

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

# Application for Group Business Overhead Expense 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  
**PHONE: 800.214.8122**

Members must be working 26 hrs/week,  
be under age 59 to apply.

## 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, and have been for the last 90 days, performing all of the duties of your regular occupation for at least 26 hours per week for your present employer? <input type="radio"/> YES <input type="radio"/> NO				
Name of Business, Business Address, City, State, Zip				
Annual Earned Income (after business expenses)	Occupation	Date of Hire		
Are you now a member of The American College of Obstetricians and Gynecologists? <input type="radio"/> YES <input type="radio"/> NO				
Membership Number				

## 2. INSURANCE REQUESTED

I would like to apply for:  New Coverage  Increase in Coverage My share of eligible expenses is \_\_\_\_\_ % Number of full-time employees \_\_\_\_\_

Monthly benefit requested (in 100 increments) \$ \_\_\_\_\_ (not to exceed the monthly expenses you actually incurred)

(\$1,000 to \$15,000 in \$100 increments for persons age 54 or under, on the effective date of your coverage. \$1,000 to \$5,000 in \$100 increments for persons age 55 or over, but under age 59 on the effective date of coverage.)

Waiting Period:  14 Days  30 Days Benefit Period: **24 Months**

## 3. SELECT YOUR PAYMENT OPTION

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

**4. PLEASE ANSWER THESE QUESTIONS. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF.**

1. During the past 5 years have you had or been treated for (Circle specific disorders experienced):
  - A. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack?  YES  NO
  - B. Injury, pain, or disorder of neck or back? Sciatica? Any disabling injury or disorder of the bones, joints, or muscles? Connective tissue disorder?  YES  NO
  - C. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder?  YES  NO
  - D. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?  YES  NO
  - E. Disease or disorder of the rectum? Vascular or blood disorder?  YES  NO
  - F. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?  YES  NO
  - G. Ulcer, or disorder of the stomach, liver, gall bladder, or pancreas? Colitis, Hepatitis, or other disorder of the small or large intestine?  YES  NO
  - H. Prostate disorder? Nephritis, nephrosis, or other kidney disease or disorder?  YES  NO
  - I. Menstrual, uterine, or ovarian disorder? Complications of pregnancy? Disorder of the breast?  YES  NO
  - J. Bronchitis, emphysema, sleep apnea, difficulty breathing, or other respiratory disease or disorders?  YES  NO
  - K. Cancer, tumor, or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?  Yes  NO
  - L. Mental or emotional problem requiring help of a physician, psychologist, or counselor?  YES  NO
  - M. A surgical operation? Or a surgical operation advised but not performed?  YES  NO
  - N. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system?  Yes  NO
  - O. Alcohol or drug abuse?  YES  NO
2. Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above?  YES  NO
3. Are you now taking prescription medication or receiving medical attention?  YES  NO

For "Yes" answers to Questions 1–3 above, please provide details in the spaced provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes."  YES  NO

QUESTION NUMBER	CONDITION	DATE OCCURED	DURATION	DEGREE OF RECOVERY	NAME & ADDRESS OF PHYSICIANS, HOSPITALS, OR CLINICS CONSULTED

**5. EXISTING AND PENDING INSURANCE**

1. Do you have any Business Overhead Expense Insurance in force or pending (including group coverage)?  YES  NO  
 If "Yes," please indicate companies and amounts: \_\_\_\_\_
2. Will this coverage applied for replace any insurance now in force?  YES  NO  
 If "Yes," please indicate which insurance and the amount being replaced: \_\_\_\_\_

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

**AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY:** I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., formerly known as the Medical Information Bureau, or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at any time by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

**Important Notice:** Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information, commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits.

A copy of this application will be attached to and made a part of your certificate.

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Signature \_\_\_\_\_ Date \_\_\_\_\_



**NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)**

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

**MIB DISCLOSURE NOTICE**

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866.692.6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734. The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

