

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 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 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 Signature (if applying) _____ Date _____