



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

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.	<input type="radio"/> M <input type="radio"/> F
<input type="radio"/> Spouse <input type="radio"/> Domestic Partner** (Full Name):	/ /	ft. in.	LBS.	<input type="radio"/> M <input type="radio"/> F
Child*** (Name is Proposed for Insurance):	/ /	ft. in.	LBS.	<input type="radio"/> M <input type="radio"/> F
Child*** (Name is Proposed for Insurance):	/ /	ft. in.	LBS.	<input type="radio"/> M <input type="radio"/> F

**Submit a completed Declaration of Domestic Partnership form—not applicable in Oregon.

Forms can be found by visiting the Resources section of the Group Hospital Indemnity Insurance page on acsmemberinsurance.org.

***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.

Following your initial billing, you will be billed twice a year on April 1 and October 1, or you may also choose to access a secure website to register and have your premium withdrawn from your bank account or charged to your credit card.

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. 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.

6. AUTHORIZATION AND SIGNATURE

I am an ACS member under age 65, not confined due to illness or injury, and request the coverage indicated. I affirm that any dependents I have enrolled meet the eligibility requirements for coverage as described. To the best of my knowledge and belief, I am eligible for such insurance and these statements I have made are true and complete.

Coverage will be effective on the date New York Life receives this request, provided eligibility requirements are met and required premium is paid when due. If I or any covered dependent is confined to a home, in a hospital, or other medical facility on that date, coverage for that person will be deferred until the day after he/she is no longer so confined, provided that such date is within 3 months of the date insurance would have taken effect and the person is still eligible.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Member'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.