ASCE | MEMBER ADVANTAGES

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

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
**Questions:** Please call 800.469.3582

**Please complete the information below and return to:** ASCE Plan Administrator, 1200 E. Glen Ave., Peoria Heights, IL 61616-5348
**Residents of Puerto Rico, please return application to:** Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

# GROUP HOSPITAL INDEMNITY INSURANCE PLAN APPLICATION

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

## 1. MEMBER INFORMATION

Full Name (Last, First, MI) _____ Social Security # _____

Street Address _____ City _____ State (or Province)* _____ ZIP Code _____

Home Phone _____ Work Phone _____ Fax Number _____

Email Address *(For internal use only. Email address will never be sold or shared.)* _____ May we contact you via text? ❍ Yes ❍ No

Marital Status: ❍ Married ❍ Divorced ❍ Widowed ❍ Single

| | Name | Date of Birth | Height | Weight | Sex |
|---|---|---|---|---|---|
| Member Name** | | / / | ft. in. | lbs. | ❍ M ❍ F |
| Spouse Name*** | | / / | ft. in. | lbs. | ❍ M ❍ F |
| Child*** | | / / | ft. in. | lbs. | ❍ M ❍ F |
| Child*** | | / / | ft. in. | lbs. | ❍ M ❍ F |

*Not available in CT, FL, LA, MN, MT, NC, NV, NH, OH, TX, VT, and WA.
**Member date of birth must also be provided when requesting spouse coverage only.
***See plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach, sign, and date an additional sheet.

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada? ❍ Yes ❍ No

Member: ❍ Yes ❍ No Country(ies): _____ If "Yes," for how long? _____

Spouse: ❍ Yes ❍ No Country(ies): _____ If "Yes," for how long? _____

## 2. MEMBER AFFILIATION

Membership in ASCE is required for participation in this plan. ASCE Membership #: _____

## 3. PAYMENT OPTION SELECTION (CHOOSE ONLY ONE)

❍ **OPTION 1:** DIRECT BILLING: Following your initial billing, you will be billed (choose one):
- ❍ Annually (July)
- ❍ Semiannually (January 1 and July 1)

❍ **OPTION 2:** ELECTRONIC FUNDS TRANSFER: I request and authorize the ASCE Group Insurance Program to make annual withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Hospital Indemnity Insurance Plan. (Enclose a VOIDED check or deposit slip, as applicable.)

**X** _____

**SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT** **DATE**

❍ **OPTION 3:** CREDIT CARD: I authorize premium contributions to be charged to my credit card ❍ Annually ❍ Semiannually

**Credit Card:** ❍ MasterCard ❍ Visa ❍ Discover ❍ American Express

Credit Card #: _____ Exp. Date: _____

**X** _____

**SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT** **DATE**

## 4. INSURANCE REQUESTED (REFER TO BROCHURE FOR ELIGIBILITY, PRINCIPAL SUMS, PREMIUM, AND COVERAGE DESCRIPTION)

**I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):**

**A. Member Option:** Daily Benefit ❍ $100 ❍ $200 ❍ $300 ❍ $400 ❍ $500

**B. Spouse Option:** Daily Benefit ❍ $100 ❍ $200 ❍ $300 ❍ $400 ❍ $500

**C. Child Option:** ❍ Yes ❍ No

## 5. BENEFICIARY DESIGNATION (INSERT NAME, RELATIONSHIP, AND SSN)

I make the following beneficiary designation with respect to all the insurance on my life under this Group Hospital Indemnity 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 (Last, First, MI)

Relationship to Member

Social Security #

## 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 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 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 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.

## 7. AUTHORIZATION AND SIGNATURE

I am an engineer under age 80 actively engaged full-time in the practice of the field or retired, not due to illness or injury, and request the coverage indicated. I affirm that any dependents I have enrolled meet the eligibility requirements for coverage as described. To the best of my knowledge and belief, I am eligible for such insurance and these statements I have made are true and complete.

Coverage will be effective on the date New York Life receives this request, provided eligibility requirements are met and required premium is paid when due. If I or any covered dependent is confined to a home, in a hospital, or other medical facility on that date, coverage for that person will be deferred until the day after he/she is no longer so confined, provided that the person is still eligible.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

The following statement by the U.S. Department of Health and Human Services (HHS) is meant to clarify the health care law.

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

**MEMBER'S SIGNATURE X** | **DATE**

(Please sign and date in ink)

**SPOUSE'S SIGNATURE X** | **DATE**

(Necessary only if spouse coverage is requested)