

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

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
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	Sex
	/ /	<input type="radio"/> M <input type="radio"/> F

Spouse Full Name [†]	Date of Birth	Sex
	/ /	<input type="radio"/> M <input type="radio"/> F

Child*	Date of Birth	Sex
	/ /	<input type="radio"/> M <input type="radio"/> F

Child*	Date of Birth	Sex
	/ /	<input type="radio"/> M <input type="radio"/> 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 AND AFFILIATED SOCIETIES

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

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

3. 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.

4. 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 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)*

Date of Birth

Relationship to Member

Social Security #

Address

Phone Number

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: 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. 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 SIGNATURE

READ AND SIGN:

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance attest to having read the Fraud Notices indicated above, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

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

Date