

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 and spouses must be working 30 hrs/week,
be under age 60 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 30 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		
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. Have you ever 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."

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. (For specific variations, see below).

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

Signature _____ Date _____

7. IMPORTANT NOTICE

For residents of Arkansas, Louisiana and West Virginia: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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 Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **For residents of the District of Columbia: 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. **For residents of Maine, Tennessee and Washington:** 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. **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **For residents of New Mexico:** 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 CIVIL FINES AND CRIMINAL PENALTIES. **For residents of Ohio:** Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of Insurance fraud. **For residents of Oklahoma:** 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. **For residents of Pennsylvania:** 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 is a crime and subjects such person to criminal and civil penalties. **For residents of Virginia:** 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.



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.

