



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 GROUP TERM LIFE INSURANCE APPLICATION

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

### 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  Widowed  Single

*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. INSURANCE REQUESTED: Refer to Plan Information for eligibility, principal sums, premium, and coverage description.

A. I hereby apply for the following Group Term Life Insurance coverage:

Member Option: Insurance Requested: \$ \_\_\_\_\_  
 Spouse Option: Insurance Requested: \$ \_\_\_\_\_  Child Option\*:  \$10,000  None

*\*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 any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? Member:  Yes  No Spouse:  Yes  No

If "Yes," Please state when you last used tobacco or nicotine products and specify the product used:

Nicotine Products Used: \_\_\_\_\_ Member: \_\_\_\_/\_\_\_\_/\_\_\_\_ Spouse: \_\_\_\_/\_\_\_\_/\_\_\_\_  
MM / YYYY MM / YYYY

C. 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.

PART I Personal Info

PART II Your Coverage

**3. INSURANCE REQUESTED (CONTINUED): Refer to Plan Information for eligibility, principal sums, premium, and coverage description.**

**RESIDENTS OF NEW YORK:** I have read the Important Replacement Information above.  Yes  No

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: \_\_\_\_\_

**4. BENEFICIARY DESIGNATION: Insert name, relationship, and SSN.**

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 as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.)

Beneficiary Name: \_\_\_\_\_  
Last First Middle Initial

Relationship to Member: \_\_\_\_\_ Social Security #: --

**5. MEMBER STATEMENT OF HEALTH:**

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	<u>MEMBER</u>		<u>DEPENDENT</u>	
	<u>YES</u>	<u>NO</u>	<u>YES</u>	<u>NO</u>
A. Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. During the past five years have you ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs? .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Details (please fill out if answered "YES" to a, b, or c): \_\_\_\_\_

**Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.**

What time and telephone number would be best to contact you? \_\_\_\_\_

**6. 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

*continued*

**6. FRAUD NOTICE (CONTINUED):**

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.

**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)

**OWNER INFORMATION, REQUIRED IF OWNER IS OTHER THAN THE MEMBER (IF OWNER IS A TRUST, PLEASE SUBMIT A COPY OF THE DOCUMENT WITH THIS APPLICATION).**

Full Name: \_\_\_\_\_ Relationship to proposed insured: \_\_\_\_\_  
Last First MI

Mailing Address: \_\_\_\_\_  
Street City State Zip

Tax ID #: \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #:    -   -

Owner's Signature X: \_\_\_\_\_ Date: \_\_\_\_\_

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

Choose one payment option (additional forms will be sent to you for EFT and CC option):  
 Direct Billing (semiannually 3/1 & 9/1)  Electronic Funds Transfer  Credit Card