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.

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):

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.

_____ _____

Member's Signature Date

For residents of Arkansas, Louisiana, Rhode Island, and West Virginia: Any person who knowlingly 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 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 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 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.

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

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