MEMORANDUM

To: Full-Time Staff

From: Rosie Kahan
   Director of Human Resources

RE: SUPPLEMENTAL LIFE INSURANCE

Date: August 31, 2007

The Supplemental Life Insurance benefit will take effect on October 1, 2007. You can purchase up to three times your annual salary to a maximum of $1,500,000 combined Basic and Supplemental Life. In addition, you can also purchase life insurance for your spouse and children.

If you are interested in signing-up for this benefit, please come into the Human Resources office, or call 212-463-0400, extensions 755/706/707.
These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The 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 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 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.

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.
American General

Statement of Insurability for Group Insurance

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

New York, New York
Administrative Office: 3600 Route 66, P.O. Box 1583, Neptune, NJ 07754-1583

GROUP POLICY NO.: ____________________ SOCIAL SECURITY NO.: __________________________________________

Use this form to give a statement for any combination of: yourself, your spouse and/or your eligible children. In all cases you must complete the EMPLOYEE/MEMBER DATA section. Please print or type all information requested.

EMPLOYEE/MEMBER DATA
1. Your full name: ___________________________ Salary: _______________ Male □ Female □
2. Mailing Address: ___________________________ City: _______________ State: _______________ Zip: _______________
3. Employed by: ___________________________ Date employed: _______________
4. Are you now working at least 30 hours per week with your present employer? Yes □ No □ Job Title _______________

PERSONAL DATA
5. Give the following details about:
   a. yourself if you are giving a statement of insurability: _______________
   b. your spouse if she or he is giving a statement of insurability: _______________
   c. your eligible children if they are giving a statement of insurability:

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<tr>
<th>Child’s name</th>
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INSURABILITY QUESTIONS
In the following questions, “person” refers to each person (you only, your spouse and/or each eligible child) who is giving a statement of insurability. Answer each question by checking the “Yes” or “No” box, as it applies.

6. WITHIN THE PAST 7 YEARS, HAVE YOU HAD AND BEEN TREATED FOR: (Circle specific disorders experienced.) YES NO
   a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? □ □
   b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? □ □
   c. Arthritis, gout, bursitis or rheumatism? □ □
   d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? □ □
   e. Disease or disorder of rectum or anus? Varicose veins or other vascular disorder? □ □
   f. Diabetes? Sugar, albumin or pus in urine? Thyroid or other glandular disorder? □ □
   g. Duodenal or stomach ulcer, or other disorder of stomach, liver, gall bladder?
      Colitis, diverticulitis, or other disorder of small or large intestine? □ □
   h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis or other kidney disorder? Urinary infection? □ □
   i. Menstrual, uterine or ovarian disorder? Disorder of the breast? □ □
   j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting or other disorder of lung or nose? □ □
   k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? □ □
   l. Mental or emotional problem requiring help of a physician or psychologist? □ □
   m. A surgical operation? A surgical operation advised but not performed? □ □

7. Have you had treatment by, or consultation with, any hospital, institution, physician or practitioner within the past 7 years? □ Yes □ No
   GIVE DETAILS BELOW IF: (A) “Yes” to any part of question 6, or (B) “Yes” to question 7 for a condition not specified in question 6.

| Question No. | Name of Person | Condition | Date Occurred | Duration | Degree of Recovery | Names & Addresses of Physicians Hospitals or Clinics Consulted |
AUTHORIZATION AND DECLARATION

1. 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 United States Life or its reinsurers any such information. Such information will pertain to my employment, or other insurance carrier or medical care, advice, treatment or supplies for any physical or mental condition. This includes that information obtained in connection with the preparation or procurement of an investigation 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 United States Life to collect and transmit such information.

2. I understand that this information will be used by United States Life solely to determine eligibility for insurance.

3. I understand that I may revoke this authorization at any time. I agree that such revocation will not affect any action which United States Life has taken in reliance upon this authorization. I understand this authorization will not be valid after 30 months, if not revoked earlier.

4. I know that I should retain a copy of this authorization for my records.

5. I agree that a photocopy of this authorization is as valid as the original.

6. To the best of my knowledge and belief, all statements made above are true and complete.

7. 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.

8. I authorize deductions from earnings for the costs of this insurance.

(Date Signed) (Signature of Employee/Member)

(Date Signed) (Signature of Spouse, if giving a statement of insurability)

(Date Signed) (Signature of child who is not a minor, if giving a statement of insurability)
Important Notice

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 Florida: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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 Maine, Tennessee, Virginia 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 Maryland: Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully 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 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.

The following statement does not apply to an application for life insurance in New York:

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.