GROUP DECREASING TERM LIFE & ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN COLLEGE OF PHYSICIANS

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 PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS?
CALL: 1-888-643-0323
ACPgroupins.service@mercer.com

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

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:

(Please make any necessary corrections to your full name and street address if shown below.)

Name: ______________________________
Last First MI

Add 1: ______________________________

Add 2: ______________________________

City, St., Zip: ______________________________

Social Security #: ☐☐☐–☐☐–☐☐☐☐

Home Phone: (____)______________

Work Phone: (____)______________

Fax: (____)______________

Email Address: ______________
Mercer Consumer will not share your email information

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)
❑ Civil Union* ❑ Domestic Partner* (Submit a completed Declaration of Domestic Partnership form — not applicable in OR.)
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any ACP Group Life Insurance Plans? ❑ Yes ❑ No
If "yes," indicate which Plan(s) and provide details (person(s) insured and amount of insurance):
❑ Term Life ❑ 10-Year Level Term Life ❑ 20-Year Level Term
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

	DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:______________	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Spouse*: ______________ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Child(ren)*: ______________ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
______________ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F

* See Plan Information/Plan 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.

2. Membership Affiliation:

Are you currently a member in good standing with the ACP? ❑ Yes ❑ No

Membership Number:______________

3. Payment Option:

(Choose only one)

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the ACP Group Insurance Program, Inc. to make ❑ monthly ❑ quarterly ❑ semiannual ❑ annual withdrawals against the account specified on the attached voided check and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Decreasing Term Life Insurance Plan. (Enclose a VOIDED check.)

X

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

❑ **OPTION 2: PERIODIC BILLING:** ❑ Semiannual ❑ Annual ❑ Quarterly

4. Insurance Requested:

(Refer to the Plan Information/Plan Details for eligibility, options and coverage description)

Initial Member Life Insurance Amount: $____________

Initial Member AD&D Insurance Amount: $____________
(not to exceed member's 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," indicate amount and company:

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 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

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE ➡

5. 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 Decreasing Term Life and Accidental Death and Dismemberment Insurance Plan and, if I am already covered under the Plan, I revoke any prior designation. 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 ❑ Secondary %: ___________

Beneficiary Name:____
Last First MI

Beneficiary's Relationship to Member: ___________________________

Beneficiary Social Security #: __________________________________

Street Address: ____

City __________________________ State _____ Zip Code _________

❑ Primary ❑ Secondary %: ___________

Beneficiary Name:____
Last First MI

Beneficiary's Relationship to Member: ________________________

Beneficiary Social Security #: _______________________________

Street Address: ____

City ________________________ State _____ Zip Code ________

6. Contact Information and Fraud Notice: (Please initial and date any changes you make on this form.)

This part of the application consists of meeting with a paramedic to take a simple exam, provide clinical specimens and give your statement of health. This data will be used for underwriting purposes by New York Life Insurance Company. Send no money at this time. If you are approved for coverage, we will advise you of your rate classification, effective date of coverage and enclose an invoice with your premium amount due.

What is the best time to contact you to arrange for a Paramedic visit to complete your Application, PARA-MED statement of health?
❑ a.m. ❑ p.m. ❑ E-mail ❑ Phone

Phone Number _____-_____-______ E-mail: _______________________________

Medical Requirements: Some, not all applicants, may need a physical exam, blood test of EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly-at your convenience and without any cost to you through our professional paramedic service. A paramedic will contact you to make an appointment.

FRAUD NOTICE – ***For residents of all states except those listed below and 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 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: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 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 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.

7. Declarations:

I **understand** that New York Life has the right to require additional medical 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 may supplements to it, while considering this request. I also understand that the coverage afforded will be inconsideration of the answers and statements set forth above.

AUTHORIZATION: I authorize hereby any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or 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, 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 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.

BE SURE TO COMPLETE ALL PAGES AND SIGN LAST PAGE ➡

7. Declarations: *(continued)*

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, Inc.; and **attest** to having read the IMPORTANT NOTICE indicated below and the Fraud Notices indicated above, 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.

Member's Signature X ______________________________ **Date**__________
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X ______________________________ **Date**__________
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

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.)

Full Name: Last	First	Middle Initial	Relationship to Proposed Insured	Daytime Phone

Mailing Address: Street	City	State	Zip Code

Tax ID#	Date of Birth	Social Security Number
	/ /	☐☐☐-☐☐-☐☐☐☐

Owner's Signature X ______________________________ Date __________
(NECESSARY ONLY IF OTHER THAN MEMBER)

BEFORE YOU MAIL THIS APPLICATION, It will greatly speed action on your application if you review it carefully. Have all questions been answered? If you have made corrections or strike-outs, these must be initialed by the member.

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.

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IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Decreasing Term Life Insurance Plan

In this notice, references to “you” and “your” include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (“MIB”). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other application for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a “need to know” basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB’s information office is: MIB, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site at www.mib.com.

For NM Residents: PROTECTED PERSONS[1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION***[2] *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1]***PROTECTED PERSON*** *means a victim of domestic abuse; who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured person.*

[2]***CONFIDENTIAL ABUSE INFORMATION*** *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

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Group Decreasing Term Life and Accidental Death & Dismemberment Insurance Plan

Underwritten by New York Life Insurance Company

For American College of Physicians Members and Their Families

ABOUT THIS PLAN

Term coverage is the purest kind of life insurance, with no costly savings features. Decreasing term life insurance is a type of term coverage in which the death benefit amount decreases as you age. This is typically because there is less need for higher coverage because, for example, children become more self-sufficient and/or your mortgage may be paid off. Accidental Death &Dismemberment (AD&D) provides additional coverage if you're seriously injured or killed due to a covered accident. This plan combines these two valuable types of insurance coverage in one plan. However, you also have the choice to only purchase the Decreasing Term Life coverage.

ELIGIBILITY

All ACP Members, Associates, Medical Students, Physician Affiliates, Non-Physician Affiliates, Fellows and Masters under age 60 may request coverage for themselves, their lawful spouse under age 60 and all unmarried dependent children ages 15 days through 25 years. In order to become insured, individuals must provide satisfactory evidence of insurability and the required premium must be paid.

A dependent who is also a member is eligible for either member or dependent coverage, but not both. If both the member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

Non-Dependent Family Members: Any eligible "nondependent" family members may also apply for coverage as long as they join ACP as an Associate Member. For membership information, please call ACP directly at 1-800-523-1546.

APPLY FOR UP TO $1,000,000 OF COVERAGE

Choose the amount of Group Decreasing Term Life Insurance you need to help protect you and your family.

Amounts Of Life Insurance:

Members–$10,000 up to $1,000,000 in $10,000 multiples.

Spouse–$10,000 up to $500,000 in $10,000 multiples, not to exceed 50% of member's coverage.

Child(ren)–$5,000. ($500 for eligible children under age six months.)

The total amount of coverage an individual may have under all group life insurance plans underwritten by New York Life Insurance Company may not exceed $2,000,000. In addition, the total amount of coverage an individual may have under all policies issued by New York Life Insurance Company to the Trustees of the American College of Physicians, Inc. Insurance Trust may not exceed the maximum benefit option for any insured person.

DOUBLE YOUR COVERAGE WITH THE GROUP AD&D OPTION

If requesting the Group Decreasing Term Life insurance, you may also request an equal amount of Group Accidental Death and Dismemberment (AD&D) insurance for yourself. This coverage allows you to double your selected life benefit amount. Then if your death is due to a covered accidental injury, the plan can pay your life benefit amount plus your AD&D benefit, which doubles your life benefit amount. It also pays a percentage of your amount if you are seriously injured and suffer significant losses described below.

Covered Loss	Percentage of Principal Sum
Loss of life	100%
Loss of two limbs	100%
Loss of sight of both eyes.	100%
Loss of one limb and sight of one eye	100%
Loss of one limb	50%
Loss of sight of one eye	50%

The injury must be directly and independently cause by an accident while coverage is in force, and must result in a Covered Loss within 365 days.

Only one principal sum (the largest applicable) is payable for a loss to the same limb due to or related to any one accident. Loss of sight means total and permanent loss. Loss of limb means severance through or above the wrist or ankle joint.

Additional Seatbelt and Airbag Benefit

Under the AD&D option, your loved ones can collect an additional benefit amount up to $25,000 or 10% of your principal sum (whichever is less) if you suffer a covered loss of life while riding in or operating an automobile and were found to be properly wearing a seatbelt.

An additional 5% will be paid if the automobile is equipped with an airbag. However, the total amount paid under the combined seatbelt and airbag benefit cannot exceed $25,000.

Exclusions and Limitations – AD&D
No benefit will be payable for: any loss that occurs during or is due or related to military service, your incarceration or participation in (except as a victim) an illegal occupation/activity or the commission of a crime, your voluntary intake of drugs, narcotics or alcohol (unless prescribed by a physician other than yourself), any declared or undeclared war or act thereof, or operation, riding in or descending from any aircraft except when riding as a passenger on a licensed, non-military aircraft; or for any loss that is due or related to: a physical or mental sickness or medical/surgical treatment thereof, or suicide or intentionally self-inflicted injury while sane or insane.

PLAN FEATURES

Amounts of Insurance at Age 65 and After

The amount of insurance for you and your spouse is based on the covered person's age at last birthday, and decreases on the premium due date coinciding with or immediately after he/she enters a new age category. After age 64 (age 50 for spouse), coverage decreases for each $10,000 option of insurance, as shown below. Premium does not decrease.

Member's Age	Each $10,000 Member Option	Spouse's Age	Each $10,000 Spouse Option
Under 65	$10,000	Under 50	$10,000
65–69	6,600	50–59	4,500
70–74	4,300	60–69	2,000
75–79	2,900	70–74	1,000
80–84	1,950	75–79	675
85–89	1,350	80–84	475
90–99*	900	85–89	325
		90–99*	200

*Coverage terminates at age 100. See Group Conversion Privilege.

The amount of children's insurance does not decrease.

Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the ACP Insurance Trust.

Waiver of Premium Benefit

If you become Totally Disabled for at least six consecutive months before age 60, your premiums for this plan will be waived until you are no longer disabled.

Total disability means an incapacity from an accidental injury or sickness which: completely and continuously prevents you from doing the material and substantial duties of any occupation for which you are reasonably qualified by education, training or experience, or; results in total and permanent loss of sight of both eyes; or results in severance, above the wrist or ankle of: (1) both hands; (2) both feet; or (3) one hand and one foot.

The amount continued will be based on the option under which you were insured at the time your disability began, subject to the age decreases previously described. You may be asked to provide proof of your Total Disability from time to time.

Valuable Living Benefit Provision "Accelerated Death Benefit"

The "Accelerated Death Benefit" option is available to help terminally ill insureds during a difficult and often financially challenging time. Under this provision you may request one advance payment equal to 50% of your (or an insured dependent's) in force life insurance to be paid while the terminally ill person is still alive. The request must be made at least 12 months prior to the insured person's scheduled coverage termination age and the amount of insurance payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs...medical bills...outstanding debts...to help pay for experimental treatments...the cost of modifications to your home...or for a family vacation-the choice is yours.

To qualify, a terminally ill insured must provide New York Life Insurance Company with proof of terminal illness and anticipated life expectancy (12 months or less), as well as any other necessary medical information requested. For additional details and limitations, please see the Certificate of Insurance.

Please note that receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult with the appropriate social services agency and seek the advice of a qualified tax advisor.

OTHER IMPORTANT INFORMATION

Exclusions

For the Group Decreasing Term Life Insurance coverage, the only exclusion is suicide. Benefits are paid for death from any cause, at any time, anywhere in the world except suicide within 12 months from the issue date, whether sane or insane.

The validity of any amount of your life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and nonpayment of premium contributions.

For the Group Accidental Death and Dismemberment Insurance coverage, the exclusions and limitations are as previously stated (see box).

Conversion Privilege

The Plan provides conversion privileges under certain circumstances of involuntary termination, as described in the Certificate of Insurance.

You Name Your Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

Ownership of Insurance

"Owner" means the person or entity with rights of ownership of this insurance as described in the Certificate of Insurance. If a transfer of ownership has been recorded by or on behalf of New York Life, or if initial ownership is by other than the member according to the information provided on the application, references throughout this Plan Information to "you" or "member" will mean "owner," as applicable.

Effective Date

Insurance will take effect on the date your application is approved by New York Life Insurance Company provided the initial contribution is paid within 31 days after the date you are billed (send no money now) and any person to be insured is actively performing the normal activities of a person in good health of like age *[NC residents: a person of like age]* on the date of approval.

Any person who is not performing his/her normal daily activities as required will not become insured until the day he/she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible.

When Coverage Ends

Coverage will end when the insured person reaches age 100 (26 for children) or earlier if: (a) premium contributions are not paid when due, (b) ACP membership ends, (c) the group plan is terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which the member belongs, and (d) if the insured requests to terminate insurance. In addition, dependent coverage will terminate when the member coverage terminates, or when the eligibility requirements are no longer being met. Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance.

In addition to the above, AD&D coverage ends when the injured person begins active duty in the armed forces.

Renewal Payments And Claims

Once you are accepted into the Plan, you will have a 31-day grace period for your payment of renewal premium contributions. When you want to submit a claim, call or write the Administrator for claim forms.

TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing of ACP. Please wait until your application for membership is accepted before initiating your insurance requests. If you have any questions regarding membership, please call ACP directly at 1-800-523-1546.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your Application may be used as the basis for rescinding your insurance.

The Group Decreasing Term Life Insurance and Accidental Death and Dismemberment Plan is medically underwritten based on the information provided by you on the Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required.

If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the Plan.

1. Truthfully complete and sign the application. Be sure to indicate whether you are requesting coverage for your dependents.
2. Complete, sign and date the Application. It is extremely important that you answer fully the questions about medical history on this form. New York Life will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage.

If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form or go to www.personal-plans.com/acp to download the form.

3. Mail your completed application to:

Administrator
ACP Group Insurance Program
P.O. BOX 10374
Des Moines, IA 50306-8812

Residents of Puerto Rico:

Please send your completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

Certificate Of Insurance

This information is only a brief description of the principal provisions and features of the Plan. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to Trustee of American College of Physicians, Inc. Insurance Trust.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Plan.

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated, and you will be sent a full refund, no questions asked!

The Group Decreasing Term Life and Accidental Death and Dismemberment Insurance Plan is underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29102-0
on Policy Form GMR

The Group Decreasing Term Life and Accidental Death and Dismemberment Insurance Plan is administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
ACP Group Insurance Program
PO Box 10374
Des Moines, IA 50306-8812

1-888-643-0323
www.personal-plans.com/acp

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

Any questions?
Please call us toll-free at 1-888-643-0323, between the hours of 7:30 am and 5:00 pm CT, Monday through Friday.

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The ACP insurance trust incurs costs in connection with this sponsored program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. ACP also receives a fee for the license of its name and logo for use in connection with this Plan.

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YOUR COST

The cost of the Group Decreasing Term Life Insurance is based on the insured person's attained age on the date coverage is issued and increases as he/she grows older. Premium contributions will vary depending on the number of units chosen.

CURRENT 2019 SEMI-ANNUAL RATES

Rates per $10,000 Option – Member Only

Member's Attained Age	Unit of Insurance†	Decreasing Term Life Premium	AD&D Premium
Under 30	$10,000	$3.00	$3.00
30–34	10,000	4.00	$3.00
35–39	10,000	5.00	$3.00
40–44	10,000	8.10	$3.00
45–49	10,000	13.30	$3.00
50–54	10,000	22.70	$3.00
55–59*	10,000	44.60	$3.00

Rates per $10,000 Option – Spouse and Child(ren)**

Spouse's Attained Age	Unit of Insurance†	Decreasing Term Life Premium
Under 30	$10,000	$8.00
30–39	10,000	10.00
40–49	10,000	18.00
50–59*	10,000	20.00

*Contact the Administrator for renewal rates at ages 60-99. Coverage terminates at age 100 -see "Conversion Privilege".

**If spouse/child coverage is requested, each eligible child will be covered for $5,000.

†Each $10,000 option begins to decrease at age 65 for member (age 50 for spouse), as previously stated.

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date, and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insurance under this group policy. For example, a class of insureds is a group of people all with the same issue age. Benefit option amounts are subject to change by agreement between New York Life Insurance Company and the Trustees of the ACP Insurance Trust.

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