AMERICAN CHIROPRACTIC ASSOCIATION

GROUP ACCIDENT INSURANCE PLAN APPLICATION
UP TO $250,000 INSURANCE PROTECTION

Official Member No. _____

Name: _____

Address: _____

City, State, Zip: _____

To Apply, Please Complete and Return to:
ACA-Endorsed Insurance Program
P.O. Box 9159
Phoenix, AZ 85068-9918

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

1 Member Information:

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Member Name: (FULL NAME: FIRST - M.I. - LAST)

Address:

City, State, Zip:

Home Phone: ( ) – Work Phone: ( ) – Sex: ◯ Male ◯ Female

Social Security #: – –

Date of Birth: – – (MONTH DAY YEAR) Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed

Email Address: (For internal use only. Email addresses will never be sold or shared.)

Are you now a member of ACA? ◯ Yes ◯ No Member Number:

RESIDENCY: 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?

Please continue on Page 2 ➡

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):

◯ **Member Only** ◯ $25,000 ◯ $50,000 ◯ $100,000 ◯ $150,000 ◯ $200,000 ◯ $250,000

◯ **Spouse** 100% of Member Amount

◯ **Child(ren)** 10% of Member Amount

If requesting spouse or child coverage, please complete below: (Please provide information for additional children on a separate, signed and dated sheet.)

Spouse Name: _____ (FIRST, M.I., LAST)

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Sex: ◯ Male ◯ Female

Child Name: _____ (FIRST, M.I., LAST)

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Sex: ◯ Male ◯ Female

Child Name: _____ (FIRST, M.I., LAST)

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Sex: ◯ Male ◯ Female

◯ **I understand I will be billed quarterly for my coverage.**

3 Beneficiary Designation: Insert name, address and relationship.

I make the following beneficiary designation with respect to all the insurance on my life under this ACA Group Accidental Death & Dismemberment 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 beneficiar , 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.)***

ACA Member's Primary Beneficiary is: _____ (FULL NAME: FIRST, M.I., LAST)

Address: _____

City, State, Zip: _____

Percent of Coverage: __ % Relationship to ACA Member: _____ Social Security Number: ___ - __ - ____

ACA Member's Secondary Beneficiary is: _____ (FULL NAME: FIRST, M.I., LAST)

Address: _____

City, State, Zip: _____

Percent of Coverage: __ % Relationship to ACA Member: _____ Social Security Number: ___ - __ - ____

Please continue on Page 3 ➡

G-29051-2 **Be Sure to Complete All Pages and Sign Last Page**

4 Fraud Notice:

For Residents of all states except 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 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 priso

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 bar 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.

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 benefit

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 information in an application for insurance is guilty of a crime and may be subject to fines and confinement in ison.

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 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 mini um 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 benefit

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.

5 Signature: Please read, sign and date in ink.

By signing and dating this application, I and my spouse (if proposed for insurance), request the insurance, understand the effective date criteria, I/we have read the Fraud Notices indicated above and attest that to the best of my knowledge and belief, the answers to the questions are true and complete.

Member's Signature (PLEASE SIGN AND DATE IN INK)

Date: ☐☐ / ☐☐ / ☐☐☐☐ (MONTH / DAY / YEAR)

Spouse's Signature
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Date: ☐☐ / ☐☐ / ☐☐☐☐ (MONTH / DAY / YEAR)