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

Application for **Group Hospital Indemnity 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
800.214.8122 | **acoginsurance.com**

1. MEMBER INFORMATION

Full Name | Male/Female | Age

Street Address | City | State | Zip

Email | Home Phone | Work Phone

Date of Birth | Birth Place (City, State)

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: ◯ Member Only Coverage ◯ Family Plan Coverage—including Member, Spouse and/or Children

Check the daily benefit you wish for yourself and any dependents you wish to enroll (spouse or child cannot exceed member's benefit amount):

Myself: ◯ $300 ◯ $200 ◯ $100 **My Spouse:** ◯ $300 ◯ $200 ◯ $100 **My Children:** ◯ $100 ◯ $50

3. DEPENDENT INFORMATION

Major Medical Plan or other Minimum Essential Coverage ◯ YES ◯ NO

Full Name | Male/Female | Age | Date of Birth

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4. SELECT YOUR PAYMENT OPTION

I prefer to pay: ◯ Quarterly Direct Bill ◯ Semiannual Direct Bill ◯ Annual Direct Bill

5. PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW TO APPLY

I hereby enroll with The United States Life Insurance Company in the City of New York, for coverage under the Group Hospital Indemnity Insurance Program. I have read and understand the conditions and exclusions of the program.

I understand that the insurance shall become effective on the first day of the month after receipt and acceptance of my enrollment form and first premium payment.

Important Notice: Any person who knowingly and with intent to defraud any insurance company or other person files a 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 may be a crime. (Fraud language varies by state.)

Signature | Date

Spouse's/Domestic Partner's Signature (if applying) | Date

G-19479

Group Policy No. G-610,190
AG-11486

ACOG-HIP-APP

5. PLEASE READ THE FOLLOWING, THEN SIGN AND DATE BELOW TO APPLY continued

Are you, covered under a Major Medical Plan or other minimum essential coverage (including Medicare Parts A & B)? ◯ YES ◯ NO

Are all those for whom coverage is requested, covered under a Major Medical Plan or other minimum essential coverage (including Medicare Parts A and B)? ◯ YES ◯ NO

Any person for whom you answered "NO" does not qualify for this coverage.

The Hospital Indemnity Policy and the associated certificates are supplemental to health insurance and ARE not a substitute for major medical coverage. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

If you do not maintain major medical coverage or other essential coverage you are not eligible for coverage under this plan. If you maintain your hospital indemnity coverage that will be affirmation to The United States Life Insurance Company in the City of New York that you also **maintain** major medical coverage or other required essential coverage.

Signature Date

Spouse's/Domestic Partner's Signature (if applying) Date