

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.

In the absence of fraud, all statements made by the applicant or the Policyholder shall be deemed representative and not warranties. 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?	<input type="radio"/> YES <input type="radio"/> 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?	<input type="radio"/> YES <input type="radio"/> NO
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis, or rheumatism, or any other neurological disorder?	<input type="radio"/> YES <input type="radio"/> NO
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears?	<input type="radio"/> YES <input type="radio"/> NO
e. Disease or disorder of the rectum? Vascular or blood disorder, except for HIV?	<input type="radio"/> YES <input type="radio"/> NO
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder?	<input type="radio"/> YES <input type="radio"/> NO
g. Ulcer, or disorder of the stomach, liver, gall bladder, or pancreas? Colitis, Hepatitis, or other disorder of the small or large intestine?	<input type="radio"/> YES <input type="radio"/> NO
h. Prostate disorder? Nephritis, nephrosis, or other kidney disease or disorder?	<input type="radio"/> YES <input type="radio"/> NO
i. Menstrual, uterine, or ovarian disorder? Complications of pregnancy? Disorder of the breast?	<input type="radio"/> YES <input type="radio"/> NO
j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders?	<input type="radio"/> YES <input type="radio"/> NO
k. Cancer, tumor, or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system?	<input type="radio"/> YES <input type="radio"/> NO
l. Mental or emotional problem requiring help of a physician, psychologist, or counselor?	<input type="radio"/> YES <input type="radio"/> NO
m. A surgical operation? Or a surgical operation advised but not performed?	<input type="radio"/> YES <input type="radio"/> NO
n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system? Answer this question NO if you have tested for HIV but have not developed symptoms of the disease AIDS or ARC.	<input type="radio"/> YES <input type="radio"/> NO
o. Alcohol or drug abuse?	<input type="radio"/> YES <input type="radio"/> NO

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

2. Other than those stated above, for any reason have you, during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, except HIV? 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 United States Life Insurance Company in the City of New York, as well as representatives of The United States Life Insurance Company in the City of New York 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). This authorization excludes disclosure of the results of a test for HIV if the applicant has not developed symptoms of the disease AIDS or ARC. Such test results shall not be discovered or published. Nothing in this caveat will prohibit this authorization from including the fact that the applicant has AIDS or ARC. 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 that such revocation may be a basis for denying benefits. 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. Failure to sign this authorization may impair the ability of The United States Life Insurance Company in the City of New York to evaluate or process your application or claim and may be a basis for denying an application or claim for benefits. 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: 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.

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

Member's Signature _____ Date _____

G-19463-ME