



**ACS Insurance
Plan Administrator**
1200 East Glen Avenue
Peoria Heights, IL 61616-5348

**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

Please complete this form and return to:
ACS Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 • **Questions:** Please call 1.800.752.0179

ACS GROUP 10-YEAR LEVEL TERM LIFE 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 _____ SS # [][][]-[][][]-[][][][][]
Last First Middle Initial

Street Address _____

City _____ State (or Province) _____ Zip Code [][][][][]-[][][][][]

Home Phone (_____) _____ Work Phone (_____) _____

Fax (_____) _____ Email _____

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

Marital Status: Married Divorced Single Widowed

Are you currently insured under any other ACS Life Plans? Yes No

If "Yes," indicate which plan(s) and provide details below (person insured and amount of insurance):

Group Term Life 10-Year Level Term Life 20-Year Level Term Life

Details: _____

	Date of Birth: MO./ DAY / YR.	Height:	Weight: LBS	Sex:
Member: _____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F

<input type="checkbox"/> Spouse* or <input type="checkbox"/> Domestic Partner** :	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Name if proposed for insurance				

Child*: _____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Name if proposed for insurance				

Child*: _____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
_____	___/___/___	___ ft. ___ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
Name if proposed for insurance				

*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.

**Complete remaining application as Spouse, and contact Plan Administrator for an additional required form to complete.

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

Member: Yes No Country(ies) _____

Spouse: Yes No Country(ies) _____

2. Membership Affiliation:

Association Membership is required for participation in this plan. ACS 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 1st and October 1st

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 Term Life Plan (enclose a VOIDED check or deposit slip, as applicable).

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT _____ DATE _____ *continued...*

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Be Sure To Complete All Pages and Sign Last Page

6. 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 all dependents to be insured:	YES	NO
a. Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you or any other person to be insured now ill or receiving medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or check-up, or been hospitalized or had an operation or had any illness, disease, or injury?	<input type="checkbox"/>	<input type="checkbox"/>
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>
e. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
f. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or being treated for:		
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>
2. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3. Fainting spells, convulsions, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4. Sugar, blood, albumin, or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes, kidney trouble, ulcers, or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
6. Disorder of breast or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervous or mental disorder, emotional condition, or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer, tumor, or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
9. Varicose veins, hemorrhoids, or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
10. Disorder of eyes, ears, nose, or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid, liver, or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
13. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
14. Other health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
g. (This question does not apply to residents of Maryland.) Have you or has your spouse had a parent, brother, or sister who, prior to age 60, was medically diagnosed by a physician as having, or being treated for, cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, or neuromuscular or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
h. Within the past two years, have you or your spouse (if proposed for insurance) participated in, or do either of you within the next two years, plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; any type of motorized racing; hang-gliding; parasailing; or bungee jumping?	<input type="checkbox"/>	<input type="checkbox"/>
i. Driver's License No.: Member: _____ Spouse: _____ State in which issued: Member: _____ Spouse: _____ Have you or has your spouse had your driver's license suspended or revoked, or had any moving violations, within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
j. Except for residents of CT and MN , in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending?	<input type="checkbox"/>	<input type="checkbox"/>
For residents of CT and MN only , in the last seven years, have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

IF YOU HAVE ANSWERED ANY QUESTIONS "YES," 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 Letter/No.	Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date	Name and Address of Physicians or other Medical Care Practitioners or Hospitals where confined or treated

7. 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 New York Life 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 and that any material misstatements or failures to report information material to the risk may be used as the basis to contest of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) insurance will become effective on the first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age [for MD and NC residents: I and any approved spouse's health status continues to be the same as stated on this application] on the approval date; (b) any person who is not performing such normal activities [for MD and NC residents: whose health status is not the same as stated on this application] as required will not become insured until the day he/she is performing such normal activities [for MD and NC continued...

residents: I and any approved spouse's health status continues to be the same as stated on this application], provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) 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.

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 AR/LA/MD: 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 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.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. ■ I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB 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 subsidiaries or the plan administrator regarding the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes. 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 applications for insurance). I understand that the information provided might include information that may predate the time frame stated on the medical questions section, if any, of this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. ■ New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB or other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). ■ This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. 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. The information New York Life obtains through this 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 this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage, my authorized agent or I will receive a copy of this signed AUTHORIZATION, and that in all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION.

By signing and dating this application, I and my spouse/domestic partner (if proposed for insurance), request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest to having read the Fraud Notices indicated above, and that to the best of my knowledge and belief, the answers to the questions are true and complete.

Member's Signature X _____ Date _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X _____ Date _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Owner Information, required if Owner is other than the applicant (if Owner is a Trust, please submit a copy of the document with this application).

Full Name: _____ Relationship to proposed insured: _____
LAST FIRST MIDDLE INITIAL

Mailing Address: _____
STREET CITY STATE ZIP CODE

Tax ID#: _____ Date of Birth: ___/___/___ Social Security #: [] [] [] - [] [] [] - [] [] []

Owner's Signature X _____ Date _____
(NECESSARY ONLY IF OTHER THAN APPLICANT)

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Be Sure To Complete All Pages and Sign Last Page
Page 4 of 4

**Do Not Send Payment: Upon approval,
you will be notified of the premium due.**

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1/09 ed. 1/09

090013G-ACS-10