GROUP TERM LIFE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN COLLEGE OF PHYSICIANS

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

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

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 #: – – Email Address:

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widow(ed) ◯ Civil Union* ◯ Domestic Partner*

*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any ACP Group Life Insurance Policies? ◯ Yes ◯ No

If "Yes," indicate which policy(s) and provide details (person insured and amount of insurance):

◯ Senior Term Life ◯ Term Life ◯ 10-Year Level Term Life ◯ 20-Year Level Term Life

Details:

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?

Member: Yes, Countries: For how long? ◯ No

Spouse: Yes, Countries: For how long? ◯ No

Member: Name First/MI/Last Date of Birth: – – MM DD YYYY

Height: ft. in. Weight: lbs. Sex: ◯ M ◯ F

Spouse*: Name (if proposed for insurance) First/MI/Last Date of Birth: – – MM DD YYYY

Height: ft. in. Weight: lbs. Sex: ◯ M ◯ F

Child(ren)*: Name (if proposed for insurance) First/MI/Last Date of Birth: – – MM DD YYYY

Height: ft. in. Weight: lbs. Sex: ◯ M ◯ F

Name (if proposed for insurance) First/MI/Last Date of Birth: – – MM DD YYYY

Height: ft. in. Weight: lbs. Sex: ◯ M ◯ F

* See Policy Details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

Continued on page 2

2 Membership Affiliation

Are you currently a member in good standing with the American College of Physicians? ◯ Yes ◯ No

Member #:

3 Insurance Requested:

(Refer to the Policy Details for eligibility, options and coverage description)

Initial Member Life Insurance Amount: $

◯ **Initial** Member AD&D Insurance (equal to life amount)

Initial Spouse* Life Insurance Amount: $

◯ **Initial** Child Insurance Amount: $5,000 each eligible child

Increase Member Life Insurance Amount from $ to $

Increase Member AD&D Insurance Amount: $ (not to exceed member's Life amount)

Increase Spouse* Life Insurance Amount from $ to $

*Spouse coverage cannot exceed 50% of member's coverage.

Note: Coverage must be in $10,000 units. Member coverage must be in force to request dependent coverage.

Do you have other life insurance in force? If "Yes," total amount in all companies:

Member $ Spouse $

Do you have other insurance applications pending? If "Yes," total amount in all companies:

Member $ Company

Spouse $ Company

Insurance Replacement

RESIDENTS OF NEW YORK—IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or be continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Member ◯ Yes ◯ No Spouse ◯ Yes ◯ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy?

Member ◯ Yes ◯ No Spouse ◯ Yes ◯ No

Continued on page 3 ➡

4 Beneficiary Designation

(Insert name, relationship, and address)
I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life and Accidental Death and Dismemberment Insurance. The beneficiary for dependent coverage shall be the insured member. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet, if necessary.)

◯ Primary ◯ Contingent ◯ %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth (MM/DD/YYYY): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

◯ Primary ◯ Contingent ◯ %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth (MM/DD/YYYY): _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

5 Statement of Health:

(Please initial any changes you make on this form.) To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

	YES	NO
1. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	◯	◯
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	◯	◯
3. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	◯	◯
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	◯	◯
5. Is any person to be insured now pregnant?	◯	◯
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	◯	◯
b. Arthritis, back trouble, bone or joint disorder?	◯	◯
c. Fainting spells, convulsions or epilepsy?	◯	◯
d. Sugar, blood, albumin or pus in urine?	◯	◯
e. Diabetes, kidney trouble, ulcers or digestive disorder?	◯	◯
f. Disorder of breast or reproductive organs or functions?	◯	◯
g. Nervous or mental disorder, emotional conditions or psychiatric care?	◯	◯
h. Cancer, tumor or cyst?	◯	◯
i. Varicose veins, hemorrhoids or hernia?	◯	◯
j. Disorder of eyes, ears, nose or sinuses?	◯	◯
k. Thyroid, liver or respiratory disorder?	◯	◯
l. Alcoholism or drug habit?	◯	◯
m. Disorder of the blood?	◯	◯
n. Other Health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ?	◯	◯
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	◯	◯
(iii) Any other impairment?	◯	◯

5 Statement of Health *(continued)*:

(Please initial any changes you make on this form.) To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

	YES	NO
7. Except for residents of Maryland, has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuro-muscular or mental illness?	◯	◯
8. Within the past two years, have you or your spouse participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	◯	◯
Have you or your spouse had a driver's license suspended or revoked or had any moving violations within the last five years?	◯	◯
10. ***Except for the residents of Minnesota and Connecticut,*** in the last seven years, have you and/ or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	◯	◯
For the residents of Minnesota and Connecticut only, in the last seven years, have you and/ or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	◯	◯

9. Driver's License No.: Member _____
Spouse _____

If you have answered any Questions "Yes" give complete details below.
(Attach a separate sheet if necessary, then sign and date it).

Name of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

6 Declarations:

I understand that New York Life 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.

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, 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, 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; the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC.; and **attest** to having read the IMPORTANT NOTICE indicated below and the Fraud Notices indicated below, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Members Signature: X _____ (PLEASE SIGN AND DATE IN INK.)

Today's Date: X ☐☐ – ☐☐ – ☐☐☐☐ (MM – DD – YYYY)

Spouse's Signature: X _____ (NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED. PLEASE SIGN AND DATE IN INK.)

Today's Date: X ☐☐ – ☐☐ – ☐☐☐☐ (MM – DD – YYYY)

Owner Information is required if owner is other than Applicant

(If Owner is a Trust, please submit a copy of the document with this application.)

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

Mailing Address: _____

City, State, Zip: _____

Relationship to Proposed Insured: _____ Daytime Phone: (☐☐☐) ☐☐☐ – ☐☐☐☐

Email Address: _____ Date of Birth: ☐☐ – ☐☐ – ☐☐☐☐ (MM – DD – YYYY)

Tax I.D. #: _____ Social Security #: ☐☐☐ – ☐☐ – ☐☐☐☐

Owner's Signature: X _____ (NECESSARY ONLY IF OTHER THAN MEMBER)

Today's Date: X ☐☐ – ☐☐ – ☐☐☐☐ (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 • 1-855-749-7908

11/20 ed.
CP-47274
104750
D3883

G-29102-0

Continued on page 6

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

RESIDENTS OF MD: Any person who knowingly or willfully presents a false and 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 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 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.