APSIT
INSURANCE FOR SCIENCE PROFESSIONALS

Please complete this form and return to: APSIT Insurance Plan Administrator, PO BOX 3930, Peoria, IL 61612-3930 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 -PHYS
- ◯ 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
- ◯ The Combustion Institute
- ◯ Council on Undergraduate Research-P/A
- ◯ 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
- ◯ Society of Vacuum Coaters
- ◯ 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): ____________________

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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? ____________________

5. 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 CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. 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 NY: For accident and health insurance only, 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 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.

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

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, 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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