

Endorsed by:



American Association of Orthodontists

For Residents of All States Except NY
CHANGE OF COVERAGE FORM
for Members of the American Association of Orthodontists

Plan Administration Office
1.800.622.0344
300 South Wacker Drive
7th Floor, Chicago, Illinois 60606

Request For Group Insurance From
New York Life Insurance Company
51 Madison Avenue • New York, NY 10010
SOCIAL SECURITY NO.
Group Policy G-14242/G-14243/G-14244
Certificate No.

MEMBER'S FULL NAME
DATE OF BIRTH
MALE FEMALE
HEIGHT FT. IN.
WEIGHT LBS.

STREET-NAME & NO.
MARITAL STATUS
PLACE OF BIRTH

CITY
STATE (OR PROVINCE)
ZIP CODE
E-MAIL ADDRESS

OFFICE PHONE: HOME PHONE: FAX NUMBER:

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS (ie. lawful spouse and unmarried, dependent children under age 25).

SPOUSE'S NAME DATE OF BIRTH
HEIGHT: FT. IN. WEIGHT: SEX: MALE FEMALE

Table with 15 columns: Child (Name), Date of Birth, Ht., Wt., M/F. Multiple rows for dependent children.

MEMBERSHIP AFFILIATION—OCCUPATIONAL STATUS:
Student?: YES NO
Are you now a member of the American Association of Orthodontists? YES NO
Membership #
Annual Earned Income \$ Orthodontic Program Year Graduated

BENEFICIARY DESIGNATION: (complete this section only if applying for Life Insurance)
I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy.
BENEFICIARY'S NAME BENEFICIARY'S RELATIONSHIP TO MEMBER SOCIAL SECURITY #
BENEFICIARY'S STREET ADDRESS CITY STATE ZIP CODE

I HEREBY APPLY FOR THE COVERAGES CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:
Please Change Coverage FROM: TO:
LONG TERM DISABILITY INCOME (From \$1,000 to \$12,500 per month in \$100 units.) MONTHLY BENEFIT \$ \$
Plan 1 Benefits begin on 31st day of disability for either accident or sickness
Plan 2 Benefits begin on 91st day of disability for either accident or sickness
Plan 3 Benefits begin on 181st day of disability for either accident or sickness
WAITING PERIOD PLAN PLAN
Add DELETE Cost of Living Adjustment (COLA) Option
Add Future Purchase Option (FPO) (From \$500 to \$2500 in \$100 units) FPO MONTHLY BENEFIT \$ \$

10 AND 20-YEAR LEVEL TERM LIFE INSURANCE
Check Life Insurance Plan desired: 10-Year Level Plan 20-Year Level Plan
Member Amount (from \$100,000 to \$2,000,000 in \$10,000 increments) \$ \$
Spouse Amount (from \$100,000 to \$1,000,000 in \$10,000 increments, not to exceed member amount) \$ \$
Child(ren) Amount \$5,000 for each dependent child up to age 25 (\$500 from 15 days old to 6 months)
\$10,000 for each dependent child up to age 25 (\$500 from 15 days old to 6 months)
Please answer the following questions.
Have you smoked or used tobacco or nicotine in any form in the last 24 months? Yes No
Has your spouse smoked or used tobacco or nicotine in any form in the last 24 months? Yes No
Is the insurance applied for intended to replace, discontinue or change (does not include increases to existing coverage) an existing policy? Yes No
For current AAO Group Term Life Insureds, please mark the correct box:
I intend to cancel my in-force AAO Term Life insurance (Group Policy G-14242-0) upon approval of this application, and replace it with the 10 or 20-Year Level Term Life coverage that I am applying for on this application.
I intend to keep my in-force AAO Term Life insurance (Group Policy G-14242-0) and add separately the new 10 or 20-Year Level Term Life coverage that I am applying for on this application.
(Note: the maximum available under all AAO life insurance plans is \$2,000,000)

GROUP HEALTH PLANS
Coverage desired for: Member Spouse Child(ren)
Check Plan Desired: \$3,000 Individual Deductible HSA-Qualified PPO Plan \$6,000 Family Deductible HSA-Qualified PPO Plan
\$5,000 Individual Deductible HSA-Qualified PPO Plan \$10,000 Family Deductible HSA-Qualified PPO Plan
\$2,250 Individual Deductible HSA-Qualified Traditional Plan \$4,500 Family Deductible HSA-Qualified Traditional Plan
Is this coverage meant to replace any medical care insurance which has been in force for at least 18 months (without a break in coverage of more than 63 days) on yourself or any other person to be insured? YES NO
If yes, please attach a copy of the certificate of creditable coverage from the prior insurance plan.

PROFESSIONAL OVERHEAD EXPENSE
(From \$500 to \$20,000 per month in \$100 increments.) MONTHLY AMOUNT \$ \$
1. Average monthly amount of Eligible Overhead Expenses in preceding 6 months? \$
2. Practicing as: Corporation? Partnership? Individual?
3. Average number of employees?
4. If corporation or partnership, for what percent of the monthly "Eligible Expenses" are you responsible? %

