255 E. Ridge Road, Rochester, N.Y. 14622

If you are between 15 and 70 years of age, you can now apply for any plan of life insurance (except Family Plan) up to \$30,000 with this application. A medical may not be required for applicants 15-35. Between the age of 35 to 40, amounts over \$20,000 require a medical, and for ages 40 to 70 a medical is required for all amounts.

See the chart below for examples of low monthly premiums on 5-year Renewable Term insurance. Dividends are payable annually starting the first year as earned, further reducing the already low cost. No agent will call on you, and you will be under no obligation. But you must live or work in New York State to qualify. Once your policy is taken out, however, it remains in force no matter where you may live. Just read this ad through, complete the application and mail it to us. We do the rest. Act today.

IMPORTANT: Read before completing application NOTIFICATION

IN ACCORDANCE WITH FEDERAL LAW
This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes informa-

tion as to your character, general reputation, personal characteristics and mode of living.

You have the right to make a written request within a reasonable period of time to receive additional information about the nature and scope of this investigation. If the application for insurance is on a minor, then the above information may be obtained on the Payor of the policy.

NOTIFICATION IN ACCORDANCE WITH MEDICAL INFORMATION BUREAU RULES

Information regarding your insurability will be treated as confidential. We may, however, make a brief report thereon to the Medical Information Bureau, a non-profit membership organization of life insurers which operates an information exchange in behalf of its members. If you apply to another Bureau member insurer for life or health insurance coverage, or a claim for benefits is submitted to such an insurer, the Bureau, upon request, will supply such insurer with the information it may have in its file. Upon receipt of a request from you, the Bureau will ar-

range disclosure of any information it may have in your file. (Medical information will be disclosed only to your attending physician.) If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660.

We may also release information in our file to other life insurers to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

Coverage	Age 20	Age 25	Age 30	Age 35	Age 40
\$10,000	\$2.70	\$2.90	\$3.10	\$ 3.60	\$ 4.90
20,000	5.00	5.40	5.80	6.80	9.40
30,000	7.50	8.10	8.70	10.20	14.10

Phone 544-5990 for annual premium costs on 5-year Renewable Term and Straight Life Insurance

Med. No.	SAVINGS BANK USE ONLY	Age (nearest birthday)	Aprv	Rate	Decl	Date	By	W Ap 1 Ap 2 Decl Not EI	Memo Chkd By	Iss Date Req Iss Date	Pol No. App Tkn By
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Part 1 APPLICATION FOR SAVINGS BANK LIFE INSURANCE - ADULT Number of Agency Bk. _____

TO: **THE NEW YORK BANK FOR SAVINGS 2**

1. Name of person to be insured (type or print)

(first) (middle) (last)

2. Home address

(number & street) (city, state) (zip code)

3. Place of birth (state or country) 4. Date of birth (mo.)(day)(year)

5. Male 6. Height (ft.-in.) 7. Weight (lbs.) 8. Amount of insurance (\$)

Female

9. (a) Primary beneficiary (if more than one, to share equally)

name and relationship to insured

address (number & street) (city, state) (zip code)

(b) Secondary beneficiary (to receive proceeds if primary beneficiaries die before the insured)

name and relationship to insured

address (number & street) (city, state) (zip code)

10. Disability waiver of premium benefit? Yes No

11. Occupation _____ 12. Kind of policy _____

13. How are Premiums to be paid? Annually Quarterly Semi-annually Monthly

14. How are Dividends to be Paid? 1. In cash 2. Reduce premiums 3. Purchase paid up additions* 4. Accumulate at interest *Not available on term insurance policies

5. Purchase one year term insurance* insurance policies

15. Automatic Premium Loan? Yes No (Not available on term insurance policies)

16. (a) Is the insurance to replace any life insurance now in force? Yes No (b) If "yes" indicate Amount(s) Company(s)

17. Give details to all "Yes" answers to Questions 18 to 21 below, including names and addresses of physicians, hospitals, dates, conditions, tests, duration and treatment.

18. Have you ever been treated for or been diagnosed as having: (a) disease of the heart, lungs, kidney, prostate, bladder, male or female organs, liver, stomach, intestines, brain or nervous system, lymph, endocrine or other glands; (b) high blood pressure, stroke, cancer or tumor, diabetes, or blood disorder? Yes No

19. Have you ever been treated for alcoholism or any drug habit? Yes No (b) Do you use alcoholic beverages? Yes No If "yes," state how much consumed per day _____ (c) Have you ever used narcotics, barbiturates, amphetamines, hallucinogens, or any prescription drug except in accordance with a physician's instructions? Yes No

20. In the last 5 years have you: (a) had a physical examination, sought treatment or consulted a physician or other practitioner for any reason? Yes No (b) been confined to a hospital or medical institution? Yes No (c) had an electrocardiogram, X-ray, or blood or urine test? Yes No

21. Have you ever been rejected, retired, or discharged from military service or employment because of a physical or other impairment? Yes No

Except as stated above, to the best of my knowledge and belief I am now in good health, and the statements contained herein are true and are made for the purpose of inducing the Savings Bank to issue a policy of life insurance. A copy of this application and Part II, if applicable, shall be attached to and made part of the policy. The policy together with the application shall constitute the entire contract and cannot be modified without written consent of the Savings Bank. I agree that, except as may be provided in a conditional receipt issued by the Savings Bank in connection with this application, the policy applied for in this application shall not take effect unless, on the date of delivery of the policy, the person to be insured is in the state of health and insurability as stated in the answers to the questions set forth above and in Part II.

Authorization: I hereby authorize any licensed physician, medical practitioner, 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 Medical Director of Savings Banks Life Insurance Fund any such information. This is a personal request from me and your cooperation will be appreciated. A photographic copy of this authorization shall be as valid as the original.

Date _____, 19____ Signature of person to be insured X _____ Soc. Sec. No. _____

The only assets of this Savings Bank which are liable for and applicable to the payment and satisfaction of the liabilities, obligations and expense of the Life Insurance Department of this Savings Bank are the assets of the Life Insurance Department of this Savings Bank

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