ASCE | MEMBER INSURANCE

Residents of Puerto Rico,
please return application to:
Global Insurance Agency
P.O. Box 9023918
San Juan, Puerto Rico 00902-3918

NEW YORK LIFE

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

Please complete this form and return to:
ASCE Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 / **Questions:** Please call 1.800.650.2723

ASCE GROUP DISABILITY INCOME APPLICATION

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

PART I Personal Info

1. MEMBER INFORMATION:

Full Name: _____ Social Security #: ☐☐☐-☐☐-☐☐☐☐
Last First MI

Street Address: _____

City: _____ State (or Province): _____ Zip: ☐☐☐☐☐-☐☐☐☐

Home Phone: (_____) _____ Work Phone: (_____) _____ Fax: (_____) _____

Email: _____ Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single

For internal use only. Email address will never be sold or shared.

	First / MI / Last	Date of Birth: MO / DAY / YR	Height:	Weight: LBS	Sex:
☐	Member Name: _____	_____/_____/_____	____ft. ____in.	_____	☐ M ☐ F
☐	Spouse Name*: _____	_____/_____/_____	____ft. ____in.	_____	☐ M ☐ F

**Member must be insured for a minimum of $600 a month benefit for Spouse to be eligible for coverage.*

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?
Member: ☐ Yes ☐ No Country(ies): _____ If "Yes," for how long? _____
Spouse: ☐ Yes ☐ No Country(ies): _____ If "Yes," for how long? _____

2. MEMBER AFFILIATION—OCCUPATIONAL STATUS: Association Membership is required for participation in this plan.

A. Are you now a member of ASCE? ☐ Yes ☐ No ASCE Membership #: _____ Exp. Date: ____/____/____
B. What is your occupation? _____ Main Duties: _____
C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties normally are performed, or other location to which travel is required. Are you at "FULL-TIME WORK"? ☐ Yes ☐ No
D. Gross Annual Income from:
Salary $: _____ Self-Employment $: _____ Self-Employment Start Date: ____/____/____
Bonus $: _____ Commissions $: _____ Total $: _____
Your gross annual earned income must be at least $20,000 for you to be eligible for this coverage.

PART II Your Coverage

3. INSURANCE REQUESTED: Refer to plan information for eligibility, options, and coverage descriptions.

I hereby apply for the coverage: ☐ New ☐ Additional
Note: If you are increasing or altering present coverage in any way, do NOT indicate in "Item A" below only the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

You may choose any Monthly Benefit Option provided it and other disability income coverage you may have does not exceed 60% of your Monthly Gross Earned Income (as defined in the brochure). If you have been self-employed for less than one year, your monthly benefit is limited to $1,050 with a 90-day Waiting Period under the Five-Year Plan.

I hereby apply for the coverage indicated below, based upon all my statements made in this Application:

☐ A. Member Monthly Benefit Option $: _____
☐ B. Member Plan Option (choose one): ☐ Career Plan ☐ Five-Year Plan
☐ C. Member Waiting Period (choose one): ☐ 30-Day ☐ 90-Day ☐ 180-Day ☐ 365-Day
☐ D. Spouse Benefit Option: (Two-year Benefit Period, $500 Monthly Benefit, 30-day Waiting Period)

3. INSURANCE REQUESTED (CONTINUED): Refer to plan information for eligibility, options, and coverage descriptions.

Do you or your spouse, if proposed for insurance, now have or are you applying for other insurance which provides benefits if you are unable to work because of disability? ☐ Yes ☐ No If "Yes," please list below:

Company:	Plan:	Monthly Benefit:	Benefit Period:

Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ☐ Yes ☐ No
(If "Yes," please indicate which coverage and the date it will be terminated: _____)

4. MEMBER STATEMENT OF HEALTH:

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	MEMBER		DEPENDENT	
	YES	NO	YES	NO
A. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐	☐	☐
B. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	☐	☐	☐	☐
C. During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?	☐	☐	☐	☐
D. Is any person to be insured now pregnant?	☐	☐	☐	☐
E. Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐	☐	☐	☐
F. During the past 24 months, has any person to be insured ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?	☐	☐	☐	☐
G. Except for the residents of Minnesota and Connecticut, has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	☐	☐	☐	☐
For residents of Minnesota and Connecticut ONLY, has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	☐	☐	☐	☐

Details (please fill out if answered "YES" to a, b, or c): _____

_____

_____

Depending on the amount of insurance 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 telephone number would be best to contact you? _____

5. FRAUD NOTICE:

FRAUD NOTICE – For Residents of all states <u>except</u> those listed below: 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. **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 AR/LA/MD/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 information 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

continued

5. FRAUD NOTICE (CONTINUED):

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 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 (5,000) 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 conviction 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 circumstances 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.

PART IV Your Signature

6. 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 authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. 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 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how information is exchanged with MIB, and that to the best of his/her knowledge and his/her belief, the answers provided to the questions are true and complete.

Member's Signature X: _____ Date: _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X: _____ Date: _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Do Not Send Payment: Upon approval, you will be notified of the premium due.

Choose one payment option (additional forms will be sent to you for EFT and CC option):

☐ Direct Billing (semiannually 3/1 & 9/1) ☐ Electronic Funds Transfer ☐ Credit Card