GROUP OFFICE OVERHEAD EXPENSE INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN COLLEGE OF PHYSICIANS

Complete this form and send no money to:
ADMINISTRATOR
ACP MEMBER INSURANCE PROGRAM
PO BOX 9947, Phoenix, AZ 85068
Questions? Call: 1.855.749.7908

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Ave., New York, NY 10010

1 Member Information:

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Member Name: (FULL NAME: LAST - FIRST - M.I.)

Home Address:

City, State, Zip:

Home Phone: ( ) – Office Phone: ( ) – Fax: ( ) –

Social Security # – – Height: ft. in. Weight: lbs. Sex: ◯ Male ◯ Female

Member Date of Birth: MM – DD – YYYY Email Address:

Do you intend to reside outside the U.S. in the next 12 months?

◯ Yes, Countries: For how long? ◯ No

2 Member Affiliation—Occupational Status:

A. Are you applying as: Full member in good standing of the American College of Physicians? ◯ Yes ◯ No

Member #:

Physician Affiliate ◯ Yes ◯ No Non- Physician Affiliate ◯ Yes ◯ No

B. Average month amount of "Covered Overhead Expenses" in preceding 6 months $

C. Practicing as ◯ Corporation ◯ Partnership ◯ Individual

D. If corporation or partnership, for what amount of monthly "Covered Expense" are you responsible? $

E. Average number of employees

F. What is your occupation?

Main Duties

G. FULL -TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ◯ Yes ◯ No

3 Insurance Requested:

Refer to the Policy Details for eligibility, options and coverage description. I request the following coverage: ◯ New ◯ Additional

I hereby apply for the coverage indicated below, based upon all my statements made in this application:

Waiting Period: ◯ 30 days ◯ 60 days **Benefit Period:** ◯ 1 year ◯ 2 years ◯ 3 years

Indicate Monthly Benefit Option desired. Choose amount of protection from $1,000 to $15,000 in increments of $500: $

Continued on page 2

3 Insurance Requested *(Continued)*

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability?

◯ Yes ◯ No If yes, please list:

COMPANY	POLICY	MONTHLY BENEFIT	BENEFIT PERIOD

4 Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you:

	YES	NO
1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?	◯	◯
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:		
A. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	◯	◯
B. Other Health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	◯	◯
(ii) Have you ever been tested positive for exposure to the HIV infection, or been diagnosed as having ARC (AIDS-Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection, or other sickness or condition derived from such infection?	◯	◯
(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	◯	◯
(iv) Any other impairment?	◯	◯
3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	◯	◯
4. Are you now pregnant?	◯	◯
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	◯	◯
6. During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	◯	◯
7. Driver's License No.: _____ State in which issued: _____		
8. ***Except for Residents of CT and MN:*** Have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	◯	◯
For Residents of CT and MN: Have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	◯	◯
9. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?	◯	◯

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4 Statement of Health: Please initial any changes you make on this form. *(Continued)*

If you have answered any of the above Questions 1-9 YES, give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery-Date	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, LLC. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the insurance administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member **requests** the insurance indicated; and the member **consents** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, LLC.; and **attest** to having read the IMPORTANT NOTICE attached and the Fraud Notices indicated below, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: X _____ **Today's Date:** ☐☐ – ☐☐ – ☐☐☐☐
MM DD YYYY

Please complete all pages and sign this page. Send no money with this application.

Once completed and dated, this should be submitted at once to:

ACP Member Insurance Program
P.O. Box 9947, Phoenix, AZ 85068 • 1-855-749-7808

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66630 ©2023 AGIA CP-34106
101411 (1 Year)
101415 (2 Year)
101416 (3 Year)
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5 Fraud Notice:

FRAUD NOTICE – ***For residents of all states except those listed below:*** 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 may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO,** the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: 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.

RESIDENTS OF CA: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR RESIDENTS OF D.C., 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.

RESIDENTS OF FL: 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.

RESIDENTS OF KS: 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 may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to any insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF OK: 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.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: 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.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.