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

Request for Group Insurance From:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Plan Administrator:

PEARL® INSURANCE
1200 E. Glen Ave., Peoria Heights, IL 61616-5348

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

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

Full Name		S.S.#
Street Address		
City	State	ZIP Code
Home Phone	Work Phone	Fax
Email		For internal use only. Email address will never be sold or shared.

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union (Eligibility of Civil Union partners is determined by State Law)

	Name	Date of Birth	Height	Weight	Sex
ACOG member					
Spouse*					

*Member date of birth must also be provided when requesting spouse coverage

In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada?

ACOG member	◯ Yes ◯ No	Country(ies)	How Long?	
Spouse	◯ Yes ◯ No	Country(ies)	How Long?	

STEP 2. MEMBER AFFILIATION

To participate in this Plan you must be in good standing with ACOG.	ACOG Member ID#

STEP 3. INSURANCE REQUESTED

I HEREBY APPLY FOR THE FOLLOWING GROUP 10-YEAR LEVEL TERM LIFE INSURANCE COVERAGE:

A. ACOG Member Option Insurance Requested

◯ 250K for expedited issuance* ◯ Other $ _____

Spouse Option **Insurance Requested $** _____

*More information will be required for limits over $250,000.

B. Tobacco/Nicotine Use

Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

ACOG Member: ◯ YES ◯ NO **Spouse:** ◯ YES ◯ NO

If "Yes", please state **when** you last used tobacco or nicotine and specify the **product.**

ACOG Member: / / _____
Spouse: / / _____

C. Current Coverage

Do you have other life insurance in force? If "Yes", total amount in all companies: ACOG Member $_____ Spouse $ _____

Do you have other insurance applications pending? If "Yes", indicate amount and company:

ACOG Member $ _____ Company _____ Spouse $ _____ Company _____

D. INSURANCE REPLACEMENT: IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK **It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed, or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue, or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help you decide whether the replacement is in your best interest.**

RESIDENTS OF NEW YORK: I have read the important replacement information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **ACOG Member:** ◯ YES ◯ NO **Spouse:** ◯ YES ◯ NO

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing policy?

ACOG Member: ◯ YES ◯ NO **Spouse:** ◯ YES ◯ NO

STEP 4. PAYMENT OPTION SELECTION

Following your initial billing, you will be billed twice a year on January 1 and July 1 or you can also access a secure website where you can register to have your premium withdrawn from your bank account or charged to your credit card.

STEP 5. BENEFICIARY DESIGNATION: INSERT NAME, RELATIONSHIP, AND ADDRESS.

I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.)

Beneficiary Name (Full Name)			Phone
Relationship to applicant		Date of Birth	S.S.#
Street Address	City	State (or Province)	Zip Code

Be Sure To Complete All Pages and Sign Last Page
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

Depending on the amount you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.

What time and phone number would be best to contact you?_____

STEP 6. FRAUD NOTICE

For residents of all states except those listed below and NEW YORK: 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 com-mits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **FOR RESIDENTS OF CA:** 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 may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bear the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **RESIDENTS OF CO:** the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **RESIDENTS OF AL/AR/LA/RI:** 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 D.C.: 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. **RESIDENTS OF FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **RESIDENTS OF KS:** Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false informa-tion in an application for insurance may be guilty of insurance fraud as determined by a court of law. **RESIDENTS OF ME:** It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits. **RESIDENTS OF MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false in-formation in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **RESIDENTS OF NJ: WARNING:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation. **RESIDENTS OF OK: 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. **RESIDENTS OF PUERTO RICO:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon convic-tion will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating cir-cumstances prevail, it may be reduced to a minimum of two (2) years. **RESIDENTS OF TN/WA:** 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. **RESIDENTS OF VA:** Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

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STEP 7. AUTHORIZATION AND SIGNATURE

I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic, or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member requests the insurance indicated; any person proposed for insurance consents to authorize the disclosure of information to and from the providers noted in the attached IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc; and the member and any person proposed for insurance attest to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how information is exchanged with MIB, and that to the best of their knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature _____ Date _____

Spouse's Signature (if applying) _____ Date _____

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For ACOG Group 10-Year Level Term Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: PROTECTED PERSONS [1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION [2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth, and address.

[1]PROTECTED PERSON means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.

[2]CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer, or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.