Please complete this form and return to: TXCPA Group Insurance Program Administrator, P.O. Box 3930, Peoria Heights, IL 61612-3930 Questions: Please call 800.845.8941

Residents of Puerto Rico, please return application to:
Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

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

GROUP HOSPITAL INDEMNITY INSURANCE PLAN

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER/EMPLOYEE INFORMATION

Full Name _____ Social Security Number _____

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Fax Number _____

Email (For internal use only. Email address will never be sold or shared.) _____

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* ◯ Domestic Partner*

* Eligibility of *Domestic Partner/Civil Union* is determined by State Law.

Applicant is: ◯ Member ◯ Employee of a TXCPA Member

If you are an Employee, complete the following: Are you actively engaged in your occupation on a full-time basis (at least 20 hours a week)? ◯ Yes ◯ No

What is the TXCPA Member Employer's Name and Address? _____

_____

LIST BELOW ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE	DATE OF BIRTH	SEX
Member (Full Name):	/ /	◯ M ◯ F
◯ Spouse ◯ Domestic Partner (Full Name):	/ /	◯ M ◯ F
Child** (Name is Proposed for Insurance):	/ /	◯ M ◯ F
Child** (Name is Proposed for Insurance):	/ /	◯ M ◯ F

**See plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

In the next 12 months, does any person proposed for insurance intend to reside outside of the U.S. or Canada?

Member/Employee: ◯ Yes ◯ No Country(ies) _____ How Long? _____

Spouse: ◯ Yes ◯ No Country(ies) _____ How Long? _____

2. MEMBERSHIP AFFILIATION

Association Membership is required for participation in this plan. TXCPA Membership # _____

3. INSURANCE REQUESTED: Refer to plan information for eligibility, premium, and coverage description.

I hereby apply for this following coverage(s): ◯ New ◯ Additional

Note: If you are increasing or altering present coverage in any way, indicate the TOTAL AMOUNT of coverage you are requesting.

PLEASE CHECK THE DAILY BENEFIT REQUESTED: ◯ $100 ◯ $75 ◯ $50

PLEASE CHECK THE PERSONS YOU WISH TO COVER: ◯ Applicant Only ◯ Applicant and 1 Dependent ◯ Applicant and 2 or more Dependents

4. PAYMENT OPTIONS

◯ **Direct Billing** Following your initial billing, you will be billed twice a year on January 1 and July 1.
You can also access a secure website where you can register to have your premium withdrawn from your bank account or charged to your credit card.

5. FRAUD NOTICES

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. **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. **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 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 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 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.

6. AUTHORIZATION AND SIGNATURE

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

By signing and dating this application, the member requests the insurance indicated, and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including mailing a brief report of my protected health information to MIB, LLC, and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how my 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/Employee's Signature (Please Sign and Date in Ink) Date

Spouse's Signature (Necessary Only if Spouse Coverage is Requested) Date

DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

231638 (3/2023 ed.)