AMERICAN CHIROPRACTIC ASSOCIATION

GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

UP TO $1,000,000 INSURANCE COVERAGE

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 85068-9159

NEW YORK LIFE

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 #: – – Height: ft. in. Weight: lbs.

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.)

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

Are you currently insured under any other ACA Life coverage? ◯ Yes ◯ No

If Yes, indicate which coverage and provide details below (person insured and amount of insurance):

PERSON(S) INSURED	AMOUNT OF INSURANCE
◯ Group Term Life	$
◯ 10-Year Level Term Life	$

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?

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

I HEREBY APPLY FOR THE FOLLOWING GROUP 10-YEAR LEVEL TERM LIFE INSURANCE COVERAGE:

◯ Member: Insurance Amount Requested $ _____ from $100,000 to $1,000,000, in $10,000 increments

◯ Spouse: Insurance Amount Requested $ _____ from $100,000 to $1,000,0000, in $10,000 increments not to exceed member amount

◯ Child(ren): Insurance amount $5,000 from 6 months to 25 years ($100 from 15 days to 6 months)

Please complete for all persons proposed for insurance. If more than two children are proposed for insurance, attach a separate sheet. Please **sign and date** the additional sheet.

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

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Height: __ ft. __ in. Weight: ___ lbs. Sex: ◯ Male ◯ Female

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

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Height: __ ft. __ in. Weight: ___ lbs. Sex: ◯ Male ◯ Female

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

Date of Birth: __ – __ – ____ (MONTH – DAY – YEAR) Height: __ ft. __ in. Weight: ___ lbs. Sex: ◯ Male ◯ Female

TOBACCO/NICOTINE USE: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Yes ◯ No ◯ If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: __ – __ – ____ (MONTH – DAY – YEAR) _____ (PRODUCT)

Spouse: __ – __ – ____ (MONTH – DAY – YEAR) _____ (PRODUCT)

INSURANCE REPLACEMENT:

IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK:

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.

Continued on page 3 ➡

2 Insurance Requested: Continued from page 2

RESIDENTS OF NEW YORK: I have read the Important Replacement Information on Page 2. 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:

Member: Do you have other life insurance in force? Yes ◯ No ◯ If "Yes," total in all companies: $

Do you have other insurance applications pending? Yes ◯ No ◯ If "Yes," amount: $

Company:

Spouse: Do you have other life insurance in force? Yes ◯ No ◯ If "Yes," total in all companies: $

Do you have other insurance applications pending? Yes ◯ No ◯ If "Yes," amount: $

Company:

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 10-Year Level Group Term Life Insurance and if I am already covered under the coverage, 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.)

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: - -

4 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?	○	○
g. (This question does not apply to residents of Maryland.) Have you or has your spouse had a parent, brother or sister who, prior to age 60, was medically diagnosed by a physician as having, or being treated for, cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, or neuromuscular or mental illness?	○	○
h. Within the past two years have you or your spouse (if proposed for insurance) participated in, or do either of you within the next two years, plan to participate in: aircraft flying other than as a passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; any type of motorized racing; hang-gliding; parasailing or bungee jumping?	○	○
i. Have you or your spouse had a driver's license suspended or revoked, or had any moving violations, within the past five years?	○	○

Member Driver's License No. ☐☐☐☐☐☐☐☐☐☐☐☐☐ State issued: ☐☐

Spouse Driver's License No. ☐☐☐☐☐☐☐☐☐☐☐☐☐ State issued: ☐☐

j. **Except for residents of CT and MN**, in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending?	○	○
For residents of CT and MN only, in the last seven years have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	○	○

If you have answered any questions "YES," give complete details on page 5. ➡

4 Statement of Health: Continued from page 4

IF YOU HAVE ANSWERED ANY QUESTIONS ON PAGE 4 "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/#	NAME(S) OF PROPOSED INSURED	ILLNESS OR CONDITION	DATE OF ONSET	DURATION	TREATMENT/ OPERATIONS	DEGREE OF RECOVERY	DATE	NAME AND ADDRESS OF PHYSICIANS OR OTHER MEDICAL CARE PRACTITIONERS OR HOSPITALS WHERE CONFINED OR TREATED

5 Fraud Notice:

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 prison.

RESIDENTS OF CA: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 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 prison.

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.

Continued on page 6

5 Fraud Notice: Continued from page 5

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.

1/13 ed.

6 Authorization and Signature:

AUTHORIZATION

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 (PLEASE SIGN AND DATE IN INK)

X _____ **Date:** ☐☐ – ☐☐ – ☐☐☐☐
MONTH DAY YEAR

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

X _____ **Date:** ☐☐ – ☐☐ – ☐☐☐☐
MONTH DAY YEAR

G-29183-0

Be Sure to Complete All Pages and Sign Last Page

RETURN COMPLETED FORM TODAY TO:
ACA-ENDORSED INSURANCE PROGRAM, P.O. BOX 9159, PHOENIX, AZ 85068-9159