



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 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 _____ Member Soc. Sec. #: [][][]-[][][]-[][][][][]
Last First Middle Initial

Street Address _____ City _____ State (or Province) _____ Zip [][][][][]-[][][][]

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

Email _____ Date of Birth: _____ Sex: _____
For internal use only. Email address will never be sold or shared. MO./ DAY / YR.

Member: _____ / / _____ M F

Spouse* or Domestic Partner**:
Name if proposed for insurance _____ / / _____ M F

Child*: _____ / / _____ M F
Name if proposed for insurance

Child*: _____ / / _____ M 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:

Membership in ACS 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 Hospital Indemnity Plan (enclose a VOIDED check or deposit slip, as applicable).

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

4. Insurance Requested: Refer to brochure for eligibility, options, premium, and coverage description.

I hereby apply for the following coverage(s): New Additional NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage. Instead, indicate the total amount of coverage you are requesting.

The daily benefit selected is:

For Myself: \$50 \$100 \$150 \$200 \$250 \$300 For Dependent Children: \$50

For Spouse*: \$50 \$100 \$150 \$200 \$250 \$300

*Spouse amount cannot exceed member amount.

(Coverage section continues on next page)

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Be Sure To Complete All Pages and Sign Last Page

4. Insurance Requested continued: Refer to brochure for eligibility, options, premium, and coverage description.

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 #, & Benefit Amount: _____

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

Spouse: Insurance Company Name, Policy #, & 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.

Fraud Notices

FRAUD NOTICE—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. **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 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.

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, 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)

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Be Sure To Complete All Pages and Sign Last Page
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