



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

American Association of Orthodontists Endorsed Long Term Disability

ENROLLMENT FORM

Plan Administrator:
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:

| 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).

- Are you now ill, or taking any prescribed medication or receiving or contemplating medical attention or surgical treatment? YES NO
- 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:
 - Heart or circulatory trouble, elevated blood pressure, pain or pressure in chest? YES NO
 - Arthritis, back trouble/disorder, bone or joint disorder? YES NO
 - Fainting spells, convulsions, or epilepsy? YES NO
 - Sugar, blood, albumin or pus in urine? YES NO
 - Diabetes, ulcers or digestive disorder? YES NO
 - Gynecological or genitourinary disorders, disorder of breasts or reproductive organs or functions? YES NO
 - Nervous or mental disorder, emotional condition or psychiatric care or psychotherapeutic treatment? YES NO
 - Cancer, tumor or cyst? YES NO
 - Varicose veins, hemorrhoids or hernia? YES NO



- 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

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.

Important Fraud Notices

Please Read the following Fraud Notices before signing the application.

FRAUD NOTICE - *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 AR/LA/MD: 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 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 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 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.

G-14242-4

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