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 DISABILITY INCOME INSURANCE

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.) _____

Please check one: ◯ Home Address ◯ Business Address

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

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

Are you presently enrolled in this plan? ◯ Yes ◯ No

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

**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 Disability Income Insurance section.

2. MEMBERSHIP AFFILIATION

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

B. What is your occupation: _____ Main Duties: _____

C. **"FULL-TIME WORK"** means the active performance for pay or profit of the regular duties of one's normal occupation on a basis of at least 25 hours each week at a place where such duties are performed, including work-at-home, or other location to which travel is required.

Are you at **Full-Time Work**?: ◯ Yes ◯ No

D. **GROSS ANNUAL INCOME:** Salary $ _____ | Self-employment $ _____ (Start Date: __/__/__) | Commission $ _____ | Total $ _____

3. INSURANCE REQUESTED—INSURANCE STATUS: Refer to Enclosed Letter For Eligibility, Options, and Coverage Descriptions.

You may choose any **Monthly Benefit Option** provided it and other disability income coverage you may have does not exceed 60% of your **Monthly Gross Earned Income** (as defined in the enclosed letter). I hereby apply for the coverage indicated below, based on all my statements made in this application:

SHORT-TERM PLAN (2-Year Benefit Period, 30-day waiting Period)

◯ **MEMBER BENEFIT PERIOD**	**COLA OPTION?** ◯ Yes ◯ No (Do you want the **Cost of Living Adjustment** option?)	**BENEFIT AMOUNT: $**_____ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)
◯ **SPOUSE BENEFIT PERIOD**	**COLA OPTION?** ◯ Yes ◯ No (Do you want the **Cost of Living Adjustment** option?)	**BENEFIT AMOUNT: $**_____ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

LONG-TERM PLAN (Benefits to age 70)

◯ **MEMBER BENEFIT PERIOD**	**COLA OPTION?** ◯ Yes ◯ No (Do you want the **Cost of Living Adjustment** option?)	**WAITING PERIOD:** ◯ 30-DAY ◯ 60-DAY ◯ 90-DAY ◯ 180-DAY ◯ 365-DAY **BENEFIT AMOUNT: $**_____ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)
◯ **SPOUSE BENEFIT PERIOD**	**COLA OPTION?** ◯ Yes ◯ No (Do you want the **Cost of Living Adjustment** option?)	**WAITING PERIOD:** ◯ 30-DAY ◯ 60-DAY ◯ 90-DAY ◯ 180-DAY ◯ 365-DAY **BENEFIT AMOUNT: $**_____ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

3. INSURANCE REQUESTED—INSURANCE STATUS Continued

Do you now have or are you applying for other insurance which provides benefits if you are unable to work because of disability? ◯ Yes* ◯ No

*If you answered "Yes" To this question, Please list details below:

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

4. PAYMENT OPTION SELECTION: Choose only one.

◯ **OPTION 1: Direct Billing**
Following your initial billing, you will be billed twice a year on *February 1* and *August 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 Disability Income 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

5. MEMBER STATEMENT OF HEALTH: Please initial any changes you make on this form.

	To the best of your knowledge and belief, answer the following questions as they apply to you and your lawful spouse, if applying.	MEMBER	SPOUSE
A.	Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	◯ Yes ◯ No	◯ Yes ◯ No
B.	During the past five years has any person to be insured ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic 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
C.	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?	◯ Yes ◯ No	◯ Yes ◯ No
D.	Is any person to be insured now pregnant?	◯ Yes ◯ No	◯ Yes ◯ No
E.	Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Worker's Compensation benefits, or on waiver of premium for life or health insurance?	◯ Yes ◯ No	◯ Yes ◯ No
F.	**Except for the residents of Minnesota and Connecticut**, has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	◯ Yes ◯ No	◯ Yes ◯ No
	For residents of Minnesota and Connecticut ONLY, has any person to be insured 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?	◯ Yes ◯ No	◯ Yes ◯ No

If answered **"Yes"** to questions A, B, or C, please include details:_____

_____

DEPENDING ON THE AMOUNT OF INSURANCE YOU ARE REQUESTING, YOU WILL BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE INSURANCE COMPANY TO ASK YOU ABOUT YOUR MEDICAL HISTORY.

What time and telephone number would be best to contact you? _____

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.