Disability Income Insurance Application for Members of the Allegheny County Bar Association

Allegheny County Bar Association

Request for Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

TO APPLY: Complete this form and return it to USI AFFINITY, 14 Cliffwood Avenue, Suite 310, Matawan, NJ 07747
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

ACXLDAVCN

1. MEMBER INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Mobile Phone Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - ____ Date of Birth: ____ /____ / ____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union is determined by state law.

Are you now a member of the Allegheny County Bar Association? ☐ Yes ☐ No If yes, Member ID#: _____

Are you presently insured by any other ACBA-sponsored plan? ☐ Yes ☐ No
If yes, provide details: _____

Do you plan to reside outside the U.S. or Canada within the next 12 months?
Member: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. OCCUPATIONAL STATUS:

a) Occupation: _____ Main Duties: _____

b) "FULL TIME WORK" means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week. Are you at FULL TIME WORK? ☐ Yes ☐ No

c) Gross Annual Income from: Salary: $_____ Self-Employment: $_____

Bonus: $_____ Commissions: $_____ **Total: $**_____

d) "ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees, and other amounts received for personal services—before deduction of income or social insurance taxes and after deduction of the normal business expense which is deductible for income tax purposes—for any 12-month period. Your gross ANNUAL NET EARNED INCOME must be at least $20,000 to be eligible for this coverage. What is your ANNUAL NET EARNED INCOME $_____
Is ANNUAL NET EARNED INCOME more than 25% above or below your previous year? $_____
If yes, what was your ANNUAL NET EARNED INCOME last year? $_____
If yes, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? $_____

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually ☐ Charge My Credit Card (see below):

I request and authorize ACBA Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual ☐ monthly charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan. Please note, the charge will be listed as "USI Insurance Services" on your statement.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

4. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to any benefits payable following the covered loss of my life under the AD&D portion of this coverage.

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #

5. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE, based upon all my statements made in this Request Form:

a) **Monthly Benefit Amount* Desired for Member Coverage:** $_____

*NOTE: If you are increasing or altering present coverage in any way, do NOT indicate just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting. Choose an amount within the ranges indicated below (in $100 increments):

Under Age 50: Up to $10,000/mo Age 50 - 54: Up to $6,000/mo Age 55 - 59: Up to $3,000/mo

b) **Waiting Period:** ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days

c) **Optional Benefit Riders:** (select all those you desire)

☐ Automatic Benefit Increase (ABI) Option ☐ Future Purchase Option ☐ Recovery Option

d) **Tobacco/Nicotine Use:** Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

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

Member _____ _____ Spouse _____ _____
MO/YR Product MO/YR Product

e) Do you now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability? ☐ Yes ☐ No If yes, provide details (insurance company, plan, monthly benefit, benefit period):

_____

f) Do you intend to discontinue any of the disability insurance listed in e) above, if the coverage applied for is approved? ☐ Yes ☐ No If yes, indicate which coverage and the date of termination:

_____

6. MEDICAL HISTORY: Please indicate the best contact number for a Service Provider to contact you and/or your spouse/Domestic partner on behalf of New York Life Insurance Company for Medical History. (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

You may be contacted by a service provider on behalf of New York Life Insurance Company to ask about your medical history.

Member:	( )	☐ Residence ☐ Business ☐ Mobile

Medical Requirements: Some, not all, applicants may need a physical exam, blood test, or EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly—at your convenience and without any cost to you—through our professional paramedic service. A paramedic will contact you to make an appointment.

7. AUTHORIZATIONS AND SIGNATURES:

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, LLC. ("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 or representative, 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. 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 consents to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, LLC.; and **attests** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

Agent Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

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: For your protection California law requires the following to appear on this form. 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 member.

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 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 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 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 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 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 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.