Underwritten by the United States Life Insurance Company in the City of New York (Herein called the Company)

Application for **Group Accidental Death & Dismemberment Insurance**

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Send your completed form to:
ACOG Member Insurance Program
1200 East Glen Avenue, Peoria Heights, IL, 61616
800.214.8122 | **acoginsurance.com**

1. MEMBER INFORMATION

Full Name | Male/Female | Age | Height | Weight

Street Address | City | State | Zip

Email | Home Phone | Work Phone

Date of Birth | Birth Place (City, State) | Members Physician's Name, Address, and Phone Number

Are you now a member of The American College of Obstetricians and Gynecologists? ◯ YES ◯ NO _____ Membership Number

2. INSURANCE REQUESTED

I would like to apply for: ◯ New Coverage ◯ Increase in Coverage

Type of coverage applying for: ◯ Member Only ◯ Member and Spouse/Domestic Partner ◯ Member and Children ◯ Family

Member: ◯ 100,000 ◯ 150,000 ◯ 200,000 ◯ 250,000 ◯ 300,000 ◯ 350,000 ◯ 400,000 ◯ 450,000 ◯ 500,000

3. SPOUSE/DOMESTIC PARTNER INFORMATION

Full Name | Male/Female | Date of Birth

Email | Home Phone | Work Phone

4. CHILD INFORMATION

Full Name | Male/Female | Date of Birth

Full Name | Male/Female | Date of Birth

5. SELECT YOUR PAYMENT OPTION

I prefer to pay: ◯ Quarterly Direct Bill ◯ Semiannual Direct Bill ◯ Annual Direct Bill

6. PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW TO APPLY

I hereby enroll with The United States Life Insurance Company in the City of New York, for coverage under the Group Accidental Death & Dismemberment Insurance Program. I have read and understand the conditions and exclusions of the program.

I understand that the insurance shall become effective on the first day of the month after receipt and acceptance of my Enrollment Form and first premium payment.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a 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. (Fraud language varies by state.)

Signature | Date

Spouse's/Domestic Partner's Signature (if applying) | Date