ACS Member Insurance
Protecting Life's Elements

Please complete this form and return to: ACS Insurance Plan Administrator, P.O. Box 3930, Peoria Heights, IL 61612-3930 Questions: Please call 844.282.2438

Residents of Puerto Rico, please return application to:
Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

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

GROUP HOSPITAL INDEMNITY APPLICATION

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER INFORMATION

Full Name _____ Social Security Number _____

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Fax Number _____

Email (For internal use only. Email address will never be sold or shared.) _____

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* ◯ Domestic Partner*

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

Are you currently insured under any other ACS life plan? ◯ Yes ◯ No If "Yes"" indicate which plan(s) and provide details below:

◯ Term Life ◯ 10-Year Level Term Life ◯ 20-Year Level Term Life Person Insured _____ Amount $ _____

LIST BELOW ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Member (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
◯ Spouse ◯ Domestic Partner** (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
Child*** (Name is Proposed for Insurance):	/ /	ft. in.	LBS.	◯ M ◯ F
Child*** (Name is Proposed for Insurance):	/ /	ft. in.	LBS.	◯ M ◯ F

**Submit a completed Declaration of Domestic Partnership form—not applicable in Oregon.
Form can be found by visiting www.acs.org/insurance and selecting the Forms tab within the Group Hospital Indemnity Insurance section.
***See plan information 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.

In the next 12 months, does any person proposed for insurance intend to reside outside of the U.S. or Canada?

Member/Employee: ◯ Yes ◯ No Country(ies) _____ How Long? _____

Spouse: ◯ Yes ◯ No Country(ies) _____ How Long? _____

2. MEMBERSHIP AFFILIATION

A. Membership is required to obtain coverage. Are you a member of ACS or AACT? Please check one: ◯ ACS ◯ AACT Membership # _____

3. PAYMENT OPTION SELECTION: Choose only one.

◯ **OPTION 1: Direct Billing**
Following your initial billing, you will be billed twice a year on *April 1* and *October 1*

◯ **OPTION 2: Electronic Funds Transfer**
I request and authorize the ACS Member Insurance Program to make withdrawals against the account specified on the attached voided check, statement savings account deposit slip, 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 due under this Hospital Indemnity Plan (enclose a VOIDED check or deposit slip, as applicable).

_____ _____
Signature(s) as required on checks issued/withdrawal made against this account Date

◯ **OPTION 3: Credit Card**
I authorize premium contributions to be charged to my credit card:

◯ **M/C** ◯ **Visa** ◯ **Discover** ◯ **AmEx**

Credit Card # _____ Exp Date _____

_____
Signature(s)
As Required On Checks Issued/Withdrawal Made Against This Account

4. INSURANCE REQUESTED: Refer to plan information for eligibility, principal sums, premium, and coverage description.

A. **I HEREBY APPLY FOR THE FOLLOWING GROUP HOSPITAL INDEMNITY INSURANCE COVERAGE**

Member Option: ◯ **$500** ◯ **$100** ◯ **$150** ◯ **$200** ◯ **$250** ◯ **$300**

Spouse Option*: ◯ **$50** ◯ **$100** ◯ **$150** ◯ **$200** ◯ **$250** ◯ **$300** * Spouse coverage cannot exceed 100% of member's coverage.

Child Option: ◯ **$50**

4. INSURANCE REQUESTED Continued

B. **OTHER COVERAGE:**

a) Are you presently insured by any other Hospital Indemnity Plan? ..... Member: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

b) If "Yes," do you intend to discontinue or change this other Plan? ..... Member: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If "Yes" complete below:

Member: Insurance Company Name, Policy #, and Benefit Amount: _____

Coverage Status: ◯ to be discontinued ◯ to be changed; please indicate New Daily Benefit Amount: $ _____

Spouse: Insurance Company Name, Policy #, and Benefit Amount: _____

Coverage Status: ◯ to be discontinued ◯ to be changed; please indicate New Daily Benefit Amount: $ _____

Coordination of Benefits (COB) applies to this plan when a covered person has hospital indemnity benefits under another plan which exceed $100 per day. COB limits the total benefits payable by all plans to the amount of the allowable expense actually incurred during each day of Hospital Confinement.

5. DECLARATIONS

I request the group insurance shown above. To the best of my knowledge and belief: the statements I have made are true and complete. I understand that insurance will be effective on the date approved by New York Life provided my initial contribution has been paid and the person(s) to be insured are performing the normal activities of a person of like age on that date. Any person not performing such normal activities on the date insurance would otherwise be effective will not become insured until the day he or 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 for insurance on that date. Any dividend apportioned to the group policy will be paid to the Group Policyholder of the Insurance Plan who will use it to reduce the cost of insurance to the insureds.

Preexisting Condition Clause—Applies to Hospital Money Plan Only: I understand and it is agreed that if any person for whom insurance is being requested has received medical treatment or advice, or has taken prescribed drugs or medicine, for an accidental bodily injury or diagnosed sickness during the 12-month period before that person was insured under the policy, no benefits will be payable for that injury, sickness, or related condition until the earlier of: (a) the day after a 12 consecutive month period has elapsed from the time that person was insured and during which no medical treatment or advice or drugs was received from that injury, sickness, or related condition; or (b) the day after a 24 consecutive month period has elapsed from the time that person was insured. Payment will be made only for losses sustained after such 12-month or 24-month period and will be in accordance with the provisions of the policy.

6. FRAUD NOTICES

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. **FOR 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. **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. **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 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 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 . AUTHORIZATION AND SIGNATURE

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 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 or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

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 in the IMPORTANT NOTICE, including mailing a brief report of my protected health information to MIB, Inc, and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, 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/Employee's Signature (Please Sign and Date in Ink) Date

Spouse's Signature (Necessary Only if Spouse Coverage is Required) Date

DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.