GROUP DISABILITY INCOME INSURANCE PLAN APPLICATION

FOR MEMBERS OF THE AMERICAN COLLEGE OF PHYSICIANS

TO APPLY:
Complete this form and return with your premium check 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

American College of Physicians
Leading Internal Medicine, Improving Lives

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:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Home Phone: (_____)_____

Work Phone: (_____)_____

E-mail Address: _____
Mercer Consumer will not share your email information.

Member's Date of Birth: _____ Sex: ☐ M ☐ F
MO. DAY YR.

Please check one: ☐ Home address ☐ Business address

Height: _____ft _____in. Weight _____lbs.

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.
Do you intend to reside outside the U.S. in the next 12 months?
☐ YES, Countries:_____ For how long? _____ ☐ No

2. Membership Affiliation – Occupational Status:

A. Are you applying as:
Full member in good standing of the ACP? ☐ Yes ☐ No 44563/44564 Membership #_____
Physician Affiliate ☐ Yes ☐ No 44563/50806 Non-Physician Affiliate ☐ Yes ☐ No 44563/51112

B. Are you now on active duty in the Military? ☐ Yes ☐ No If yes, the date active duty commenced _____

C. Total of annual Military Allowances and Special Pay (Not including Basic Pay). $_____

D. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at "FULL-TIME WORK"? ☐ Yes ☐ No

E. What was your annual earned income (net after business expenses) as reported for federal tax purposes last year? $_____

3. Insurance Requested:

Refer to the Plan Information/Plan 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:

GROUP DISABILITY INCOME INSURANCE
Indicate Monthly Benefit Option desired. Choose amount of protection from $500 to $12,500 in increments of $500: $_____

Benefits not to exceed 66 2/3% of AVERAGE MONTHLY INCOME (as defined in the brochure) when combined with your other insurance unless insurance is provided and paid for by your employer, in which case the benefit amount can be up to 75% of Earned Income.

a. Waiting Period: ☐ 30 days ☐ 60 days ☐ 90 days ☐ 180 days

b. PAYMENT OPTION SELECTED:
❑ **Option 1:** PERIODIC BILLING: ☐ Annually ☐ Semiannually ☐ Quarterly Premium Contribution Enclosed: $_____
❑ **Option 2:** Electronic Funds Transfer (EFT): I request and authorize the Administrator, ACP Group Insurance Program to make monthly withdrawals against the account specified on the attached check or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions under this plan. (Enclose a VOIDED check and a check for the first monthly payment.)

X_____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED AGAINST THIS ACCOUNT DATE

3. Insurance Requested: continued

c. Cost of Living Option: ☐ Yes ☐ No

d. 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	Plan	Monthly Benefit	Benefit Period

e. Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ❑ Yes ❑ No
If Yes, please indicate which coverage and the date it will be terminated _____

4. Statement of Health: Please initial and date 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) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?..... ☐ ☐
(iii) 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. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... ☐ ☐

9. ***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? ..... ☐ ☐
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? ..... ☐ ☐

10. Are you currently incarcerated, or have an arrest pending, or during the past 15 years, (7 in Maryland) served time in prison? .... ☐ ☐

11. If you have answered any of the above Questions 1-10 "YES," give complete details on next page. (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 and 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, 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 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 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 my protected health information to MIB, Inc.; 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 _____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

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.

9/13 ed.

DI113E-ACP

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: 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 any 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 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 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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income 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.*

New York Life Insurance Company **7/15 ed.**

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Group Disability Income Insurance Plan

Underwritten by New York Life Insurance Company

FOR AMERICAN COLLEGE OF PHYSICIANS MEMBERS

INSURE YOUR INCOME – YOUR MOST VALUABLE ASSET

Your most important asset is your ability to earn income. Even if you are young and healthy, a serious illness or injury could put you out of work for months or even years – thus jeopardizing your livelihood. A reliable source of disability income protection is this Group Disability Income Insurance Plan exclusively for ACP members.

Even if you have some disability insurance through your employer, it may not be enough. Many employers provide only a short-term salary continuation plan or short-term disability income plan. This Plan can be used to supplement benefits provided by your employer plan or as primary protection.

This Plan is designed to provide you with a regular monthly income when you are totally disabled and unable to work as the result of an illness or injury.

WHO IS ELIGIBLE?

ACP members and affiliate members, both Physician and Non-Physician, who are under age 62 who are at FULL-TIME WORK are eligible to request coverage. (Student members are not eligible unless working full-time.)

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are performed.

This coverage is only available to residents of the United States (except territories).

HOW THE PLAN WORKS

Covered Total Disability

The Plan is designed to pay Monthly Benefits when you are Totally Disabled. Benefits begin at the end of the waiting period, provided you are Totally Disabled.

1. **For ACP Members:** Totally Disabled means an incapacity from an injury or sickness that completely and continuously prevents you from doing the material and substantial duties of your medical speciality or specialties.
2. **For Physician Affiliate Members:** Totally Disabled means an incapacity from an injury or sickness that you suffer while you are insured under the policy, but only if such incapacity completely and continuously prevents you from doing the material and substantial duties of your usual occupation.
3. **For Non-Physician Affiliate Members:** Totally Disabled means an incapacity from an injury or sickness that you suffer while you are insured under the policy, but only if such incapacity completely and continuously prevents you from doing the material and substantial duties of:
    a. For the first 24 months, after your selected waiting period,your usual occupation,
    b. After the 24 month period, any occupation for which you are qualified by reason of education, training or experience.

Note: You will not be considered Totally Disabled if at any time you are engaged in any gainful occupation.

Long Term Disability benefits can be paid up to age 67 when you are Totally Disabled before age 60. Other monthly total disability/residual/partial disability benefits can be paid up to certain limits:*

For Disability Beginning	Maximum Benefit Period
Before age 60	Up to age 67
Age 60-63	Up to 5 years
Age 64	Up to 4 years
Age 65	Up to 3 years
Age 66	Up to 2 years
Age 67 to termination age	Up to 1 year

*See Exclusions and Limitations

Note: Benefits for disabilities due to mental disorders are limited to a maximum of 24 monthly payments. Benefits for any disability resulting from the voluntary intake of alcohol and/or narcotics/ controlled substances are limited to 12 monthly payments.

Choice of Monthly Benefit

You have a wide choice of monthly benefit options, from $500 to $12,500 (in $500 units); however, the option you choose, together with any other disability income insurance you may have, or for which you are applying cannot exceed 66 2/3% of your AVERAGE MONTHLY INCOME. This limitation is increased to 75% if your "other" disability insurance is paid for by your employer.

AVERAGE MONTHLY INCOME means, as of any date, a person's average monthly wages, salaries, commissions, fees and any other amounts received by such person for personal services, including the cost of his or her fringe benefits and share of total surplus; except that: For a person in military service, AVERAGE MONTHLY INCOME means, as of any date, the sum of such person's Military Allowances and Special Pay, excluding basic pay. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income. AVERAGE MONTHLY INCOME is computed before deduction of any income taxes or social insurance taxes and after deduction of normal and usual business expenses that are deductible for income tax purposes.

Choice of Waiting Period

You also have a choice of four waiting periods before benefit payments begin: 30, 60, 90 or 180 days. A waiting period is the number of consecutive days that you must be Totally, Residually or Partially Disabled before benefits commence. Coverage with a longer waiting period is less expensive.

PLAN FEATURES

Waiver of Premium

After you have been Totally Disabled for 90 consecutive days, or your waiting period, whichever is greater, and you begin to receive benefits for Total Disability, all future premium contributions under the Plan will be waived for as long as you receive benefits for that disability.

Benefits for Recurring Disability

Successive periods of disability which are due to the same or related causes will be considered a single period of disability unless separated by return to FULL-TIME WORK for six consecutive months or more. Separate, unrelated periods of disability will be considered a single period of disability unless separated by a return to FULL-TIME WORK of at least one full day.

Rehabilitation Benefit

This benefit is designed to help certain disabled individuals return to the work force. Under this provision, a professional rehabilitation staff reviews case histories and identifies those individuals who appear to have the greatest likelihood of rehabilitation. Individuals selected by New York Life Insurance Company will be offered the option of participating in a rehabilitation program at no cost to them. Participation is voluntary and benefits will not be reduced due to participation in the program.

Partial Disability and Residual Disability Benefits

If a covered illness or injury prevents you from performing some but not all of the substantial duties of your medical specialty(ies), you may be eligible for a Partial Disability Benefit. If, while recovering from a Total Disability, you are able to resume some but not all of said duties, you may be eligible for a Residual Disability Benefit. These benefits are based on a percentage of your pre-disability earnings. To qualify for either the Partial Disability or Residual Disability benefit, you may not be earning more than 80% of your pre-disability AVERAGE MONTHLY INCOME and you must not have reached the Maximum Benefit Period. Refer to your Certificate of Insurance for more information on these benefits.

Cost of Living Benefit (Optional Coverage)

This option offers disability coverage that, once benefits begin, can help keep pace with the rate of inflation. Monthly benefits will be adjusted annually from the date the waiting period begins. Adjustments may be made to the monthly benefit paid in the second and each succeeding year. The adjustment amount will be based on the consumer price index for urban consumers (CPI-U) up to a maximum 6% increase per year and an overall maximum increase of one times the original benefit. Once you are no longer disabled and benefit payments stop, the monthly benefit returns to the original option amount. This benefit only applies to disabilities commencing before you reach age 65.

ADDITIONAL PLAN INFORMATION

Effective Date

You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you are at FULL-TIME WORK on that date. If you are not at FULL-TIME WORK as required, coverage will not become effective until the day you are at FULL-TIME WORK, provided such date is within three months of the date insurance would have been effective and you are still eligible for insurance.

Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date specified by New York Life Insurance Company.

Note: There are instances where New York Life Insurance Company may be able to offer insurance, at the same cost, by eliminating coverage for a specific impairment or disease.

When Coverage Ends

Once coverage is validly in force, it may be continued to the April 1st anniversary date on or immediately after you reach age 70. Coverage will end earlier if: you cease FULL-TIME WORK other than for reasons of disability, cease to be an ACP member, fail to pay premium contributions when due, enter full-time active duty in the armed forces (coverage may be restored upon termination of active duty status, subject to policy guidelines) or the group plan is terminated or modified by the policyholder or New York Life Insurance Company to end insurance on the group of insureds to which you belong.

Exclusions And Limitations

The Plan does not provide benefits for any disability that occurs during or is due or related to: intentionally self-inflicted injury while sane or insane, declared or undeclared war or any act thereof, or incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; PRE-EXISTING CONDITION (except as noted below); or any impairment or disease specifically excluded from your coverage.

No benefits are payable for any disability for which you are not under the regular care of a licensed physician or surgeon other than yourself, your business associate, or member of your immediate family or household.

The Plan limits benefits for disabilities due to mental disorders to 24 months. Benefits for disabilities due to the voluntary intake of alcohol or narcotics/controlled substance (unless prescribed by a doctor other than yourself) are limited to 12 months.

A PRE-EXISTING CONDITION is an injury or illness for which you consulted a physician, took medication, or received medical services or supplies during the immediate 12-month period prior to becoming insured under this Plan. Benefits are not payable for a disability due to a PRE-EXISTING CONDITION until the end of the earlier of: 12 consecutive months during which you have not consulted a physician, took medication, or received medical services or supplies, or; 24 months.

HOW TO APPLY

The Group Disability Income Insurance 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; failure to supply accurate information may invalidate coverage. 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. Refer to the Plan description for benefits and premium cost as you fill out the application. Remember, only ACP members (as described under Who Is Eligible) may apply.
2. Make out your check for the total amount of premium due, payable to: Administrator, ACP Group Insurance Program.

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.

(Also, be sure to include a voided check, as applicable, if you select the Electronic Funds Transfer (EFT) Option. You must also include the amount of your first monthly payment in the total check amount above.)

3. Mail the completed application with your check to:
   Administrator
   ACP Group Insurance Program
   PO BOX 10374
   Des Moines, IA 50306-8812

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, see the ACP home page at www.acponline.org or call ACP membership at 1-800-523-1546.

Regular Member

Certified by The American Board of Internal Medicine, American Osteopathic Board of Internal Medicine, one of the Royal Colleges in internal medicine, or the American Board of Psychiatry and Neurology in neurology. Or, if not board certified, has successfully completed an approved internal medicine training program, a combined internal medicine residency, or a neurology program.

Physician Affiliate Member

Any physician (MD, DO or equivalent) who is **not** trained as an internist, neurologist, or Doctor of Osteopathy who has completed an internal medicine residency, or who does not qualify for full ACP Membership, and who maintains his or her credentials to practice.

Affiliate Membership – licensed non-physician healthcare professionals who are part of a Patient-care team led by an internist (MD, DO or equivalent), and who maintains his or her professional credentials to practice. Affiliate membership shall be extended to physician assistants; nurse practitioners or other advanced practice nurses; registered nurses; pharmacists and doctors of pharmacy; and clinical psychologists.

CERTIFICATE OF INSURANCE

When you become insured you will be sent a Certificate of Insurance summarizing your insurance coverage. This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms are set forth in the policy issued by New York Life Insurance Company to the Trustees of the American College of Physicians, Inc. Insurance Trust.

MEDICAL REQUIREMENTS

New York Life reserves the right to request medical information needed to determine an applicant's eligibility for coverage. Based upon the age of the person proposed for insurance and the amount of coverage requested, a physical exam, EKG, blood test or other medical information may be required.

Not all applicants will have to supply additional information. However, if required, 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.

Requests for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

HOW TO FILE A CLAIM

To file a claim, write the Administrator for the proper forms.

30-DAY FREE LOOK

When you become insured, you will be sent a Certificate of Insurance summarizing your coverage. If you're not completely satisfied with the terms you may return it, without claim, within 30 days and your premium will be promptly refunded. No questions asked! Your insurance will then be invalidated.

This Group Disability Income Insurance Plan Is Underwritten By:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29030-0
on Policy Form GMR-FACE/G-29030-0

This Group Disability Income Insurance Plan Is Administered By:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
ACP Group Insurance Program
P.O. BOX 10374
Des Moines, IA 50306-8812

Questions?
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

Questions?
We're Only a Phone Call Away

If you have questions about your eligibility, what the Plan covers or how to complete the application, just give us a call toll-free at 1-888-643-0323 between 7:30 AM and 5:00 PM, Monday through Friday, CST, or you can e-mail us at ACPgroupins.service@mercer.com. One of our service representatives will be able to immediately provide you with the information you need.

The ACP Insurance Trust incurs costs in connection with this sponsored plan. 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 the Plan.

YOUR COST

The insurance cost is based on the waiting Period, Monthly Benefit, and on your attained age when coverage becomes effective. Coverage increases on the April 1st anniversary date or immediately after the date you reach a higher age bracket. Premium contributions will vary depending upon the options and amounts chosen.

Current 2019 Semiannual Premium Rates per $1,000 Monthly Benefit

	30-Day Waiting Period		60-Day Waiting Period		90-Day Waiting Period		180-Day Waiting Period	
Insured Member's Age		**15% Premium Discount***		**15% Premium Discount***		**15% Premium Discount***		**15% Premium Discount***
Under 30	$65.00	$55.25	$57.00	$48.45	$49.00	$41.65	$40.00	$34.00
30–34	86.00	73.10	68.00	57.80	53.00	45.05	44.00	37.40
35–39	104.00	88.40	86.00	73.10	70.00	59.50	59.00	50.15
40–44	122.00	103.70	107.00	90.95	88.00	74.80	78.00	66.30
45–49	184.00	156.40	157.00	133.45	137.00	116.45	115.00	97.75
50–54	268.00	227.80	238.00	202.30	210.00	178.50	170.00	144.50
55–59	381.00	323.85	351.00	298.35	296.00	251.60	244.00	207.40
60–69+	458.00	389.30	422.00	358.70	360.00	306.00	317.00	269.45

Cost of Living Benefit Option – Current 2019 Semiannual Premium Rates Per $1,000 Monthly Benefit

Insured Member's Age		**15% Premium Discount***
Under 30	$12.00	$10.20
30–34	13.00	11.05
35–39	19.00	16.15
40–44	23.00	19.55
45–49	31.00	26.35
50–54	39.00	33.15
55–59	43.00	36.55
60–64+	21.00	17.85

+Renewal at ages 62 and over.

*The current 15% premium discount is effective through March 31, 2020. Although not guaranteed, the Group Disability Income Insurance Plan for ACP members has returned premium discounts for several years.

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 insured's. For example, a class of insureds is a group of people with the same issue age. 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.