




# American Physical Therapy Association Group Insurance Application



Complete this Application form and return to:  
Healthcare Providers Services Organization  
159 County Line Rd.  
Hatboro, PA 19040-9635 Questions? 1-800-982-9491

Please print in ink or type all answers – initial and date any changes you make to this form

 <b>Request for Group Insurance From New York Life Insurance Company</b> 51 Madison Avenue • New York, NY 10010	<b>GROUP POLICY</b> G-30371-0; G-30372-0; G-30373-0 G-30374-0; G-30375-0; G-30376-0		CERTIFICATE NUMBER	
	SOCIAL SECURITY NO.		DATE OF BIRTH MM/ DD /YYYY	

MEMBER'S FULL NAME (Last, First, MI)			<input type="checkbox"/> MALE	HEIGHT	WEIGHT
			<input type="checkbox"/> FEMALE	FT. IN.	LBS.
BILLING ADDRESS (STREET)		CITY	STATE	ZIP CODE	
HOME ADDRESS (STREET)		CITY	STATE	ZIP CODE	
HOME PHONE ( ) ( ) ( )	OFFICE PHONE ( ) ( ) ( )	FAX NUMBER ( ) ( ) ( )	EMAIL ADDRESS		

MARITAL STATUS:  Single  Married  Divorced  Widowed  Civil Union\*  Domestic Partnership  
 Maiden name \_\_\_\_\_ Eligibility determined by State Law

Do you intend to reside outside the U.S. or Canada in the next 12 months?  
 Member:  Yes  No Country(ies) \_\_\_\_\_ For how long? \_\_\_\_\_  
 Spouse:  Yes  No Country(ies) \_\_\_\_\_ For how long? \_\_\_\_\_

**MEMBERSHIP AFFILIATION** (Membership is required to participate in this plan)

Are you a member in good standing of the American Physical Therapy Association (APTA)?  Yes  No  
 Membership Number \_\_\_\_\_ Are you presently insured by any APTA insurance plan?  Yes  No  
 If yes, indicate which plan(s) and provide details (person(s) insured and amount) \_\_\_\_\_

**OCCUPATIONAL STATUS** Must be completed if applying for Disability Insurance

What is your occupation? \_\_\_\_\_ Main Duties \_\_\_\_\_

FULL-TIME WORK means actively performing the regular deities 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 now at FULL-TIME WORK?  Yes  No

Gross Annual Income from: Salary \$ \_\_\_\_\_ Bonus \$ \_\_\_\_\_ Commissions \$ \_\_\_\_\_  
 Self Employment \$ \_\_\_\_\_ (Self Employment Start Date \_\_\_\_\_) **Total \$** \_\_\_\_\_

Your gross annual earned income must be at least \$20,000 for you to be eligible for this coverage.

**IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS** lawful Spouse/Domestic Partner and unmarried, dependent children from 15 days to age 21 (25 if full time student). Domestic Partner will be referred to as Spouse throughout this document.  
*If necessary attach a separate signed and dated sheet to provide additional dependent information*

SPOUSE'S FULL NAME: (Last, First, MI)		SOCIAL SECURITY NO.		DATE OF BIRTH	<input type="checkbox"/> MALE	HEIGHT	WEIGHT
					<input type="checkbox"/> FEMALE	ft. in.	lbs.
Child (Name)	Date of Birth	<input type="checkbox"/> MALE	[REDACTED]	Child (Name)	Date of Birth	<input type="checkbox"/> MALE	[REDACTED]
1.	/ /	<input type="checkbox"/> FEMALE		3.	/ /	<input type="checkbox"/> FEMALE	
Child (Name)	Date of Birth	<input type="checkbox"/> MALE	[REDACTED]	Child (Name)	Date of Birth	<input type="checkbox"/> MALE	[REDACTED]
2.	/ /	<input type="checkbox"/> FEMALE		4.	/ /	<input type="checkbox"/> FEMALE	

**BILLING OPTION SELECTION** If EFT is elected, an authorization form will be mailed to you when coverage is approved

**OPTION 1: Electronic Funds Transfer (EFT)**  Monthly  Quarterly  Semi-Annual  Annual  
**OPTION 2: Periodic Billing**  Quarterly  Semi-Annual  Annual

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**I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):**

(Refer to [www.HPSO.com/APTA](http://www.HPSO.com/APTA), the brochure or your certificate for eligibility, options and coverage descriptions)

**NOTE (1):** If you are increasing or altering present coverage in any way, only indicate the additional amount of coverage you are applying for. Exclude the amount you may already have under the plan.

**NOTE (2):** The maximum amount of Life Insurance available to any one person under all life insurance plans combined may not exceed \$2,000,000 for member and \$1,000,000 for your Spouse.

**NOTE (3):** For spouse to be insured, the member must be insured and Spouse coverage may not exceed member coverage amount.

**NOTE (4):** For Long and Short Term Disability Income Insurance, you may choose any Monthly Benefit for which you/your spouse are eligible, provided it and any other disability income coverage you may/your spouse have does not exceed 66 2/3% of your AVERAGE MONTHLY INCOME as defined in the brochure.

**Term Life Insurance (G-30371-0)**  
**Member** coverage available from \$100,000 up to \$1,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_  
**Spouse** coverage available from \$100,000 up to \$1,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_  
**Child(ren)** (limited to \$1,000 from 15 days to 6 months) .....  \$10,000 each

**10-Year Level Term Life Insurance (G-30372-0)**  
**Member** coverage available from \$100,000 up to \$2,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_  
**Spouse** coverage available from \$100,000 up to \$1,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_

**20-Year Level Term Life Insurance (G-30373-0)**  
**Member** coverage available from \$100,000 up to \$2,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_  
**Spouse** coverage available from \$100,000 up to \$1,000,000 in increments of \$50,000 ..... \$ \_\_\_\_\_

**Long Term Disability Income Insurance (G-30374-0)**  
**Member** Total Monthly Benefit Desired (\$100 to \$10,000 in \$100 increments) ..... \$ \_\_\_\_\_  
**Waiting Period**.....  60-day  90-day  180-day  
**Maximum Benefit Period**.....  Plan 1: Five Year Plan  Plan 2: Age 65  
**Optional Benefits** - By checking the boxes below, I hereby apply for the following Optional Benefits  
 Cost of Living Adjustment (COLA) Option  
 Catastrophic Disability Option  
**Spouse** Total Monthly Benefit Desired (\$100 to \$10,000 in \$100 increments) ..... \$ \_\_\_\_\_  
**Waiting Period**.....  90-day  
**Maximum Benefit Period** (may not exceed member).....  Plan 1: Five Year Plan  Plan 2: Age 65  
**Optional Benefits** - By checking the boxes below, I hereby apply for the following Optional Benefits  
 Cost of Living Adjustment (COLA) Option  
 Catastrophic Disability Option

**Short Term Disability Income Insurance (G-30375-0)**  
**Waiting Period:** 1<sup>st</sup> Day Accident / 8<sup>th</sup> Day Sickness      **Maximum Benefit Period:** 6 Months  
**Member** Total Monthly Benefit Desired (\$1,200 to \$4,000 in \$100 increments) ..... \$ \_\_\_\_\_  
**Spouse** Total Monthly Benefit Desired (\$1,200 to \$4,000 in \$100 increments) ..... \$ \_\_\_\_\_

**Business Overhead Expense Insurance (BOE) (G-30376-0)**  
**Waiting Period:** 30-day      **Maximum Benefit Period:** 24 Months  
**Member** Total Monthly Benefit Desired (\$500 to \$15,000 in \$100 increments) ..... \$ \_\_\_\_\_  
1. What was your average monthly amount of eligible overhead expenses in the past 6 months? \_\_\_\_\_  
2. If practicing as a partnership or corporation, for what percentage of these were you responsible? \_\_\_\_\_ %  
3. What was your average number of employees over the last 6 months? \_\_\_\_\_

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**LIFE INSURANCE QUESTIONS** Must Be Completed if applying for Life Insurance (including Basic Protection Package)

Do you have other life insurance in force? **Member:**  Yes  No **Spouse:**  Yes  No  
 If "Yes," total amount in all companies: **Member:** \$ \_\_\_\_\_ **Spouse:** \$ \_\_\_\_\_

Do you have other insurance applications pending? If "Yes," indicate amount and company:  
**Member:**  Yes  No Amount \$ \_\_\_\_\_ Company \_\_\_\_\_  
 Amount \$ \_\_\_\_\_ Company \_\_\_\_\_  
**Spouse:**  Yes  No Amount \$ \_\_\_\_\_ Company \_\_\_\_\_  
 Amount \$ \_\_\_\_\_ Company \_\_\_\_\_

**REPLACEMENT INFORMATION** Must Be Completed if applying for Life Insurance (including Basic Protection Package)

**Residents of ALL States (except New York):** Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? **Member:**  Yes  No **Spouse:**  Yes  No

**Residents of New York:** I have read the Important Replacement Information below. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Member:**  Yes  No **Spouse:**  Yes  No

**IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK**

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue, or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

**DISABILITY INSURANCE QUESTIONS** Must Be Completed if applying for Disability Insurance including BOE

**MEMBER:** Do you have in force or are you applying for any other disability income insurance?  Yes  No

If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above?  Yes  No

If yes, indicate which, and date it will be terminated \_\_\_\_\_

**SPOUSE:** Do you have in force or are you applying for any other disability income insurance?  Yes  No

If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above?  Yes  No

If yes, indicate which, and date it will be terminated \_\_\_\_\_

Do Not Send Payment now - You will be billed when coverage is approved

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**MEDICAL HISTORY Please indicate the best contact number for a Service Provider to contact you and/or your spouse on behalf of New York Life Insurance Company for Medical History.**

(Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

<b>Member</b>	Contact # _____ (xxx) xxx-xxxx <input type="checkbox"/> Residence <input type="checkbox"/> Business <input type="checkbox"/> Mobile	<b>Spouse</b>	Contact # _____ (xxx) xxx-xxxx <input type="checkbox"/> Residence <input type="checkbox"/> Business <input type="checkbox"/> Mobile
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**I request** the group insurance shown on page(s) 2 of this application. 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 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, and on any supplemental forms, 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 insurance will become effective on the first day of the month on or following the day approved by New York Life if: (a) I am alive on that date and the initial contribution is paid within 31 days after the date I am billed; (b) I and any approved dependents are actively performing the normal activities of a person in good health of like age on the effective (residents of NC "performing normal activities" is replaced by the requirement that health status remains the same as stated on the application); and (c) for Disability and Overhead Insurance, I am actively working 20 or more hours per week on the date such insurance would take effect;

**AUTHORIZATION:** I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("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 or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used 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 and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated above including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL

Member's Signature \_\_\_\_\_ Date \_\_\_\_\_

Spouse's Signature \_\_\_\_\_ Date \_\_\_\_\_  
(Necessary only if Spouse coverage is requested)

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GMA-AC-IR

**SEND NO MONEY NOW! We'll send you a premium notice upon approval.**

**Just complete, sign and mail the application to:**

HPSO • 159 East County Line Road • Hatboro, PA 19040-9635 • 1-800-982-9491

Residents of Puerto Rico Only – Mail your application to Global Insurance Agency P.O. Box 9023919, San Juan, PR 00902-3918

## ***FRAUD NOTICES – Please read before signing the application***

**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.

**RESIDENTS OF CA:** 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

**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 and 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** (applicable to Accident and Health Insurance only): 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.

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Healthcare Providers Service Organization is a registered trade name of Affinity Insurance Services, Inc.; (TX 13695); (AR 100106022); in CA, MN & OK, AIS Affinity Insurance Agency, Inc. (CA 0795465); (MN 8427); (OK 10014790); in CA, Aon Affinity Insurance Services, Inc., (CA 0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY and NH, AIS Affinity Insurance Agency.

CA Insurance License #0795465 and #0G94493

## IMPORTANT NOTICE:

### How New York Life Obtains Information and Underwrites Your Request for ACS Group Insurance

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, Inc. (“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 a 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 applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, of the 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, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866- 692-6901 Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

**For NM Residents:** *PROTECTED PERSONS<sup>1</sup> have a right of access to certain CONFIDENTIAL ABUSE INFORMATION<sup>2</sup> 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.*

<sup>1</sup> **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 person or prospective insured person.

<sup>2</sup> **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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.