Senior Group Term Life Insurance

ACP
American College of Physicians
Leading Internal Medicine, Improving Lives

Negotiated For ACP Members And Their Families

ACP Program Administrator
12421 Meredith Drive
Urbandale, IA 50398

NEW YORK LIFE

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

To Apply:

Complete this form and return to:
Administrator
ACP Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

For residents of Puerto Rico, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

Questions? 1-888-643-0323

Send No Money Now

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.

1 MEMBER INFORMATION

Name

Address

City State ZIP

Please check one:
☐ Home address
☐ Business address

Home Phone **Social Security #**

Date of Birth **Height** ft. in. **Weight** lbs. **Sex** ☐ Male ☐ Female

Email (For internal use only for important announcements, time-sensitive bulletins or member notifications. Neither ACP nor the Plan Administrator will sell or rent your email address under any circumstances.)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union*

☐ Domestic Partner* ((Submit a completed Declaration of Domestic Partnership form—not applicable in OR.)

*Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Spouse/Eligible Partner

Name

Social Security #

Date of Birth **Height** ft. in. **Weight** lbs. **Sex** ☐ Male ☐ Female

Are you presently insured under any ACP Group Life Insurance Plans? ☐ Yes ☐ No

If "Yes," indicate which plan(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, Country For How Long? ☐ No

Spouse: ☐ Yes, Country For How Long? ☐ No

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Please complete all pages and sign on page 4

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2 MEMBERSHIP AFFILIATION

Are you now a member of the American College of Physicians? ☐ Yes ☐ No

Membership # _____ Expiration Date _____

(Membership in ACP is required for participation in the plan.)

3 INSURANCE REQUESTED (Please refer to the brochure for eligibility, options and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING INSURANCE COVERAGE(S)

SENIOR GROUP TERM LIFE INSURANCE: Member (Choose one amount) ☐ $50,000.00 ☐ $100,000.00

Spouse* (Choose one amount) ☐ $50,000.00 ☐ $100,000.00

*Spouse/eligible partner coverage cannot exceed member coverage.

Do you have any other life insurance in force? ☐ Yes ☐ No

If "Yes," total amount in all companies: Member $ _____ Spouse $ _____

Do you have other insurance applications pending? ☐ Yes ☐ No

If "Yes," indicate total amount in all companies: Member $ _____ Company _____

Spouse $ _____ Company _____

Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member _____ (MO/YR) _____ (Product) Spouse _____ (MO/YR) _____ (Product)

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

4 BENEFICIARY DESIGNATION (Insert name, relationship and address)

I make the following beneficiary designation with respect to all insurance on my life under this Group Senior Term Life Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (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, then sign and date it.)

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____ (Last) (First) (MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____ (Last) (First) (MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

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Please complete all pages and sign on page 4

5 STATEMENT OF HEALTH (Please initial any changes you make to this form.)

To the best of your knowledge and belief answer the following questions as they apply to you and your spouse, if applying for spousal coverage.

		Member		Spouse	
1.	Is any person proposed for insurance now taking any prescribed medication or, receiving or contemplating any medical attention or surgical treatment?	☐ Yes	☐ No	☐ Yes	☐ No
2.	During the past five years, has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated high blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotheraputic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis or unexplained weight loss?	☐ Yes	☐ No	☐ Yes	☐ No
3.	During the past five years, has any person proposed for insurance been counseled, treated or hospitalized for the use of drugs or alcohol?	☐ Yes	☐ No	☐ Yes	☐ No
4.	During the past five years has any person proposed for insurance suffered from incontinence or required assistance in bathing, toileting, dressing, eating, cooking or transferring?	☐ Yes	☐ No	☐ Yes	☐ No
5.	Has any person proposed for insurance 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, neuromuscular or mental illness?	☐ Yes	☐ No	☐ Yes	☐ No

Please note: Mental disorders include Neurocognitive diseases such as Alzheimers, dementia, neurosis, etc.

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS, GIVE COMPLETE DETAILS BELOW.
(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various" or "miscellaneous.")

Question No.	Name of Proposed Insured	Illness or Condition—Date of Onset—Duration—Treatment—Operation—Degree of Recovery and Date	Name and Address of Physicians or Other Practitioners and Hospitals Where Confined or Treated

YOU MAY BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE TO ASK ABOUT YOUR MEDICAL HISTORY

	PLACE	DAY	TIME OF DAY
Best place and time to contact you (Choose one of each):	☐ Residence ☐ Business	☐ Weekdays ☐ Weekends	☐ Morning (7:00–12:00) ☐ Afternoon (12:00–5:00) ☐ Evening (5:00–8:00) ☐ Night (8:00–11:00)

Please complete all pages and sign on page 4

6 AUTHORIZATION

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, MIB, Inc. (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 Plan 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 redisclosed 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 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 your protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how our information is exchanged with MIB, and that to best of your knowledge and belief, the answers provided to the question are true and complete.

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

MEMBER'S SIGNATURE X _____ **DATE** _____

(PLEASE SIGN AND DATE IN INK.)

SPOUSE'S SIGNATURE X _____ **DATE** _____

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED. PLEASE SIGN AND DATE IN INK.)

Questions?
Call 1-888-643-0323
Email: ACPgroupins.service@mercer.com

SEND NO MONEY NOW!
You will be billed upon approval