



Request for Group Insurance From: New York Life Insurance Company 51 Madison Ave. New York, NY 10010

Enrollment Form For Members of the American Association of Orthodontists

Affinity Insurance Services, Inc. 159 East County Line Road Hatboro, PA 19040-1218 (800) 622-0344 www.aao-insurance.com

1. PLEASE COMPLETE THE INFORMATION BELOW AND RETURN TO THE PLAN ADMINISTRATOR

Group Policy G-14242-3

Certificate No. \_\_\_\_\_

Member's Full Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State (or Province) \_\_\_\_\_ Zip Code \_\_\_\_\_

Social Security # \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male Female Height \_\_\_\_ ft. \_\_\_\_ in. Weight \_\_\_\_ lbs. Marital Status: Maiden Name: \_\_\_\_\_ Married Divorced Single Widowed

Office Phone #: ( ) \_\_\_\_\_ Home Phone #: ( ) \_\_\_\_\_

Fax #: ( ) \_\_\_\_\_ Email Address: \_\_\_\_\_

Membership Affiliation

Are you now a member of the American Association of Orthodontists? Yes No Membership # \_\_\_\_\_

Are you a student? Yes No Orthodontic Program \_\_\_\_\_ Year Graduated \_\_\_\_\_

Are you presently insured by any American Association of Orthodontists Endorsed Insurance Plan? YES NO

If yes, provide details \_\_\_\_\_

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

Member: Yes No If yes, how long? \_\_\_\_\_ Country \_\_\_\_\_

2. PAYMENT OPTION SELECTION:

Please Bill Me: Annually Semi-Annually Quarterly

Send No Money With This Application

3. OCCUPATIONAL STATUS:

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

FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? Yes No

Gross Annual Income from: Salary \$ \_\_\_\_\_ Self Employment \$ \_\_\_\_\_

Bonus \$ \_\_\_\_\_ Commissions \$ \_\_\_\_\_ Total \$ \_\_\_\_\_

4. I HEREBY APPLY FOR LONG TERM DISABILITY INSURANCE BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION (Refer to the brochure for eligibility, options and coverage descriptions)

New Additional NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage, instead, indicate the TOTAL amount of coverage you are requesting.

Select the Waiting Period (Disability benefits beginning the day after the waiting period.) Plan 1 30 Days Plan 2 90 Days Plan 3 180 Days

Fill in the Monthly Benefit Amount: \$1,000 to \$12,500 (in \$100 units) \_\_\_\_\_ (not to exceed 60% of monthly earned income when combined with your other disability insurance)

Cost of Living Adjustment (COLA) Option: Yes No

Future Purchase Option (FPO): Yes No (From \$500 - \$2,500 in \$100 units): Amount: \_\_\_\_\_

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability:

Yes No If "Yes," please list:

Table with 4 columns: Company, Plan, Monthly Benefit, Benefit Period

Will the coverage applied for with us replace any of the above? YES NO (If so, indicate which, and date it will be terminated.) \_\_\_\_\_

5. 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).

- 1. Are you now ill, or taking any prescribed medication or receiving or contemplating medical attention or surgical treatment? YES NO
2. During the past five years, have you ever been medically diagnosed by a physician or any other medical care practitioner as having been treated for:
a. Heart or circulatory trouble, elevated blood pressure, pain or pressure in chest? YES NO
b. Arthritis, back trouble/disorder, bone or joint disorder? YES NO
c. Fainting spells, convulsions, or epilepsy? YES NO
d. Sugar, blood, albumin or pus in urine? YES NO
e. Diabetes, ulcers or digestive disorder? YES NO
f. Gynecological or genitourinary disorders, disorder of breasts or reproductive organs or functions? YES NO
g. Nervous or mental disorder, emotional condition or psychiatric care or psychotherapeutic treatment? YES NO
h. Cancer, tumor or cyst? YES NO
i. Varicose veins, hemorrhoids or hernia? YES NO

G-14242-3

Endorsed by:

American Association of Orthodontists



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- j. Disorder of eyes, ears, nose or sinuses?  YES  NO
- k. Thyroid, kidney, respiratory or liver disorder (including hepatitis)?  YES  NO
- l. Blood disorder, enlarged lymph nodes or immunodeficiency disorder?  YES  NO
- m. Unexplained weight loss or accidental injury?  YES  NO
- n. Other health or physical impairment including:
  - (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome(AIDS) or AIDS-related Conditions (ARC)?  YES  NO
  - (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past 5 years?  YES  NO
  - (iii) Any other impairment?  YES  NO
- 3. During the past 5 years have you been counseled, treated or hospitalized for the use of Alcohol or Drugs?  YES  NO
- 4. Are you now pregnant?  YES  NO
- 5. Are you now disabled, or have you applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?  YES  NO
- 6. Except for residents of Minnesota and Connecticut, in the last seven years, have you and /or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending?  YES  NO  
**For residents of Minnesota and Connecticut only**  
 In the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?  YES  NO
- 7. If you have answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

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:

**5. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY**

**I request** the group insurance shown on page one 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 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 first day of the month on or 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 am actively performing any and all duties of my occupation on the approval date; If I am not performing such duties/activities as required, I will not become insured until the day I am performing such duties/activities, provided such date is within three months of the date insurance would have been effective and I am still eligible for insurance; and (c) such insurance may be subject to any impairment restriction(s) established by New York Life and (d) any dividend apportioned to the group policy will be paid to the group policyholder.

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.

**AUTHORIZATION: I authorize** disclosure of the types of information detailed in this AUTHORIZATION, 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, laboratories, insurance company or MIB to release prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, 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. 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). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies. 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. The information New York Life obtains through this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage I or my authorized agent will receive a copy of this signed AUTHORIZATION, and that in all circumstances, I or my authorized agent may request a copy of this AUTHORIZATION.

**By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information to the providers noted, and attest that I have read the Fraud Notices enclosed, and that to the best of my knowledge and belief, the answers to the questions are true and complete.**

**Member' s Signature** \_\_\_\_\_ **Date** \_\_\_\_\_  
 G-14242-3 (Please sign in ink)

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Please see insert for compensation disclosure information.

**BEFORE YOU MAIL THIS APPLICATION,**

It will greatly speed action on your application if you will review it carefully. Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strike-outs, these must be initialed by the member.

**Once completed and dated, this application should be submitted at once to the address below:**  
 Affinity Insurance Services, Inc. • 159 E. County Line Rd., Hatboro, PA 19040-1218 • Phone: 1-800-622-0344