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

TO APPLY please send this completed form to:
ACS Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 **Questions:** Please call 1.800.752.0179

ACS MEMBER INSURANCE PROGRAM

GROUP DISABILITY INCOME APPLICATION

PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

PART I Personal Info

1. Member Information:

Full Name ____
Last First Middle Initial

Street Address ____

City ____________________ State (or Province) ______________ Zip Code ☐☐☐☐☐-☐☐☐☐

Please check one: ☐ Home Address ☐ Business Address Social Security # ☐☐☐-☐☐-☐☐☐☐

Home Phone (_______) ____________________ Work Phone (_______) ____________________

Fax (_______) ____________________ Email ____________________
For internal use only. Email address will never be sold or shared.

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

List below only those individuals applying for coverage	Birth Date: MO./ DAY / YR.	Height: Ft. In.	Weight: LBS	Sex:
Member (Full Name):				☐ M ☐ F
Eligible Dependent ☐ Spouse or ☐ Domestic Partner* (Full Name):				☐ M ☐ F

*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)____________________

PART II Your Coverage

2. Membership Affiliation—Occupational Status:

a. Association Membership is required for participation in this plan. ACS Membership #______________

b. What is your occupation? ______________ Main Duties ______________

c. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties normally are performed, or other location to which travel is required.
Are you at FULL-TIME WORK? ☐ Yes ☐ No

d. Gross Annual Income from: Salary $__________ Self-Employment $__________ (Self-Employment Start Date ___/___/____) Bonus $__________ Commissions $__________ Total $__________

3. Insurance Requested—Insurance Status: Refer to brochure for eligibility, options, and coverage description.

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 brochure).

I hereby apply for the coverage indicated below, based on all my statements made in this application:

continued...

COVERAGE APPLYING FOR: (Refer to brochure for eligibility, options, and coverage descriptions.)

☐ **Member Benefit Period Option A** (2-year benefit period, 30-day waiting period)

Do you want the Cost of Living Adjustment Option? ☐ Yes ☐ No **Benefit Amount: $**_________________ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

☐ **Member Benefit Period Option B** (benefits to age 70)

Waiting Period: ☐ 30-Day ☐ 60-Day ☐ 90-Day ☐ 180-Day ☐ 365-Day

Do you want the Cost of Living Adjustment Option? ☐ Yes ☐ No **Benefit Amount: $**_________________ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

☐ **Spouse Benefit Period Option A** (2-year benefit period, 30-day waiting period)

Do you want the Cost of Living Adjustment Option? ☐ Yes ☐ No **Benefit Amount: $**_________________ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

☐ **Spouse Benefit Period Option B** (benefits to age 70)

Waiting Period: ☐ 30-Day ☐ 60-Day ☐ 90-Day ☐ 180-Day ☐ 365-Day

Do you want the Cost of Living Adjustment Option? ☐ Yes ☐ No **Benefit Amount: $**_________________ (from $100 to $10,000 a month in $100 increments, not to exceed 60% of your basic monthly earnings)

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 "Yes," please list:

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 1st and August 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 Disability Income Plan (enclose a VOIDED check or deposit slip, as applicable).

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

☐ **Option 3:** Credit Card: I authorize premium contributions to be charged to my credit card:

☐ MasterCard Credit Card #_______________________________ Exp. Date____________

☐ Visa ☐ Discover

☐ American Express

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SIGNATURE(S) AS REQUIRED ON CHECKS/WITHDRAWALS ISSUED AGAINST THIS ACCOUNT DATE

5. Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you and your spouse (if proposed for insurance):

[California residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.]

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
1. Is any person to be insured now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐	☐	☐
2. During the past five years, has any person to be insured ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:				
a) Heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor, or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose, or sinuses, unexplained weight loss, or accidental injury?	☐	☐	☐	☐

continued...

5. Statement of Health continued: Please initial any changes you make on this form.

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
b) Other health or physical impairment including:				
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐	☐	☐	☐
(ii) Chronic cough, persistant diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	☐	☐	☐	☐
(iii) Any other impairment?	☐	☐	☐	☐
3. During the past five years, has any person to be insured ever been counseled, treated, or hospitalized for the use of alcohol or drugs?	☐	☐	☐	☐
4. Is any person to be insured now pregnant?	☐	☐	☐	☐
5. Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐	☐	☐	☐
6. During the past two years, has any person to be insured participated in, or does any person plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang-gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	☐	☐	☐	☐

7. Driver's License: Member No: ______________________________ State Issued: _________
Spouse No: ______________________________ State Issued: _________

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
8. During the past five years, has any person to be insured had his or her driver's license suspended, or revoked, or had any moving violations?	☐	☐	☐	☐
9. During the past 24 months, has any person to be insured ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gun?	☐	☐	☐	☐
10. **Except for the residents of MN and CT,** 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?	☐	☐	☐	☐
For residents of MN and CT 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?	☐	☐	☐	☐

[Florida residents only—answer the following:]	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
Have you ever been tested positive for exposure to the HIV infection, or been diagnosed as having ARC (AIDS-related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection, or other sickness or condition derived from such infection?	☐	☐	☐	☐

11. If you have answered any of the above Questions 1–10 "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-Operation-Degree of Recovery and Date	Name and Address of Physicians or other Practitioners and Hospitals where confined or treated

6. 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 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 <u>except</u> those listed below <u>and</u> 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.

PART IV Your Signature(s)

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 **X**______________

(PLEASE SIGN AND DATE IN INK)

Spouse's Signature **X**______________________________ Date **X**______________

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

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.

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