ASCE | MEMBER INSURANCE

NEW YORK LIFE

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

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

To Apply: Please complete this form and return to:
ASCE Member Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348
Questions: Please call 1.800.650.2723

ASCE GROUP TERM LIFE APPLICATION

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 ______________________________ SS # ___-__-____
Last First Middle Initial

Street Address ______________________________

City ______________ State (or Province) ______________ Zip Code _____-____

Home Phone (_____) ______________ Work Phone (_____) ______________ Fax (_____) ______________

Email ______________________________ Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed
For internal use only. Email address will never be sold or shared.

Are you currently insured under any other ASCE Life Plans? ☐ Yes ☐ No
If "Yes," indicate which plan(s) and provide details below (person insured and amount of insurance):

☐ Term Life ☐ 10-Year Level Term Life ☐ 20-Year Level Term Life Details: ______________________________

____

		Date of Birth: MO./ DAY / YR.	Height:	Weight: LBS	Sex:
Member:	**Member date of birth must also be provided when requesting spouse coverage only.**	___/___/___	___ ft. ___ in.	________	☐ M ☐ F
Spouse*:	____________ Name if proposed for insurance (First/MI/Last)	___/___/___	___ ft. ___ in.	________	☐ M ☐ F
Child*:	____________ Name if proposed for insurance (First/MI/Last)	___/___/___	___ ft. ___ in.	________	☐ M ☐ F
Child*:	____________ Name if proposed for insurance (First/MI/Last)	___/___/___	___ ft. ___ in.	________	☐ M ☐ F

*See Plan Information/Plan Details 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?

Member: ☐ Yes ☐ No Country(ies)______________________________ If "Yes," for how long? __________
Spouse: ☐ Yes ☐ No Country(ies)______________________________ If "Yes," for how long? __________

2. Membership Affiliation: (Association Membership is required for participation in this plan.)

Are you now a member of ASCE? ☐ Yes ☐ No Membership #______________________ Exp. Date: ___/___/___

3. Payment Option Selection: Choose only one.

☐ **Option 1: Direct Billing:** Following your initial billing, you will be billed twice a year on March 1 and September 1.

☐ **Option 2: Electronic Funds Transfer:** I request and authorize the ASCE Member Insurance Program to make ☐monthly ☐quarterly ☐semiannual ☐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 Term Life Plan (Enclose a VOIDED check or deposit slip, as applicable).

____
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 ☐monthly ☐quarterly ☐semiannually ☐annually: Credit Card #______________________ Exp. Date____________ ☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

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

G-10500-1 **Be Sure To Complete All Pages and Sign Last Page**

PART II Your Coverage

4. Insurance Requested: Refer to plan information for eligibility, options, and coverage description.

I HEREBY APPLY FOR THE FOLLOWING GROUP TERM LIFE INSURANCE COVERAGE:

A. MEMBER OPTION:

☐ **Initial Insurance Amount:** $____________________

☐ Additional Insurance Amount requested from: $____________________ to $____________________

SPOUSE OPTION:

☐ **Initial Insurance Amount:** $____________________

☐ Additional Insurance Amount requested from: $____________________ to $____________________

CHILD OPTION: ☐ $10,000 for all eligible dependent children (NOTE: Member coverage must be in force to request child coverage.)

B. TOBACCO/NICOTINE USE: Have you or your spouse (if proposed for coverage) used tobacco or nicotine in any form, including nicotine patches or nicotine chewing gum, within the last 12 months?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If "Yes," when were tobacco or nicotine products last used? Member: ____ /____ (MONTH/YEAR) Spouse: ____ /____ (MONTH/YEAR)

C. INSURANCE REPLACEMENT:

RESIDENTS OF NEW YORK: IMPORTANT REPLACEMENT INFORMATION

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?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

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

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

ALL RESIDENTS:
Do you have other life insurance in force? If "Yes," total amount in all companies:

Member: $________________________ Spouse: $________________________

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

Member: $______________ Company_________________________ Spouse: $______________ Company_________________________

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—or owner of the coverage if other than the member—as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, please contact the Administrator.) (1) In naming more than one beneficiary, please note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. (2) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

A. ☐ Primary ☐ Secondary ______% Beneficiary Name: ____ (Last / First / Middle Initial)

Address: ____ (Street / City / State / Zip Code)

Relationship to Member_____________________________________ Social Security # : ☐☐☐-☐☐-☐☐☐☐

B. ☐ Primary ☐ Secondary ______% Beneficiary Name: ____ (Last / First / Middle Initial)

Address: ____ (Street / City / State / Zip Code)

Relationship to Member_____________________________________ Social Security # : ☐☐☐-☐☐-☐☐☐☐

PART III Your Health

6. Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured: YES NO

a. Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance? ☐ ☐
b. Are you or any other person to be insured now ill or receiving medical attention or surgical treatment? ☐ ☐
c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination or check-up, or been hospitalized, or had an operation, or had any illness, disease, or injury? ☐ ☐
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ ☐
e. Is any person to be insured now pregnant? ☐ ☐
f. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or being treated for:
 1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ☐ ☐
 2. Arthritis, back trouble, bone or joint disorder? ☐ ☐
 3. Fainting spells, convulsions, or epilepsy? ☐ ☐
 4. Sugar, blood, albumin, or pus in urine? ☐ ☐
 5. Diabetes, kidney trouble, ulcers, or digestive disorder? ☐ ☐
 6. Disorder of breast or reproductive organs or functions? ☐ ☐
 7. Nervous or mental disorder, emotional condition, or psychiatric care? ☐ ☐
 8. Cancer, tumor, or cyst? ☐ ☐
 9. Varicose veins, hemorrhoids, or hernia? ☐ ☐
 10. Disorder of eyes, ears, nose, or sinuses? ☐ ☐
 11. Thyroid, liver, or respiratory disorder? ☐ ☐
 12. Alcoholism or drug habit? ☐ ☐
 13. Disorder of the blood? ☐ ☐
 14. Other health or physical impairment including:
  (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ ☐
  (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years? ☐ ☐
  (iii) Any other impairment? ☐ ☐

IF YOU HAVE ANSWERED ANY QUESTIONS "YES," GIVE COMPLETE DETAILS BELOW.
(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various," or "miscellaneous.")

Question Letter/No.	Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and Address of Physicians or other Medical Care Practitioners or Hospitals where confined or treated:

7. Fraud Notices

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.

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 belief, the answers provided to the questions are true and complete.

PART IV Your Signature(s)

Member's Signature **X**____ Date **X**______________
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature **X**____ Date **X**______________
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Owner Information, required if owner is other than the applicant (If Owner is a Trust, please submit a copy of the document with this application).

Full Name: ____ Relationship to proposed insured:________________
LAST FIRST MIDDLE INITIAL

Mailing Address: ____
STREET CITY STATE ZIP CODE

Tax ID#:______________________________ Date of Birth: ___/___/___ Social Security #: ___-__-____

Owner's Signature **X** ____ Date________________
(NECESSARY ONLY IF OTHER THAN APPLICANT)

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