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 DISABILITY INCOME 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

In the next 12 months do you intend to reside outside the U.S. or Canada? ◯ YES ◯ NO

If YES, list country(ies): _____ For how long? _____

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

2. MEMBER AFFILIATION

A. 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

B. OCCUPATION

What is your occupation? _____

Main Duties: _____

C. FULL-TIME WORK

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties normally are performed, or other location to which travel is required. Are you at "FULL-TIME WORK"? ◯ YES ◯ NO

D. GROSS ANNUAL INCOME:

Salary $_____ Self-employment $_____ (Self-employment Start Date: _____ /_____ /_____)

Bonus $_____ Commission $ _____ **TOTAL $** _____

Your gross annual earned income must be at least $20,000 for you to be eligible for this coverage.

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

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

I HEREBY APPLY FOR THE COVERAGE: ◯ **New** ◯ **Additional**

Note: If you are increasing or altering present coverage in any way, do NOT indicate in "Item A" below only the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

You may choose any Monthly Benefit Option, provided it and other disability income coverage you may have does not exceed 60% of your Monthly Gross Earned Income (as defined in the brochure). If you have been self-employed for less than one year, your monthly benefit is limited to $1,050.

I HEREBY APPLY FOR THE COVERAGE INDICATED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:

◯ **A. Member Monthly Benefit Option: $** _____ *An administrative fee of $.50 will be added to your premium bill for all modes other than annually.*

◯ **B. Member Waiting Period (choose one):** ◯ **60-Day** ◯ **90-Day**

Do you now have, or are you applying for, other insurance which provides benefits if you are unable to work because of disability? ◯ YES ◯ NO If YES, please list:

Company	Plan	Monthly Benefit	Benefit Period

Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ◯ YES ◯ NO

If YES, please indicate which coverage and the date it will be terminated: _____

4. STATEMENT OF HEALTH:

	To the best of your knowledge and belief, answer the following questions as they apply:	Member
A.	Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	◯ Y ◯ N
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?	◯ Y ◯ N
C.	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?	◯ Y ◯ N
D.	Are you now pregnant?	◯ Y ◯ N
E.	Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits, or on waiver of premium for life or health insurance?	◯ Y ◯ N
F.	During the past 24 months, have you ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?	◯ Y ◯ N
G.	*Except for the residents of Minnesota and Connecticut*, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	◯ Y ◯ N
	For residents of Minnesota and Connecticut ONLY, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	◯ Y ◯ N

Details (please complete 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? _____

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5. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY

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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("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, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. 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; any person proposed for insurance consents to authorize the disclosure of information to and from the providers noted in the attached IMPORTANT NOTICE including making a brief report of my protected health information to MIB, Inc.; and the member and any person proposed for insurance 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 their knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: *(PLEASE SIGN AND DATE IN INK)* Date

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