GROUP DISABILITY INCOME INSURANCE APPLICATION

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

TO APPLY:
Send no money now.
Complete this form and return to:
ADMINISTRATOR
ACM GROUP INSURANCE PROGRAM
P.O. BOX 14533 • Des Moines, IA 50306

For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS? Call: 1-800-503-9230
customerservice.service@getamba.com

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address: _____
AMBA will not share your email information.

Member's Date of Birth: _____ Sex: ❑ M ❑ F
MO. DAY YR.

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. Weight _____lbs.

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)

❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Do you intend to reside outside the U.S. in the next 12 months?
❑ YES, Countries:_____ For how long? _____ ❑ No

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the Association for Computing Machinery? ❑ Yes ❑ No Membership # _____

B. What is your occupation? _____
Main Duties: _____

C. "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 are normally performed. Are you at "FULL-TIME WORK"? ❑ Yes ❑ No

D. YOUR ANNUAL NET EARNED INCOME* $_____
Is your ANNUAL NET EARNED INCOME more than 25% above or below your previous year? ❑ Yes ❑ No
If YES, what was your ANNUAL NET EARNED INCOME last year? $ _____
If YES, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? $ _____

*As defined in the attached brochure.

Your ANNUAL NET EARNED INCOME must be at least $20,000 for you to be eligible for this coverage.

3. Insurance Requested: Refer to the Plan Information/Plan Details for eligibility, options, and coverage description.

I request the following coverage: ❑ new ❑ additional

If you are increasing or altering your present amount of coverage, indicate the new TOTAL AMOUNT below.

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 70% of your Basic Monthly Pay, as defined in the brochure.

I hereby apply for the coverage indicated below, based upon all my statements made in this application.

Your ANNUAL NET EARNED INCOME must be at least $20,000 for you to be eligible for this coverage.

Member **Monthly Benefit Option:** $_____

Waiting Period: ❑30-day ❑90-day ❑180-day

Do you now have or are you now applying for any 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.) _____

Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the ACM Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check, and such bank to process the withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Insurance Plan. (Enclose a voided check.)

_____

SIGNATURE (S) AS REQUIRED ON ALL CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT

❑ **Option 2:** Periodic Billing: ❑ Quarterly ❑ Annual ❑ Semiannual

4. Statement of Health: Please initial and date any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you and your spouse (if proposed for insurance).

		YES	NO
1.	Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?	❑	❑
2.	During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:		
	a. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or 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, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	❑	❑
	b. Other Health or physical impairment including:		
	(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑	❑
	(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	❑	❑
	(iii) Any other impairment?	❑	❑
3.	During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	❑	❑
4.	Are you now pregnant?	❑	❑
5.	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?	❑	❑

4. Statement of Health: ***(continued)*** Please initial and date any changes you make on this form.

		YES	NO
6.	During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?.....	❑	❑
7.	Driver's License No.: _____ State in which issued: _____		
8.	During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?.....	❑	❑
9.	Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?.....	❑	❑
	If "Yes," please state when you last used tobacco or nicotine products and specify the product used:		
	_____ Mo/Yr _____ Product		
10.	**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?.....	❑	❑
	For residents of Minnesota and Connecticut, 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?.....	❑	❑
11.	If you have answered any of the above Questions 1-10 "YES," give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")		

Question Letter/No.	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

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 or MIB, LLC ("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; and the member consents to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC; and attest to having read the IMPORTANT NOTICE and the Fraud Notices below, including how our information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature_____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

G-30853-0 **PLEASE DO NOT SEND ANY PREMIUM UNTIL NEW YORK LIFE INSURANCE APPROVES THIS APPLICATION. UNTIL APPROVAL IS GRANTED AND A EFFECTIVE DATE IS SPECIFIED NO COVERAGE IS IN FORCE FOR THIS COVERAGE.**

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 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 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 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.

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 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 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: 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 PR: 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 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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income Insurance Plan

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, LLC ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other application for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site at www.mib.com.

***For NM Residents: PROTECTED PERSONS**[1] have a right of access to certain **CONFIDENTIAL ABUSE INFORMATION**[2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a **PROTECTED PERSON** by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1]***PROTECTED PERSON** means a victim of domestic abuse; who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured person.*

[2]***CONFIDENTIAL ABUSE INFORMATION** means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company **7/15 ed.**

ACM Group Disability Income Insurance

Association for Computing Machinery

Underwritten by New York Life Insurance Company

INSURE YOUR INCOME—ONE OF YOUR MOST VALUABLE ASSETS

One of your most valuable assets is your ability to earn income. A sudden accident or illness could jeopardize the career and the lifestyle you have worked so hard to build. This coverage can help replace the sizable amount of lost income you would suffer if you were Totally Disabled — income you'll need to help meet personal expenses: food, clothing, loans, mortgages, cars, tuitions, medical expenses, bills, credit cards, phone and other utilities, and more. That's something medical insurance can't do for you.

The ACM Group Disability Income Insurance Plan can help provide you with a monthly income should you be forced to stop working due to a disability. With this coverage you can receive from $100 to $3,000 a month should you become totally disabled because of a covered injury or sickness.

WHO IS ELIGIBLE?

Members of the ACM who are under age 60 and at FULL-TIME WORK can request coverage, provided they have an ANNUAL NET EARNED INCOME of at least $20,000. However, members on active duty in the armed forces are not eligible. This coverage is only available to residents of the following states: AZ, GA, HI, IN, IA, MA, MI, NE, NJ, OK, PA, RI, TN and the District of Columbia.

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation on the basis of at least 30 hours per week at the place where such duties are normally performed.

"ANNUAL NET EARNED INCOME" means —

1. If you are self-employed, your (a) wages, salaries, fees, commissions, and any other amounts received for personal services; and (b) if your business is incorporated, the cost of fringe benefits and your share of the monthly net profit of the corporation, whether received or not received; or

2. If you are not self-employed, your basic rate of monthly compensation from your employer, including commissions.

This amount is computed before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes, for any 12-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

You decide how much monthly income insurance protection you want.

Only you know the amount of monthly insurance protection you would need should you become totally disabled . . . and the amount of protection you can afford to purchase. With this coverage, you can select from $100 to $3,000 (not to exceed 70% of your basic monthly pay) in monthly benefits in increments of $100. Choose a monthly benefit package that fits your needs as well as your budget.

HOW IT WORKS

This coverage pays you monthly benefits (after your waiting period is over) for disabilities caused by a covered injury or sickness, as long as you remain totally disabled, up to age 65, if total disability begins prior to age 63. Benefits are payable for 2 years, but not beyond age 70 if total disability begins on or after age 63 but prior to age 70. Benefits for disabilities resulting from mental disorder are reduced as noted in "Exclusions".

If the monthly benefit plus income benefits you receive from other sources (as described in the Certificate of Insurance) exceeds 70% of your basic monthly pay, then the monthly benefits to be paid under these plan will be reduced by the amount by which the total income benefit exceeds such 70%.

Monthly benefits will end on the date you fail to give required proof of continuing total disability; your total disability ends; the maximum benefit period ends; or you die.

Choice of Waiting Period

You also have a choice of three waiting periods: 30, 90 or 180 days. A waiting period is the number of consecutive days that you must be disabled before benefits commence. Coverage with a longer waiting period is less expensive.

When Coverage Ends

Your insurance will end at the earliest of: the date the group policy ends or is amended to end coverage for your class; the end of the period for which the last premium was paid by insured; the date you cease at FULL-TIME WORK, as defined, for reasons other than total disability; the date you begin full-time active military duty; the premium due date coinciding with or next following the date you attain age 70.

IMPORTANT FEATURES

The Group Cost reflects the mass purchasing power of ACM. This combined buying power helps reduce the high cost of insurance coverage when compared to the rates of individually purchased insurance. Purchasing insurance with similar benefits on your own could cost you considerably more.

Benefit Taxation. Consult your tax advisor regarding the taxable nature of benefits.

Repeat Claims for the same disability will be treated as a new claim if 180 or more continuous days of full-time active employment separate the claims. Otherwise, the second claim will be considered part of the original claim unless it is due to unrelated causes.

No Premium Payments Required During Disability. Your coverage continues without premium payment after you have been receiving total disability benefits for at least six continuous months. Payment of premiums resumes when you stop receiving monthly benefits.

Current 2026-2027 Quarterly Premiums
per $1,000 Benefit

Age	30 day Waiting period	90 day Waiting Period	180 day Waiting Period
Under Age 30	$20.70	$14.30	$12.65
30 – 34	29.40	20.30	17.95
35 – 39	40.80	28.15	24.90
40 – 44	50.70	35.00	30.95
45 – 49	86.40	59.60	52.70
50 - 54	126.90	87.55	77.40
55 – 59*	186.30	128.55	113.65

Premiums apply at your age when insurance becomes effective and increase as you enter a higher age bracket. Note: You will never be singled out for a rate increase, although the Insurance Company reserves the right to modify premiums on a collective basis if necessary.

Only those under age 60 may apply.

Coverage terminates at age 70.

To Compute Your Premium: Multiply the premium for your age group by the number of $100 units of monthly benefits you select.

The monthly benefit amount you elect can not exceed 70% of your Basic Monthly pay. Each monthly benefit you receive under Plan I will be reduced by the sum of any other income you receive that month from other sources (as described in the Certificate of Insurance). If the monthly benefit paid under Plan II or Plan III, plus income benefits you receive from other sources (as described in the Certificate of Insurance) exceeds 70% of your basic monthly pay, then the monthly benefits to be paid under this policy will be reduced by the amount by which the total income benefit exceeds such 70%.

Definition of Disability

Total disability means, during the waiting period and next 24 months, the complete inability to perform the material duties of your regular job. After such 24 months, total disability means the complete inability to perform the material duties of any gainful job for which you are reasonably fit by training, education or experience.

Your regular job is that which you were performing on the day before total disability began. The total disability must be a result of a covered injury or sickness and to be considered totally disabled, you must also be under the regular care of a physician.

Definition of Basic Monthly Pay

Basic Monthly Pay is the monthly average of your ANNUAL NET EARNED INCOME, using the immediately preceding period that produces the highest figure:

- preceding tax year;
- preceding two tax years; or
- the entire period, if less than 12 months.

Pre-Existing Condition: Means an injury or sickness for which the insured person: incurred charges, received medical treatment, consulted a physician, or took prescribed drugs within 12 months before the effective date of insurance. If total disability is due to a pre-existing condition, and the disability begins within 24 months of the effective date of insurance, no benefits will be paid unless the insured person has not: incurred charges, received medical treatment, consulted a physician, or taken prescribed drugs, for such condition, or any complication of it, for 12 continuous months, while insured.

Exclusions: No benefits will be paid for any disability due to: intentionally self-inflicted injury, whether sane or insane; normal pregnancy, normal childbirth or voluntary abortion (complications of pregnancy are covered); war or an act of war; incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; military service, or; pre-existing condition, except as noted above.

Moreover, no benefits are payable for any disability for which you are not under the regular care of a licensed physician other than yourself a or member of your immediate family.

Benefits for Mental, Nervous, or Emotional Disorders are limited to a maximum of 12 monthly benefits that will be paid while such disability continues. This limitation does not apply while you are institutionalized.

SEND NO MONEY — YOU WILL BE BILLED IF YOUR APPLICATION IS APPROVED.

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated and you will receive a full refund — no questions asked!

HOW TO APPLY

1. Complete the enclosed Application Form. It is extremely important that you answer fully the questions about medical history on this form. New York Life will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage. Please note that New York Life retains the right to request additional medical information and may contact you directly.

2**.** Mail the Application Form to:
ACM Group Insurance Program
P.O. BOX 14533
Des Moines, IA 50306

Residents of Puerto Rico:
Please send your completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

Send no money now. You will be billed upon approval.

ABOUT YOUR REQUEST FOR COVERAGE

New York Life reserves the right to request medical information to determine an applicant's medical eligibility for coverage. Based on the age of the person proposed for insurance and the amount of coverage requested, a physical examination, EKG, blood test or other information may be required.

Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid by the Program.

Request for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

HOW TO FILE A CLAIM

To file a claim, write the Administrator for claim forms.

This Group Disability Insurance is Underwritten by:

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30853-0
on Policy Form GMR-FACE/G-30853-0

This Group Disability Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)

ACM Group Insurance Program
P.O. BOX 14533
Des Moines, IA 50306

Any questions?
1-800-503-9230
www.acminsure.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are as set forth in the group policy issued by New York Life Insurance Company to the Qualified Association and Organization Trust.

10/25 ed.

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