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? ◯ YES ◯ 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? ◯ YES ◯ 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

G-19464-MO
A-6575-1109-W

Group Policy No. G-610,188
AG-11487

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

1. Have you during the past 10 years 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? Vascualr 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, Hepatitus, 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.

Signature Date

8. PLEASE RETAIN FOR YOUR RECORDS

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.

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