ASCE | MEMBER ADVANTAGES

1200 E. Glen Avenue, 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 Avenue, 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 Avenue, 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 HIGH-LIMIT ACCIDENT INSURANCE 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 FL, NC, VT, WA, U.S. Territories (except Puerto Rico), Quebec
**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 a separate sheet. Please sign and date the 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):
- ❍ Annual (July)
- ❍ Semiannual (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 High-Limit Accidental 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 ❍ Annual ❍ Semiannual

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: ❍ Initial Insurance Amount: $ _____

❍ Additional Insurance Amount Requested From: $_____ to $ _____

B. Spouse Option: ❍ Initial Insurance Amount: $ _____ (NOTE: Spouse coverage cannot exceed 100% of member's coverage.)

❍ Additional Insurance Amount Requested From: $_____ to $ _____

C. Child Option: ❍ $10,000 for all eligible dependent children (NOTE: Member coverage must be in force to request child coverage.)

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 High-Limit Accident 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 understand that New York Life Insurance Company 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; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated [above, below, on the reverse of this page, on the attached, enclosed], including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and 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)