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

FRAUD NOTICES

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

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

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

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

RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

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

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for The Senior Group 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 (TTY 866 346-3642). For Canadian residents the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. 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 **8/12 ed.**

ACP Senior Group Term Life Insurance Plan

Underwritten by New York Life Insurance

A good value comes down to what you get for what you pay.

This Senior Group Term Life Insurance Plan is designed to be a solid value, offered to ACP members in good standing within the association.

What you get:

- A choice of benefit amounts to help suit your specific needs
- The opportunity to bring your current coverage up to date
- Important coverage that helps replace your income and to pay final expenses, including funeral costs, mortgage payoff and outstanding debt
- Helps protect you even more with three valuable accelerated "living" benefits. These living benefits advance a cash benefit payment to you ("accelerated" benefit payments) if you become seriously ill with a qualifying condition such as cancer

What you pay:

Member-only rates negotiated on your behalf.

The ACP Senior Group Term Life Insurance Plan is offered to eligible ACP members and their lawful spouses. For this reason, we are able to make it available to members in good standing at economical rates. The chart below shows the rate for the benefit amount you select, based on your age and smoking status.

ACP Senior Group Term Life Insurance Plan

The initial cost of insurance is based on the individual's attained age when insurance becomes effective, the amount of insurance selected and tobacco/nicotine use. The cost increases as the insured grows older.

Current 2019 Monthly† Premium Contributions

	$50,000.00				$100,000.00			
	MALE		FEMALE**		MALE		FEMALE**	
Age	Nonsmoker	Smoker	Nonsmoker	Smoker	Nonsmoker	Smoker	Nonsmoker	Smoker
45–49††	$31.13	$52.00	$17.63	$29.42	$52.92	$88.42	$29.92	$50.00
50–54	38.50	64.38	22.42	37.46	65.50	109.42	38.08	63.67
55–59	54.67	91.25	34.08	56.92	92.92	155.08	57.92	96.75
60–64	76.88	128.38	51.46	85.92	130.67	218.25	87.50	146.08
65–69	99.38	165.96	71.04	118.58	168.92	282.17	120.83	201.67
70–74*	149.17	249.04	111.29	185.83	253.58	423.42	189.25	315.92

†You will be billed semi-annually. Additional payment options including monthly Electronic Funds Transfer (EFT) can be selected after first billing.

††Spousal rates only. Spouse amount cannot exceed member coverage.

*For rates after age 74, contact the administrator.

**Male rates apply to all coverage issued to Montana residents, regardless of a person's gender.

The premium contributions shown reflect the current rates and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date, but not more than once in any 12-month period, and on 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 insureds under this group policy. For example, a class of insureds is a group of people all with the same issue age and tobacco/nicotine usage. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustee.

Who is Eligible?

ACP members between ages 50-74 are eligible to apply for coverage for themselves, their lawful spouses age 45-74. In order to become insured, satisfactory evidence of insurability must be provided and the required premium must be paid.

If both member and spouse are covered as members, neither may insure the other as spouse.

This coverage is available only for residents of the United States (excluding CT, NY, UT and territories) and Puerto Rico.

Effective Date

Note: *Residents of NC*: *Any reference to "performing the normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application*. You and your spouse will become insured on the date specified by New York Life Insurance Company provided the initial premium contribution received within 31 days after you are billed, satisfactory evidence of insurability has been submitted, and you and your spouse are performing the normal activities of a person in good health of like age. For any proposed insured who is not performing such normal activities on the date insurance would otherwise have taken effect, insurance will not take effect until the day he/she is performing such normal activities, provided such date is within three months of the date insurance would otherwise have taken effect and the person is still eligible. Spouse coverage will not take effect prior to member insurance.

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 Insurance Company.

Your Choice of 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.

Incontestability

The validity of any amount of your insurance that has been in force for two years during your lifetime will not be contested except for insurance eligibility provisions or nonpayment of premium contributions.

Accelerated "Living" Benefits: Partial "living" benefits may be paid before death for any one cause which occurs before the insured person reaches age 80: terminal illness, chronic illness or permanent critical condition.

Benefit Amount: For Qualifying Event:+	**$50,000** Accelerated Benefits	**$100,000** Life Benefit Amount
Terminal Illness* (50% of death benefit amount)	$25,000	$50,000
Chronic Illness** or Permanent Critical Condition*** (25% of amount of insurance)	$12,500	$25,000

*Terminal Illness is a condition for which the patient has a life expectancy of 12 months or less.

**Chronic Illness means an illness: (a) with one or more of the following characteristics: permanency, residual disability, requires rehabilitation training, or requires a long period of supervision, observation or care; and (b) which a LICENSED HEALTH CARE PRACTITIONER* certifies the covered person is unable to perform any two of the following Activities of Daily Living for a continuous period of 180 days: bathing, dressing, toileting, Transferring (Defined as the ability to move in and out of bed, chair or wheelchair with or without the aid of equipment such as: a cane, walker, crutches, grab bars, or other support devices), eating or continence.

***Permanent Critical Condition means a medical condition for which a covered person: (a) is certified by a LICENSED HEALTH CARE PRACTITIONER* as having a severe cognitive impairment; (b) is required to be continuously confined in a Convalescent Care Facility (does not include: a rest home; a place for care of the aged alcoholics, mentally ill or drug addicts; and/or a place for custodial care.) Hospice (to qualify, the HOSPICE must meet the standards of the National Hospice Organization and the applicable state licensing requirements), Nursing Home (does not include a rest home, an assisted living facility or a place for care of the aged, alcoholics or drug addicts) or at home; (c) is required to be under substantial supervision to protect the covered person from threats to health and safety due to such severe cognitive impairment; and (d) is required to be under a plan of care prescribed by a LICENSED HEALTH CARE PRACTITIONER.*

*LICENSED HEALTH CARE PRACTITIONER means: licensed physician or osteopath; a registered professional nurse, or licensed social worker, who is operating within the scope of his or her license.

+Maximum Benefit Payable: No more than one Accelerated Benefit is payable for any one (1) Terminal Illness; Chronic Illness; or Permanent Critical Condition. With respect to a Chronic Illness or Permanent Critical Condition, only one Qualifying Event is payable. Also, in order to have a minimum Death Benefit equal to 25% of the Amount of Insurance, no more than 75% of the Amount of Insurance is payable for Qualifying Events on each covered person.

QUESTIONS?

1-888-643-0323

ACPgroupins.service@mercer.com

www.acpgroupinsurance.com

NOTE: If the Death Benefit is reduced by a payment of an accelerated benefit; premiums due are based on the reduced level of death benefit.

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.

Exclusions

Benefits will be paid in the event of death, anywhere in the world regardless of cause, except for suicide within 24 months of the certificate effective date, in which case the only amount payable is a return of the applicable contributions.

Conversion Privilege

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

Certificate of Insurance

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustees, Inc. Insurance Trust of the 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. Your request is subject to New York Life Insurance Company's approval and more medical information may be requested. You may be contacted by a Service Provider who will obtain additional medical history from you.

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 contribution. When you want to submit a claim, call or write the Administrator for claim forms.

Your request is subject to New York Life Insurance Company's approval and more medical information may be requested. You may be contacted by a Service Provider who will obtain additional medical history from you.

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 the Trustee of the Life Insurance Plan for Members of the American College of Physicians.

When Insurance Ends

Coverage can remain in force until you reach age 90, provided you remain a member of ACP, premium contributions are paid when due, and the group policy is not terminated or modified by the trustees or New York Life to end insurance for the group of insureds to which you belong. Your spouse's coverage will end when your coverage ends, or when he/she is no longer your lawful married spouse, or when he/she reaches age 90. Upon your death, coverage for your insured spouse may continue as described in the Certificate of Insurance.

Coverage for the "Living" Benefits ceases when the insured person reaches 80.

HOW TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing with ACP. Please wait until your application for membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact ACP directly.

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. We also request that you provide the following information for everyone you are requesting coverage on as well as on any named beneficiary: full name, address, date of birth, Social Security number, and telephone number. Please call 1-888-643-0323 to complete this request. If you prefer enclose a separate piece of paper with this information together with your application.

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 invalidating your insurance.

The Senior Group Term Life Insurance Plan is medically underwritten based on the information provided by you on your 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 medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the Plan.

Apply in Three Easy Steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application. Be sure to indicate if you are requesting coverage for your spouse.
2. Complete, sign and date the Application.

   DO NOT SEND MONEY NOW. YOU'LL BE BILLED LATER.

3. Mail the 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

If you have questions about your eligibility or the features of this Plan, call a Customer Service Representative toll-free at 1-888-643-0323.

This is a life insurance benefit that also gives you the option to accelerate some of the death benefit in the event that you are certified with a chronic illness or permanent critical condition as described in the certificate.

IMPORTANT NOTICE: This coverage is not intended to be a federally tax-qualified long-term care insurance contract under Internal Revenue Code (IRC) Section 7702B. Therefore, the premiums payable do not qualify as long-term care insurance premiums and are not deductible from gross income for federal income tax purposes. A Chronic Illness or Permanent Critical Condition acceleration is subject to the federal per diem limits set forth in IRC Section 7702B. Under this acceleration, New York Life will not pay claimants more than the federal per diem limits. Assuming the amount you receive in the aggregate from all applicable policies does not exceed the federal per diem limits set forth in IRC Section 7702B, the benefits provided by the Chronic Illness or Permanent Critical condition acceleration are intended to be excludable from federal gross income under Section 101 (g) of the IRC. Receipt of an accelerated death benefit may affect eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences. Accelerating benefits before applying for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Clients can contact the appropriate social service agency (e.g., the Medicaid Unit of your local Department of Public Welfare or the Social Security Administration Office) for more information.

This Senior Group Term Life Insurance Plan Is Administered By:

MERCER
MAKE TOMORROW, TODAY

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
ACPgroupins.service@mercer.com

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

This Senior Group Term Life Insurance Plan Is Underwritten By:

NEW YORK LIFE

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29102-2
on Policy Form GMR-FACE/29102-2

Where Can I Find More Information?

If you are interested in learning more about this and other ACP member benefits, you can go to www.acpgroupinsurance.com.

ID# 1792116

QUESTIONS?


1-888-643-0323


ACPgroupins.service@mercer.com


www.acpgroupinsurance.com