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

Application for **Group 10 and 20-Year Level Term Life Insurance**

The American College of Obstetricians and Gynecologists
WOMEN'S HEALTH CARE PHYSICIANS

Send your completed form to:
ACOG Member Insurance Program,
1200 E. Glen Ave., Peoria Heights, IL, 61616
PHONE: 800.214.8122

Members and spouses must be working 30 hrs/week and under age 50 to apply for the 20-year plan and under 60 for the 10-year plan.

STEP 1. MEMBER INFORMATION Please Print or Type

◯ Male ◯ Female

Name

Social Security Number | Membership Number

Member's Home Address

City | State | Zip Code

Place of Birth | Birthdate (mm/dd/yyyy)

Age | Weight (lbs.) | Height (ft./in.)

Home Phone | Work Phone

Email Address

Beneficiary | Relationship to You

Birthdate (mm/dd/yyyy) | SS# | Phone Number

Name and Address of Member's Physician

Are you working at least 30 hrs/week? ◯ YES ◯ NO

Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise, your beneficiary will be your children, parents, siblings, or estate, in that order.

SPOUSE/DOMESTIC PARTNER INFORMATION Please Print or Type

◯ Male ◯ Female

Name

Social Security Number

Spouse's/Domestic Partner's Home Address

City | State | Zip Code

Place of Birth | Birthdate (mm/dd/yyyy)

Age | Weight (lbs.) | Height (ft./in.)

Home Phone | Work Phone

Email Address

Beneficiary | Relationship to You

Birthdate (mm/dd/yyyy) | SS# | Phone Number

Name and Address of Spouse's/Domestic Partner's Physician

Are you working at least 30 hrs/week? ◯ YES ◯ NO

Unless otherwise requested, the member will be the beneficiary of any spouse insurance applied for.

STEP 2. SELECT YOUR COVERAGE AMOUNT

Term of Coverage: ◯ 10-Year ◯ 20-Year

Member Amount: ◯ $250,000 ◯ $500,000 ◯ $1,000,000 ◯ $2,000,000 ◯ Other ________ ($100,000 to $2,000,000, in $10,000 units)

Spouse Amount: ◯ $250,000 ◯ $500,000 ◯ $1,000,000 ◯ $2,000,000 ◯ Other ________ ($100,000 to $2,000,000, in $10,000 units)

STEP 3. ANSWER HEALTH QUESTIONS AND PROVIDE DETAILS TO ANY "YES" ANSWERS

	MEMBER	SPOUSE
1. Has the applicant/member or spouse, if applying, ever been diagnosed with, or been treated for: chest pain; disease or disorder of the heart, liver, kidneys, blood, or lungs; high blood pressure; stroke or other neurological disorder; mental/nervous disorder; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or tested positive for an immune disorder?	◯ YES ◯ NO	◯ YES ◯ NO
2. Has the applicant/member or spouse, if applying, during the past 5 years, been diagnosed with, or been treated for drug or alcohol abuse?	◯ YES ◯ NO	◯ YES ◯ NO
3. Has the applicant/member or spouse, if applying, during the past five years, consulted a licensed medical provider or been confined or treated in any hospital or similar institution, for any reason other than those stated above?	◯ YES ◯ NO	◯ YES ◯ NO
4. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	◯ YES ◯ NO	◯ YES ◯ NO
5. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	◯ YES ◯ NO	◯ YES ◯ NO
6. Has the applicant/member or spouse, if applying, ever had life or health insurance declined, modified, or rated?	◯ YES ◯ NO	◯ YES ◯ NO
For "Yes" answers to Questions 1-6 above, 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" in the box at the right.	◯ YES	

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

References to "Spouse" include Domestic Partnerships.

Be sure to complete all pages and sign the last page

STEP 4. FINANCIAL SECTION - Complete This Section if Application is for Over $1,000,000

Proposed Insured's Annual Income: Earned Income $ ______________ Other Income $ ______________

Total Assets: $ ______________ Total Liabilities: $ ______________ Net Worth: $ ______________

Occuptation: ______________ Indicate Income of Proposed Insured's Spouse, if Applying: $ ______________

STEP 5. EXISTING AND PENDING INSURANCE

Life insurance in force and/or pending on proposed insured's life, including business insurance (If none, check "None.") ◯ None

	Name of Company	Type of Coverage	Life Amount	Year Issued	Do You Plan to Replace This Coverage?
Member/Applicant			$		◯ YES ◯ NO
Spouse			$		◯ YES ◯ NO

STEP 6. 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.**

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Bank Name and Address

STEP 7. 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, 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 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.

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Member's Signature Date

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Spouse's Signature (if applying) Date

G-19430-MN

30-DAY FREE LOOK

NO RISK. NO OBLIGATION. SEND NO MONEY NOW. If your application is approved we will notify you to make your first premium payment. Upon its receipt, you will receive a Certificate of Insurance to review at your leisure. If you are not completely satisfied with its benefits and terms, return it within 30 days for a full no-questions-asked refund.