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 had, 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; drug or alcohol abuse; diabetes; cancer or tumor; Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	◯ YES ◯ NO	◯ YES ◯ NO
2. Has the applicant/member or spouse, if applying, during the past five 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	◯ YES ◯ NO
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	◯ YES ◯ NO	◯ YES ◯ NO
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	◯ YES ◯ NO	◯ YES ◯ NO
For "Yes" answers to questions 1-4 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 to 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: $ _____

Occupation: _____ 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.**

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. (This warning does not apply in Virginia. For state specific variations, see below.)

Member's Signature Date

Spouse's Signature (if applying) Date

G-19430

For residents of Arkansas, Louisiana, Rhode Island, and West Virginia: 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 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 Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **For residents of Tennessee, Virginia, 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 Maryland:** Any person who knowingly and willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and be subject to fines and confinement in prison. **For residents of New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **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/she 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.

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.