AMERICAN PHYSICAL SOCIETY INSURANCE TRUST

Group Term Life Insurance Application

Up to $1,000,000 in valuable term life insurance exclusively for APSIT members

Your immediate response is requested.

It's easy to apply for this exclusive coverage. Just follow these simple instructions.

1. Determine the benefit amount that's best for you and your family.

2. Print clearly and answer all questions fully.

3. Sign and return this application in the postage-paid envelope provided. SEND NO MONEY now. You will be billed upon underwriting approval of your application.

Complete this form and return to APSIT Plan Administrator.

Herbert V. Friedman, Inc.
119 North Park Avenue, Suite 202
Rockville Centre, NY 11570-4179

Questions? Call toll-free 1-800-272-1637
Monday-Friday 9:00 a.m. to 5:00 p.m. E.T.
www.hvfinc.com

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

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

- ☐ American Physical Society
- ☐ American Geophysical Union
- ☐ Optical Society of America
- ☐ American Astronomical Society
- ☐ American Association of Physics Teachers
- ☐ Acoustical Society of America
- ☐ Society of Physics Students
- ☐ American Vacuum Society
- ☐ Sigma Pi Sigma Physics Honor Society
- ☐ American Crystallographic Association
- ☐ American Association of Physicists in Medicine
- ☐ Society of Rheology

Please Print in Dark Ink or Type all Answers. Do Not Erase. Initial all Changes. | Group Policy G-29068-0

1. MEMBER INFORMATION

Name _____

Address _____

City _____ State ____ Zip _____

CERTIFICATE NO.		SOCIAL SECURITY NO.
DATE OF BIRTH		SEX ☐ MALE ☐ FEMALE
MARITAL STATUS	HEIGHT ft. in.	WEIGHT lbs.
OFFICE PHONE ( )		HOME PHONE ( )

Do you intend to reside outside the U.S. or Canada in the next 12 months?

Member: ☐ Yes Country _____ ☐ No **Spouse:** ☐ Yes Country _____ ☐ No

If Yes, for how long _____

2. PAYMENT MODE ☐ Annual ☐ Semi-Annual

3. DEPENDENT INFORMATION

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children from age 14 days to age 23; 25 if fulltime student)

FULL NAME (First, Last. Middle Initial)	DATE OF BIRTH (mo/day/yr)	HEIGHT (Ft., In)	WEIGHT (Lbs.)	MALE OR FEMALE
SPOUSE				
CHILD				
CHILD				
CHILD				

(If more than 3 children. please list on a separate sheet.)

4. INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE COVERAGES INDICATED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION.

- Please indicate if request is for: ☐ New Coverage ☐ Change In Coverage
- IF REQUEST IS TO CHANGE EXISTING COVERAGE INDICATE ONLY ADDITIONAL AMOUNT DESIRED.
  ☐ Member Amount $ _____ ☐ Spouse Amount $ _____
  ☐ Child(ren) Amount $10,000 Term Life per child ($1,000 from 14 days old to 6 months)
- Present Occupation and Duties: Member: _____ Spouse: _____
- Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches, and nicotine chewing gum with in the last 24 months? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No
- **Insurance Replacement**
  Is the Insurance applied for intended to replace, discontinue or change any other existing policy? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

5. BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to all insurance on my life under this Group Life Insurance Plan. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. 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.

NAME OF BENEFICIARY: Last	First	Middle Initial	Relationship	Social Security #

BENEFICIARY'S ADDRESS: Street Name & Number	City	State	Zip Code

6. STATEMENT OF HEALTH: (Please initial any changes you make on this form.) To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse, if also to be insured.

	YES	NO
1. Are you or your spouse disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐	☐
2. Are you or your spouse now ill, or receiving medical attention or surgical treatment?	☐	☐
3. During the past 5 years have you or your spouse consulted any physician or other medical care practitioner, other than for routine physical examination or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	☐	☐
4. Are you or your spouse taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐
5. Are you or your spouse now pregnant?	☐	☐
6. During the past 5 years, have you or your spouse ever been medically diagnosed by a physician as having or been treated for:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐
b. Arthritis, back trouble, bone or joint disorder?	☐	☐
c. Fainting spells, convulsions, or epilepsy?	☐	☐
d. Sugar, blood, albumin or pus in urine?	☐	☐
e. Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐
f. Disorder of breast or reproductive organs or functions?	☐	☐
g. Nervous or mental disorder, emotional conditions or psychiatric care?	☐	☐
h. Cancer, tumor or cyst?	☐	☐
i. Varicose veins, hemorrhoids or hernia?	☐	☐
j. Disorder of the eyes, ears, nose, or sinuses?	☐	☐
k. Thyroid, liver or respiratory disorder?	☐	☐
l. Alcoholism or drug habit?	☐	☐
m. Disorder of the blood?	☐	☐
n. 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		

7. If you have answered any questions "Yes", give complete details below. (Attach a separate sheet if necessary, sign and date.) Please print.

QUESTION NUMBER	NAME(S) OF PROPOSED INSURED	ILLNESS OR CONDITION-DATE OF ONSET-DURATION-TREATMENT-OPERATIONS-DEGREE OF RECOVERY AND DATE:	NAME AND ADDRESS OF PHYSICIANS OR OTHER PRACTITIONERS AND HOSPITALS WHERE CONFINED OR TREATED:

I request the group insurance shown above. 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 New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask Now 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) Insurance will become effective on the earliest of the first day or the fifteenth day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age on the effective date; (b) any person who is not performing their normal duties as required will not become insured until the day he/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; and (c) any dividend apportioned to the group policy will be paid to the Trustees of APSIT.

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 purposes 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.

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 D.C., the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant.

FOR 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.

FOR 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.

FOR 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.

FOR 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.

AUTHORIZATION: I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance).

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. My 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. A photocopy of this AUTHORIZATION and request form shall be a valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

SIGNATURE(S)

To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Member's Signature X _____ **Date** _____

(Please sign and date in ink)

To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Spouse's Signature X _____ **Date** _____

(Necessary only if spouse coverage is requested)

DO NOT SEND YOUR CHECK WITH THIS APPLICATION FORM. YOU WILL BE BILLED FOR THE APPROPRIATE AMOUNT.

OWNER INFORMATION (required if owner is other than member)

Name: _____
Last First Middle Initial Relationship to Proposed Insured

Daytime Phone: (_____)_____

Mailing Address: _____
Street City State Zip Code

Social Security #: _____ Date of Birth ___/___/___ Tax ID #: _____

Owner's Signature X _____
(Necessary only if other than member) Date