



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

**AMERICAN ASSOCIATION OF ORTHODONTISTS
ENDORSED GROUP 10 OR 20 YEAR LEVEL TERM LIFE
ENROLLMENT FORM**

Plan Administrator:
Affinity Insurance Services, Inc.
159 E. County Line Road
Hatboro, PA 19040
(800) 622-0344

Complete this form and return to the Plan Administrator

1. MEMBER INFORMATION

Group Policy No. G-14243 (10 yr.), G-14244 (20 yr.) Certificate No. _____

Name: _____ Home Phone # (____) _____ Height _____ ft. / ____ in.

Address: _____ Work Phone # (____) _____ Weight _____ lbs.

City: _____ Fax # (____) _____ Sex M F

State: _____ Zip: _____ Soc. Sec. # _____ -- _____ -- _____ Date of Birth ____/____/____

Home E-mail address _____

Marital Status Married Maiden Name _____ Divorced Single Widowed

I am a Member of American Association of Orthodontists: Membership # _____

Date you Became a Member ____/____/____ Annual Earned Income \$ _____

Are you presently insured by any American Association of Orthodontists 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 Spouse Yes No If yes, how long? _____

2. PAYMENT OPTION SELECTION

Choose only one PERIODIC BILLING: Quarterly Semi-Annually Annually

3. DEPENDENT INFORMATION

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under 25).
Attach separate sheet to provide additional dependent information.

Dependent Full Name (ie. Mary J. Doe)	Date of Birth (mo/day/yr)	Height (Ft., In)	Weight (Lbs.)	Male or Female
Spouse's Full Name				
Child				
Child				
Child				

4. INSURANCE REQUESTED

(Refer to the brochure or your certificate for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Change

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

Group Life Insurance: Term Selection (check one) 10-year 20-year

a) Total Member Amount Desired:
(from \$100,000 to \$2,000,000 in units of \$10,000) \$ _____

b) Total Spouse Amount Desired:
(from \$100,000 to \$1,000,000 in units of \$10,000) \$ _____

NOTE: Spouse coverage cannot exceed member coverage

c) Total Child Amount Desired:
 \$5,000 each insured child (\$500 from 14 days to 6 months)
 \$10,000 each insured child (\$500 from 14 days to 6 months)

d) Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?

Member Yes No Spouse Yes No

If yes, when did you last use tobacco or nicotine products?
Member _____ Mo/Yr Spouse _____ Mo/Yr

e) Insurance Replacement Information

RESIDENTS OF ALL US STATES (EXCEPT NY): 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: 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.

INSURANCE QUESTION: RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. Is the life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?
Member Yes No Spouse Yes No

5. BENEFICIARY DESIGNATION

I 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. (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Primary Beneficiary:	Last	First	Middle Initial	Relationship	Social Security #
Beneficiary Address:	Street	City	State	Zip Code	% of Benefits

If necessary, attached separate signed and dated sheet to provide additional beneficiary information

6. STATEMENT OF HEALTH

(Please initial any changes you make on this form.)

To the best of your knowledge or belief, answer the following questions as they apply to you and all dependents to be insured.

<p>1. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
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6. STATEMENT OF HEALTH (CONTINUED)

	Yes	No		Yes	No
3. During the past 5 years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	7. Has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>	Note: Genetic Family History is not applicable to Maryland residents		
5. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	8. Within the past two years have you or your spouse participated in, or do either of you plan within the next two years to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping or organized motorcycle racing, or any type of organized motorized racing?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past 5 years has any person to be insured ever been medically diagnosed as having or been treated for:			9. Driver's License No.: Member _____ Spouse _____ State in which issued: (Member) State/Province _____ (Spouse) State/Province _____ Have you or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>	10. 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	<input type="checkbox"/>	<input type="checkbox"/>
b. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>	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 been arrested and convicted for any reason?		
c. Fainting spells, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>			
e. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
f. Disorder of breast or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>			
g. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>			
h. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>			
i. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>			
j. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>			
k. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
l. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>			
m. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>			
n. Other health or physical impairment including:					
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>			
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>			
(iii) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>			

If you have answered "Yes" to any of the above Questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it).

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 Medical Care Practitioners and Hospitals where confined or treated:

I request the group insurance shown on page 1 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 (or additional insurance) will become effective on the first day of the month on or following the date approved by New York Life if I and any approved dependents are alive on that date and the initial contribution is paid within 31 days after the date I am billed, and (b) any dividend apportioned to the group policy will be paid to the policyholder.

I authorize disclosure of the types of information detailed in the AUTHORIZATION below, 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.

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 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. **FOR RESIDENTS OF D.C.**, the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by 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 AR & LA:** 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 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. **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 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 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 denial of insurance benefits. **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.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or 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 and to others whom I authorize in writing. 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed 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 to the best of my knowledge and belief, the answers to the questions are true and complete.

Member Signature X _____ **Date** _____

(PLEASE SIGN AND DATE IN INK)

Spouse Signature X _____ **Date** _____

(Necessary only if Spouse Coverage is requested)

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A-8273-0110W

GMA-PRSI

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 strikeouts, these must be initialed by the member.

IMPORTANT NOTICE - How New York Life Underwrites Your Request for Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may take a brief report to MIB; however, we will not disclose our underwriting decision. 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.

MIB is a non-profit, membership organization of life insurance companies, which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to an MIB company, medical or non-medical information may be given to the Bureau, which may then be furnished to member companies.

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 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 at MIB Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (781) 751-6000. For Canadian residents, the address is MIB Information Office, 330 University Avenue, Suite 501, Toronto, Canada M5G 1R7, telephone (416) 597-0590. For hearing impaired TTY 866-346-3642.

For NM residents, PROTECTED PERSONS (1) have a right of access to certain CONFIDENTIAL ABUSE INFORMATION (2) 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.

- (1) 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 or prospective insured.
- (2) 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 counseling relationship.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean there is any insurance in force before the effective date is determined by New York Life.

New York Life

4/03

AFFINITY INSURANCE SERVICES, INC. COMPENSATION AND OTHER DISCLOSURE INFORMATION

Life and Health, a division of Affinity Insurance Services, Inc., exclusively offers the American Association of Orthodontists Insurance Program as an agent of the New York Life Insurance Company and provides administrative services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 12.2% of your paid premium as compensation for marketing and administrative services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer and there will be no other fees or charges to you.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at www.aon.com/market_relationships for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit www.aon.com/market_relationships for more detail on these agreements.

Your signature on your application, check, and/or authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Affinity.