

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

Application for Group 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 East Glen Avenue, Peoria Heights, IL, 61616
PHONE: 800.214.8122

Members and spouses must be working 30 hrs/week,
be under age 60 to apply.

STEP 1. MEMBER INFORMATION Please Print or Type

Male Female

Name (First, Middle, Last)

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

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 INFORMATION Please Print or Type

Male Female

Name (First, Middle, Last)

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

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

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. PLEASE ANSWER THESE BRIEF QUESTIONS

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 (EXCEPT FOR HIV)?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> 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 (EXCEPT FOR HIV)?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
3. Has the applicant/member or spouse, if applying, used tobacco or nicotine in any form during the past 12 months?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> NO
4. Is the applicant/member or spouse, if applying, now taking prescription medication or receiving medical attention?	<input type="radio"/> YES <input type="radio"/> NO	<input type="radio"/> YES <input type="radio"/> 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 at the right.

YES

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

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			\$		<input type="radio"/> YES <input type="radio"/> NO
Spouse			\$		<input type="radio"/> YES <input type="radio"/> 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, 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 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). This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. 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 anytime 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. I understand that failure to sign this authorization may impair the ability of the Company to evaluate claims and process this application and may be a basis for denying this application or claim for benefits.

"Wherever the term "Spouse" appears will read as Domestic Partner throughout 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.

Member's Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____

G-19430-ME

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