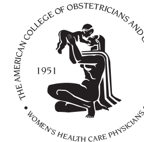
The United States Life Insurance Company in the City of New York (Herein called the Company)

APPLICATION FOR:
Member Disability Income 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 26 hrs/week and be under age 60 to apply.

Home Office: 175 Water Street, New York, NY 10038

STEP 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 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

Occupation Annual Earned Income (after business expenses)

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

STEP 2. INSURANCE PLAN OPTIONS

From the chart below, select the maximum monthly benefit in $100 increments.

Monthly Benefit Amount: $ ______
(Cannot exceed 70% of your basic monthly pay.)

Status	Minimum	Maximum
Member (Up to Age 49)	$1,000	$10,000
Member (Age 50-59)	$1,000	$5,000
Resident (Up to Age 59)	$1,000	$3,000

Benefit Period: Select only one.
- ◯ **Plan A:** To age 65
- ◯ **Plan B:** 60 months
- ◯ **Plan C:** 24 months

Waiting Period (in days)**:**
- ◯ **60 Days**
- ◯ **90 Days** (Plans A or B only)
- ◯ **180 Days** (Plans A or B only)

Optional Benefit(s): (Available only at time of initial application)
- ◯ **Catastrophic Disability Benefit** ◯ **$1,000** ◯ **$2,000** ◯ **$3,000** (Not available with Plan C)
- ◯ **Cost of Living Increase Option (COLA)** (Must be under age 50 to apply for COLA)

Premiums to Be Paid: ◯ Quarterly ◯ Semiannually ◯ Annually

STEP 3. PLEASE ANSWER THESE BRIEF QUESTIONS. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

1. Have you ever had or been treated for (circle specific disorders experienced):

Question	Answer
a. Disease or disorder of the heart, murmur, chest pain, rhuematic fever, elevated blood pressure, stroke, aneurysm, or transient ischemic attack?	◯ YES ◯ NO
b. Injury, pain, or disorder of the 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, difficult 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

STEP 3. PLEASE ANSWER THESE BRIEF QUESTIONS. TO THE BEST OF YOUR KNOWLEDGE AND BELIEF:

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 please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes."	◯ YES

Question #	Condition	Date Occured	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals, or Clinics Consulted

STEP 4: EXISTING AND PENDING INSURANCE

1. Do you have any disability 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: ____________________

STEP 5: SELECT YOUR PAYMENT MODE

I prefer to pay by: ◯ Electronic Funds Transfer ◯ Credit Card ◯ Quarterly Direct Bill ◯ Semiannual Direct Bill ◯ Annual Direct Bill

Electronic Funds Transfer: By selecting this option, your monthly premium will automatically be withdrawn from your checking account. Please provide the information requested below. **Payment not required at time of application. Please include a blank voided check with your application.**

____

Bank Name and Address

STEP 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.

____

Member's Signature | Date

G-19463-CA

California Insurance License Number 0F76076