

GROUP HIGH-LIMIT ACCIDENT PROTECTION APPLICATION

For Members of ACerS



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

To apply, please complete this application, sign, date and return it with your first modal premium check made payable to Selman & Company:

ACerS Members' Insurance Program
6110 Parkland Boulevard
Cleveland, OH 44124
1-800-556-7614

PLEASE PRINT IN INK OR TYPE ALL ANSWERS, AND INITIAL ANY CHANGES YOU MAKE ON THIS FORM.

1. Member Information

Last Name	First	M.I.	Date of Birth / /	
Social Security No.			<input type="checkbox"/> Male <input type="checkbox"/> Female	
Address		City	State	Zip
Home Phone		Work Phone		

2. Dependent Information (only if proposed for coverage)

Spouse Name (last, first, middle)	Date of Birth / /
Child's Name (last, first, middle)	Date of Birth / /
Child's Name (last, first, middle)	Date of Birth / /

If more than two children are proposed for insurance, attach a separate sheet.

Does any person proposed for insurance intend to reside outside the U.S. or Canada within the next 12 months? ... Yes No
If Yes, please provide the name(s) of the person(s) and country(ies) involved:

3. Membership Affiliation

Are you now a member of ACerS? Yes No Membership # _____

4. Insurance Requested (Refer to brochure for eligibility, Principal Sums, premiums, and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):

a. For Members Not Currently Insured:

I request insurance in the initial amount of \$ _____ for myself; \$ _____ for my spouse*

I also request coverage for my eligible child(ren). Yes No

b. For Members Currently Insured:

I wish to increase amounts of insurance as follows:

from \$ _____ to \$ _____ for myself; from \$ _____ to \$ _____ for my spouse*

I wish to add dependent coverage as follows:

for my spouse* in the initial amount of \$ _____; for my eligible child(ren) Yes No

*Spouse coverage may not exceed member coverage.

c. Payment Information

<input type="checkbox"/> Please send me a bill.	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual
<input type="checkbox"/> Please withdraw premiums from my checking or savings account. (Be sure to complete and return the enclosed Automatic Payment Option Form.)	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual <input type="checkbox"/> Annual

A \$.50 per month administrative fee will be added to your bill.

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5. Beneficiary

I make the following beneficiary designation with respect to all the insurance on my life under this Group High-Limit Accident Insurance Plan, and if I am already covered under the plan(s), I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy(ies). (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 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.

Beneficiary Name		Relationship to Member	
Street Address	City	State	Zip

FRAUD WARNING STATEMENTS

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 is a crime and subjects such person to criminal and civil penalties. **For 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. **For residents of DC, the following also applies:** 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 LA:** 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. **Residents of VA:** Any person who, with intent to defraud or knowingly that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated the law. **Residents of 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 is a crime and shall be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

6. Member Declaration

I request the group insurance shown on the reverse side. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. I understand that insurance will be effective on the date approved by New York Life, provided my initial contribution has been paid and the person(s) to be insured are performing the normal activities of a person in good health of like age [*NC residents: a person of like age*] on that date. Any person not performing such normal activities on the date insurance would otherwise be effective will not become insured until the day he or she is performing such activities provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance on that date.

MEMBER'S SIGNATURE (in ink)X _____ Date _____

SPOUSE'S SIGNATURE (in ink)X _____ Date _____

(NECESSARY ONLY IF SPOUSE COVERAGE IS BEING REQUESTED.)

SIGNATURE OF OWNER (in ink)X _____ Date _____

(NECESSARY ONLY IF MEMBER TRANSFERRED OWNERSHIP OF HIS/HER HIGH-LIMIT ACCIDENT PROTECTION INSURANCE.)

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Form GMA-GI

3/08 ed.
0308 ADD ACerS APP



Automatic Payment Option (APO)
Savings or Checking Account Deduction Authorization Form

1. Applicant's Information *(proposed insured)*

Applicant's Name _____ Date of Birth ____/____/____

Street Address _____

City _____ State _____ Zip Code _____

Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:

Policy Number: _____ Type of Insurance: _____

2. Financial Institution Information

Depositor Name (Payor) _____

(As it appears on Financial Institution Records)

Financial Institution Name _____ Account Number _____

(Include Branch Name)

Financial Institution City _____ State _____ Zip Code _____

3. Account Selection: I authorize an automatic deduction from my *(please choose one)*:

Checking Account. Attach a sample VOIDED check.

Savings Account. Account Number: _____ Routing Number: _____

Premium deduction should be made:

Monthly **Quarterly** **Semi-Annually** **Annually**

Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.

4. Signature/Authorization

In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.

Signature of **Depositor** _____

Print Name of **Depositor** _____ **Date** ____/____/____

Signature of **Applicant/Insured** *(If different from Depositor)* _____

Print Name of **Insured/Applicant** _____ **Date** ____/____/____

5. Agreements & Conditions

Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of \$15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

OFFICE USE ONLY Insured ID: _____ APO Effective Date: _____
