



Please complete this form and return to:

ASCE Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 / **Questions:** Please call 1.800.650.2723

ASCE 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.

PART I Personal Info

1. MEMBER INFORMATION:

Full Name: _____ Social Security #: [][][]-[][][]-[][][][][]
Last First MI

Street Address: _____

City: _____ State (or Province): _____ Zip: [][][][][]-[][][][][]

Home Phone: (____) _____ Work Phone: (____) _____ Fax: (____) _____

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

	First / MI / Last	Date of Birth: MO / DAY / YR	Height:	Weight: LBS	Sex:
<input type="checkbox"/> Member Name [†] :	_____	____/____/____	____ ft. ____ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse Name*:	_____	____/____/____	____ ft. ____ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child*:	_____	____/____/____	____ ft. ____ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child*:	_____	____/____/____	____ ft. ____ in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F

[†]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?

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 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 Group High-Limit Accidental Insurance 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

Annual Semiannual Credit Card: MasterCard Visa Discover American Express

Credit Card # _____ Exp Date _____

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

7. 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 his/her 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)