APSIT
AMERICAN PHYSICAL SOCIETY INSURANCE TRUST

Please complete this form and return to: APSIT Insurance Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 Questions: Please call 800.272.1637

Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

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

APSIT GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER INFORMATION

Name _____ Social Security # _____

Street Address _____

City _____ State (or Province)** _____ Zip _____ Email *(For internal use only. Email address will never be sold or shared.)* _____

Work Phone _____ Fax Number _____ Home Phone _____ Cell Phone _____

May we contact you via text message? ◯ YES ◯ NO Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single

Member Full Name	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	◯ M ◯ F

Spouse Full Name†	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	◯ M ◯ F

Child*	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	◯ M ◯ F

Child*	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	◯ M ◯ F

†Member date of birth must also be provided when requesting spouse coverage only. Member coverage must be in force to request spouse and child coverage.
*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 If YES, list country(ies): _____ For how long? _____

Spouse: ◯ YES ◯ NO If YES, list country(ies): _____ For how long? _____

**Not available in FL, NC, VT, WA, U.S. Territories (except Puerto Rico), or Quebec

2. MEMBER AFFILIATION

I am a member of *(check all that apply)*:

- ◯ Acoustical Society of America
- ◯ American Geophysical Union
- ◯ American Association for the Advancement of Science
- ◯ American Association of Physicists in Medicine
- ◯ American Association of Physics Teachers
- ◯ American Astronomical Society
- ◯ American Crystallographic Association
- ◯ American Institute of Aeronautics and Astronautics
- ◯ American Meteorological Society
- ◯ American Nuclear Society
- ◯ American Physical Society
- ◯ Astronomical Society of the Pacific
- ◯ AVS
- ◯ Biomedical Engineering Society
- ◯ Biophysical Society
- ◯ Council on Undergraduate Research
- ◯ Cryogenic Society of America
- ◯ The Electrochemical Society
- ◯ Geological Society of America, Inc.
- ◯ Health Physics Society
- ◯ IEEE Nuclear & Plasma Sciences Society
- ◯ International Centre for Diffraction Data
- ◯ Laser Institute of America
- ◯ Materials Research Society
- ◯ Microscopy Society of America
- ◯ National Society of Black Physicists
- ◯ Optical Society of America
- ◯ Sigma Pi Sigma
- ◯ Society for Applied Spectroscopy
- ◯ Society of Physics Students
- ◯ Society of Rheology
- ◯ SPIE

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

3. PAYMENT OPTION SELECTION: CHOOSE ONLY ONE.

◯ **OPTION 1: Direct Billing:** Following your initial billing, you will be billed (Choose one): ◯ Annual (May) ◯ Semiannual* (May 1 and November 1)

◯ **OPTION 2: Credit Card:** I authorize premium contributions to be charged to my credit card: ◯ Annual (May) ◯ Semiannual* (May 1 and November 1)

Credit Card: ◯ MasterCard ◯ Visa ◯ Discover ◯ American Express Credit Card #_____ Exp Date _____

_____

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

*An administrative fee of $.50 will be added to your premium bill for all modes other than annually.

4. INSURANCE REQUESTED: REFER TO PLAN INFORMATION FOR ELIGIBILITY, PRINCIPAL SUMS, PREMIUM, AND COVERAGE DESCRIPTION

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):

A. Member Option: ◯ Initial Insurance Amount: $ _____ ◯ Additional Insurance Amount requested from: $_____ to $_____

B. Spouse Option:* ◯ Initial Insurance Amount: $ _____ ◯ Additional Insurance Amount requested from: $_____ to $_____

C. Child Option: ◯ $10,000 for all eligible dependent children (Member coverage must be in force to request child coverage.)

*Spouse coverage cannot exceed 100% of member's coverage.

5. BENEFICIARY DESIGNATION: INSERT NAME, RELATIONSHIP, AND SOCIAL SECURITY NUMBER

I make the following **beneficiary designation** with respect to all the insurance on my life under this **Group Accidental Death & Dismemberment 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)* Date of Birth

Relationship to Member Social Security #

Address Phone Number

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 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 and no 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: *(PLEASE SIGN AND DATE IN INK)* Date

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

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE