APPLICATION FOR GROUP DISABILITY INSURANCE

Underwritten by The United States Life Insurance Company in the City of New York
(Herein called the Company)
Administrative Office: P.O. Box 10374, Des Moines, IA 50306-8812

1. Name of Association ACM, The First Society in Computing

2. Member/Applicant's Name _____ ❑ Male ❑ Female
First Middle Last

3. Membership Number (if any) _____ 4. E-mail address _____

5. Member/Applicant's Address _____
Number Street City State Zip Code

6. Name and Address of Member/Applicant's Physician _____

7. Home Phone No. (_____)_____ Work Phone No. (_____)_____

8. **PERSONAL DATA**

Age	Date of Birth (MM/DD/YR)	Place of Birth	Height Ft. In.	Weight Lbs.
			ft. in.	Lbs

9. Are you now, and have you been for the last 90 days, performing all of the duties of your regular occupation for at least 30 hours per week for your present employer? ❑ Yes ❑ No

10. Occupation _____ 11. Annual Earned Income (after business expenses) $_____

12. Date of Hire _____

13. Employer Name and Address _____

INSURANCE REQUESTED

14. **Disability Insurance**

Waiting Period: ❑ 30 days (Plan I or Plan II Only) ❑ 90 days (Plan III Only)

Monthly Benefit: _____ (not to exceed 70% of your monthly income)

Note: The monthly benefit amount is based upon your Annual Earned Income (after business expenses)

Benefit Period: ❑ Plan I ❑ Plan II ❑ Plan III

15. I wish to pay: ❑ Direct Bill ❑ Quarterly ❑ Semiannually ❑ Annually
❑ Automatic Check Withdrawal (If you select Automatic Check Withdrawal, please complete the request form.)

PLEASE COMPLETE AND SIGN APPLICATION

❑ 13108/12616 (Plan II and III)
❑ 19435/19436 (Plan I)

13108/12616/ 1018/52247

Association for Computing Machinery

Please answer these brief questions.

To the best of your knowledge and belief:

1. Have you ever had or been treated for (Circle specific disorders experienced):

a. Disease or disorder of the heart, murmur, chest pain, rheumatic fever, elevated blood pressure, stroke, aneurysm or transient ischemic attack? ❑ Yes ❑ No	h. Prostate disorder? Nephritis, nephrosis or other kidney disease or disorder? ❑ Yes ❑ No
b. Injury, pain or disorder of the neck or back? Sciatica? Any disabling injury or disorder of the bones, joints or muscles? Connective tissue disorder? ❑ Yes ❑ No	i. Menstrual, uterine or ovarian disorder? Complications of pregnancy? Disorder of the breast? ❑ Yes ❑ No
c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis or rheumatism, or any other neurological disorder? ❑ Yes ❑ No	j. Bronchitis, emphysema, sleep apnea, difficult breathing, or other respiratory disease or disorders? ❑ Yes ❑ No
d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract or other disorder of the eyes or ears? ❑ Yes ❑ No	k. Cancer, tumor or mass? Deformity or loss of limb? Congenital defect? Disease or disorder of the lymphatic system? ❑ Yes ❑ No
e. Disease or disorder of the rectum? Vascular or blood disorder? ❑ Yes ❑ No	l. Mental or emotional problem requiring help of a physician, psychologist or counselor? ❑ Yes ❑ No
f. Diabetes or elevated glucose? Sugar or albumin in urine? Thyroid or other glandular disorder? ❑ Yes ❑ No	m. A surgical operation? Or a surgical operation advised but not performed? ❑ Yes ❑ No
g. Ulcer, or disorder of stomach, liver, gall bladder or pancreas? Colitis, Hepatitis, or other disorder of small or large intestine? ❑ Yes ❑ No	n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or disorders of the immune system? ❑ Yes ❑ No
	o. Alcohol or drug abuse? ❑ Yes ❑ No

2. Have you during the past 5 years, consulted any physician or other practitioner or been confined or treated in any hospital or similar institution, for any reason other than those stated above? ❑ Yes ❑ No

3. Are you now taking prescription medication or receiving medical attention? ❑ Yes ❑ No

For "Yes" answers to questions 1-3 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes". ❑ Yes ❑ No

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

PLEASE COMPLETE AND SIGN APPLICATION

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EXISTING AND PENDING INSURANCE SECTION

4. Do you have any disability insurance in force or pending? (including group coverage) ❑ Yes ❑ No
   (If "Yes", please indicate companies and amounts) _____

5. Will this coverage applied for replace any insurance now in force? ❑ Yes ❑ No
   (If "Yes", please indicate which insurance and the amount being replaced) _____

AUTHORIZATION AND DECLARATION OF EACH PERSON GIVING A STATEMENT OF INSURABILITY
I hereby authorize any licensed physician, medical practitioner, pharmacy, pharmacy benefit manager and other sources, hospital, clinic, or other medical or medically related facility, insurance company, the MIB, Inc., or other organization, institution or person that has any records or knowledge of me or my health, to give to the Company or its reinsurers any such information. Such information will pertain to my employment, or other insurance coverage and medical care, advice, treatment or supplies for any physical or mental condition. This includes information obtained in connection with the preparation or procurement of an investigative consumer report as defined under the Fair Credit Reporting Act(s). To facilitate the rapid submission of such information, I authorize all said sources, except the MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand that this information will be used by the Company solely to determine eligibility for insurance. I understand that I may revoke this authorization at anytime by giving written notice to the Company. I agree that such revocation will not affect any action, that any source has taken in reliance upon this authorization. I understand this authorization will be valid for 24 months from the effective date of coverage, if not revoked earlier. I know that I should retain a copy of this authorization for my records. I agree that a photocopy of this authorization is as valid as the original. To the best of my knowledge and belief, all statements made above are true and complete. I understand that my application for group insurance will be accepted or declined on the basis of these statements. Insurance will take effect only if a certificate is issued based on this application and the first premium is paid in full (a) during the lifetime of all proposed insureds; and (b) while there is no change in the insurability or health of such person from that stated in the application.

Important Notice: Any person who knowingly and with intent to defraud any insurance company, files or causes to be filed, a claim for payment of a loss, containing any false or incomplete information commits a fraudulent insurance act that may be a crime and may subject such person to incarceration, fines and denial of benefits. (For state specific variations refer to next page of this application.)

A copy of this application will be attached to and made a part of your certificate.

Date_____ Member/Applicant's Signature _____

PLEASE COMPLETE AND SIGN THIS PAGE OF APPLICATION

Association for Computing Machinery

Important Notice

For residents of Arkansas, Louisiana and West Virginia: 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 Colorado: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies.

For residents of the District of Columbia: 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.

For residents of Florida: 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 Kentucky: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For residents of Maine, Tennessee and Washington:
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.

For residents of New Jersey: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

For residents of New Mexico: 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 CIVIL FINES AND CRIMINAL PENALTIES.

For residents of New York: 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 also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For residents of Ohio: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

For residents of Oklahoma: 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 Pennsylvania: 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.

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These Notices must be detached and retained by the applicant

MIB DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. The United States Life Insurance Company in the City of New York or its reinsurers may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file.

Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866 692-6901. If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The United States Life Insurance Company in the City of New York, or its reinsurers, may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

NOTICE AS REQUIRED UNDER THE FAIR CREDIT REPORTING ACT(S)

This is to inform you that as part of our procedure for processing your insurance application, an investigative consumer report may be requested for the preparation of a report whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted or who may have knowledge of any such items of information. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living. You have the right to make a written request to be informed as to whether or not such consumer report was requested, and if such report was requested, the name and address of the consumer reporting agency to whom the request was made. You may receive a copy of this report by contacting such agency.

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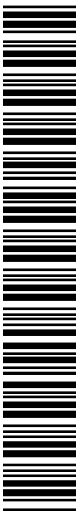

AUTOMATIC CHECK WITHDRAWAL REQUEST: By selecting Automatic Check Withdrawal, your premium will automatically be withdrawn from your checking account. Please provide the information requested below.

Checking Account

Routing #: ____ ____ ____ ____ ____ ____ ____ ____ ____ Account #: _____

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If you dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

Signature of Premium Payer: _____ **Date:**_____

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ACM Group Disability Income Insurance Plan

Association for Computing Machinery

An Insurance Program That Works For You When You Are Unable To Work!

If you were disabled, the last thing you would want to worry about is paying the bills. Yet, if you became disabled your income would stop and your bills, along with expenses relating to your disability, would continue.

With rising medical costs, one disabling accident or illness could cost you thousands of dollars. Just one disability could take away your earning power, your savings and send you deeply into debt.

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 Plan you can receive from $100 to $3,000 a month-should you become totally disabled because of a covered injury or sickness.

The benefits you receive from this Insurance Plan could help you pay:

- Mortgage or rent payments
- Food and clothing
- Telephone, gas and electric bills
- Car payments and insurance premiums
- Education for your children
- Retirement plans
- Credit card bills and other financial obligations

You've worked hard to establish your financial security. Don't let an unexpected injury or sickness diminish it. Help protect your most valuable asset ... your income. Apply today for the ACM Group Disability Income Insurance Plan.

WHO MAY APPLY?

All ACM members in good standing are eligible to apply if they are under age 60 and actively working full-time at least 30 hours per week.

When Insurance Ends

Your insurance will end at the earliest of the date the group policy ends, when you fail to pay your required premium when due, when you cease full-time employment for reasons other than total disability, or you attain age 65 (age 70 for Plan II and Plan III described below).

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 Plan, 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.

You decide how long the payments continue.

PLAN I: This Plan pays you monthly benefits (after your 30-day waiting period is over) for disabilities caused by a covered injury or sickness, as long as you are totally disabled, for up to 12 months but not beyond age 65.

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).

PLAN II: This Plan pays you monthly benefits (after your 30-day waiting period is over) for disabilities caused by a covered injury or sickness, as long as you are totally disabled, up to age 65, if total disability begins prior to age 63, or for 2 years, but not beyond age 70 if total disability begins on or after age 63 but prior to age 70.

PLAN III: This Plan pays you monthly benefits (after your 90-day waiting period is over) for disabilities caused by a covered injury or sickness, as long as you are totally disabled, up to age 65, if total disability begins prior to age 63, or for 2 years, but not beyond age 70 if total disability begins on or after age 63 but prior to age 70.

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 these plan will be reduced by the amount by which the total income benefit exceeds such 70%.

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

IMPORTANT PLAN FEATURES

The Economical Group Cost is due to 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 plans. Purchasing a plan 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 totally disabled for at least six continuous months as long as monthly benefits are being paid. Payment of premiums resumes when you stop receiving monthly benefits.

Reliable Underwriter. The United States Life Insurance Company In the City of New York, is a major provider of various forms of life, accident and disability insurance.

Economical Semi-Annual Premiums
Per $100 Monthly Benefit (Rates as of 08/2017)

AGE	PLAN I	PLAN II	PLAN III
Under 30	$2.28	$4.14	$2.86
30–34	3.24	5.88	4.06
35–39	4.50	8.16	5.63
40–44	5.58	10.14	7.00
45–49	9.48	17.28	11.92
50–54	13.98	25.38	17.51
55–59	20.46	37.26	25.71
60–64*	30.00	46.38	32.00
65*	N/A	46.38	32.00

Premiums apply at applicant's age when insurance becomes effective and at attained age on renewal dates. 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.

*For renewal purposes only—only those under age 60 may apply.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

Under Plan I, coverage terminates at age 65. Under Plans II and III, 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. SEND NO MONEY — YOU WILL BE BILLED IF YOUR APPLICATION IS APPROVED.

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 these plan will be reduced by the amount by which the total income benefit exceeds such 70%.

Definition of Disability

Under Plan I, total disability means the complete inability to perform the material duties of your regular job.

Under Plans II and III, 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. Under both plans, the total disability must be a result of any 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 means your monthly rate of pay from your employer. Such rate will be that in effect on the date before total disability begins. "Basic monthly pay" includes commissions but not bonuses, overtime pay, or other extra compensation.

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 a period of disability during which the insured is not under the direct care and treatment of a licensed physician; intentionally self-inflicted injury, normal pregnancy, normal childbirth or voluntary abortion (complications of pregnancy are covered); war or an act of war; committing a crime or an attempt to do so.

Note: Plan II and Plan III are provided under a separate group policy number. Benefits for Mental, Nervous, or Emotional Disorders are limited to a maximum of 12 monthly benefits that will be paid while such disability continues, unless hospital confined at the end of the 12-month period. Benefits may be paid beyond this 12 month period if hospital confined (as described in the Certificate of Insurance).

SEND NO MONEY ... YOU WILL BE BILLED LATER.

Coverage will be effective following approval of your Application, provided your premium is paid and you are actively at work on that date. You must be actively at work on the date your insurance is to take effect. If not, insurance will take effect on the day you resume such work.

30-DAY FREE LOOK

When you receive your Certificate of Insurance read it over carefully. If it's not exactly what you had in mind simply send it back to us within 30 days and you pay nothing. No questions asked ... no obligation whatsoever ... you must be 100% satisfied with your insurance!

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HOW TO APPLY

1. Complete the application included in this package.
2. Return your completed application to the Insurance Administrator for your Association:

Administered By:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
ACM Group Insurance Plans
P.O. Box 10374
Des Moines, IA 50306-8812

1-800-503-9230
http://www.acminsure.com

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC
MN Insurance License #40291395
OK Insurance License #100100336
TX Insurance License #1850385

Underwritten By:
The United States Life Insurance Company in the City of New York
3600 Route 66
P.O. Box 1580
Neptune, NJ 07754-1580

Policies issued by The United States Life Insurance Company in the City of New York (US Life). Issuing company USL is responsible for financial obligations of insurance products and is a member of American International Group, Inc. (AIG). Products may not be available in all states and product features may vary by state. Policy #'s G-133,773 and G-133,774, Form # G-19000.

This brochure is a brief description of benefits only and is subject to the terms, conditions, exclusions and limitations of the group policy.

The most prominent independent ratings agencies continue to recognize The United States Life Insurance Company in the City of New York in terms of insurer financial strength. For current insurer financial strength ratings, please consult the Web site at www.americangeneral.com/ratings.

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Policy #G-133,773 (Plan I) and
G-133,774 (Plan II and III)

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