Group Term Life Insurance Application for Members of the Allegheny County Bar Association

Allegheny County Bar Association

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

ACXKACJCA

TO ENROLL: Complete this form and return it during your eligibility period 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.

1. MEMBER INFORMATION:

Last Name _____ First Name _____ Middle Initial _____

Street Address _____ City _____ State _____ Zip Code _____

( ) Home Phone Number _____ ( ) Office Phone Number _____ ( ) Mobile Number _____

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

Social Security #: ____ - ____ - _____ Date of Birth: ____ /____ / ____ Sex: ☐ Male ☐ Female

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

Are you presently insured by any other ACBA-sponsored coverage? ☐ Yes ☐ No

If yes, provide details: _____

Do you plan to reside outside the U.S. or Canada within the next 12 months?

☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. PAYMENT OPTION (Choose only one):

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

I request and authorize the 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 coverage. 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: _____

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☐ **$100,000 GROUP TERM LIFE INSURANCE**

RESIDENTS OF NEW YORK—IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help you decide whether the replacement is in your best interest.

RESIDENTS OF NY: I HAVE READ THE IMPORTANT REPLACEMENT INFORMATION ABOVE. IS THE INSURANCE APPLIED FOR INTENDED TO REPLACE, IN WHOLE OR IN PART, ANY EXISTING INSURANCE OR ANNUITY? ☐ YES ☐ NO

RESIDENTS OF ALL OTHER STATES: IS THE INSURANCE APPLIED FOR INTENDED TO REPLACE, DISCONTINUE OR CHANGE AN EXISTING POLICY? ☐ YES ☐ NO

Tobacco/Nicotine Use: Have you used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?

☐ Yes ☐ No If Yes, please indicate the date you last used such product and indicate the product used:

Product: _____ Month/Year: _____

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BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED

4. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to only the insurance requested in this application for this Group Term Life Insurance. 1) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2) If naming a Trust, please indicate the full name and date of the Trust. (Attach a separate sheet if necessary, then sign and date.

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #		Benefit %
				☐ Primary ☐ Secondary	
				☐ Primary ☐ Secondary	

5. AUTHORIZATIONS AND SIGNATURES:

By signing and dating this application, the member **requests** the insurance indicated and **attests** to having read the Fraud Notices indicated below, 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.)

FRAUD NOTICES

FRAUD NOTICE – For Residents of all states except those listed below and NY: 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 knowinglypresents 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: 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.

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 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.

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