

# **GROUP ACCIDENT INSURANCE APPLICATION** UP TO \$250,000 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



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

#### Member Information:

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

| Member<br>Name:   |
|---|
| (FULL NAME: FIRST - M.I LAST)   |
| Address:  |
| City,<br>State, Zip:  |
| Home Phone: ( ) Male Female Sex: Male Female  |
| Social Security #:  |
| Date of Birth: 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:  |
| <b>RESIDENCY:</b> 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

Be Sure to Complete All Pages and Sign Last Page

| I HEREBY APPL  | eque<br>V FOR   |   |  |  | OVE   | SVCE   |  |  |   |  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
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| Member O   | $\sim$  |   |  | <b>\</b> .   |   | $\sim$   | <b>(3).</b><br>\$100,00  | 00   | $\bigcirc$  | \$150,0  | 00   | (   | <b>``\$</b>   | 200,0  | 00   | (                              | <b>``\$</b>                   | 250,                          | .000                        |                              |                               |                 |
| Spouse   | -   | 0% of Mei   |  |  |   | 0  | + , -  |  | Ŭ   | + , -  |  |   | <u> </u>  | ,-   |  |                                | U T                           | ,                             |                             |                              |                               |                 |
| Child(ren)   | 10  | % of Mem  | ber Ar   | nount  |   |  |  |  |   |  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| If requesting spou<br>signed and dated   |   | nild cover  | age, p   | lease c  | omple   | te bel   | ow: (Pl  | ease   | provi   | de info  | orma   | atior   | n for   | addit  | iona   | al ch                          | ildre                         | n or                          | nas                         | sepa                         | irate                         | ,               |
| Spouse Name:   |   |   |  |  |   |  |  | FIRS   | T, M.I.   | , LAST   | -  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Date of Birth:   | ONTH  | DAY -   | <br>YE   | AR   | S   | ex: C  | ) Male   |  | Fem   | ale  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Child Name:  |   |   |  |  |   |  |  | FIRS   | Г, М.I.   | , LAST   | _  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Date of Birth:   | ONTH  | DAY -   | <br>YE   | AR   | S   | ex: (  | ) Male   |  | ) Fem   | ale  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Child Name:  |   |   |  |  |   |  |  | FIRS   | Г, М.I.   | , LAST   | -  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Date of Birth:   | ONTH  | DAY -   | <br>Ye   | AR   | S   | ex: (  | ) Male   | C  | Fem   | ale  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| I understand   | l I will k  | oe billed o   | quarter  | ly for ı   | ny co   | verage   |  |  |   |  |  |   |   |  |  |                                |                               |                               |                             |                              |                               |                 |
| Beneficiary  | ng bene   | ficiary de  | signati  | on witł  | n respe                                       | ect to a   | all the i  | nsura  | nce o   | n my l   | ife u  | inde  | r this  | ACA  |  |                                |                               |                               |                             |                              |                               |                 |
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G-29051-2

Be Sure to Complete All Pages and Sign Last Page

#### 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.

FOR 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.

**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.

## 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/our 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 |  |
|--|------------------------|--|
| Snouse's Signature                               |                        |  |

Spouse's Signature

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

G-29051-2

### Be Sure to Complete All Pages and Sign This Page

Return completed form today to: ACA-Endorsed Insurance Program, P.O. Box 9159, Phoenix, AZ 85068-9159

