



Endorsed by  
American  
Association of  
Orthodontists

# American Association of Orthodontists Group Health Plans APPLICATION FORM

Plan Administration Office  
159 East County Line Road  
Hatboro, PA 19040  
1.800.622.0344

|   |                     |                 |
|---|---------------------|-----------------|
| Request For Group Insurance From<br><b>New York Life Insurance Company • 51 Madison Avenue • New York, NY 10010</b> | SOCIAL SECURITY NO. | Certificate No. |
|---|---------------------|-----------------|

|                    |               |  |                   |                |
|--------------------|---------------|--|-------------------|----------------|
| MEMBER'S FULL NAME | DATE OF BIRTH | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE | HEIGHT<br>FT. IN. | WEIGHT<br>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 SOCIAL SECURITY NO. \_\_\_\_\_

| Child (Name) | Date of Birth | Ht. | Wt. | M/F | Child (Name) | Date of Birth | Ht. | Wt. | M/F | Child (Name) | Date of Birth | Ht. | Wt. | M/F |
|--------------|---------------|-----|-----|-----|--------------|---------------|-----|-----|-----|--------------|---------------|-----|-----|-----|
|              |               |     |     |     |              |               |     |     |     |              |               |     |     |     |
|              |               |     |     |     |              |               |     |     |     |              |               |     |     |     |

**MEMBERSHIP AFFILIATION—OCCUPATIONAL STATUS:** Student? YES  NO

Are you now a member of the American Association of Orthodontists? YES  NO  Membership # \_\_\_\_\_

Orthodontic Program \_\_\_\_\_ Year Graduated \_\_\_\_\_

**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

**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.

**HEALTH QUESTIONS:**

**ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED:**

|  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Are you or any other person to be insured now ill, receiving or contemplating medical attention or surgical treatment? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Is any person to be insured now pregnant? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has any person to be insured ever had:  |                          |                          |
| a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arthritis, back trouble, bone or joint disorder? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fainting spells, convulsions, or epilepsy? .....  | <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 breasts 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"/> |

**Residents of Maine: You are not required to disclose whether you have been tested for HIV if you have not developed symptoms of the disease; AIDS or AIDS Related Complex (ARC) in your answer to the following questions.**

m. Disorder of the blood?  
*"disorder of the blood" includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease).* .....

n. Other health or physical impairment including:  
 (i) Acquired Immune Deficiency Syndrome(AIDS) or AIDS-related Condition (ARC)?  
*ARC (AIDS RELATED COMPLEX) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause.* .....

(ii) Any other disorder of the immune system?  
*"disorder of the immune system" includes hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, the immune-deficiency disorders, both congenital and acquired. Also included are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others.* .....

(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years? circled .....

(iv) Any other impairment? .....

6. If you have answered Question 1 "No," or any of the other Questions "Yes," 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. |
|------------------------------|---|--|
|                              |   |  |
|                              |   |  |
|                              |   |  |
|                              |   |  |

**Send no money with this application.** Be sure to complete and sign the reverse side.

**I request** the group insurance shown on the reverse side. 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, and that such insurance may be subject to any impairment restriction(s) established by New York Life. 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 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) medical insurance will become effective on the first of the month on or following 30 days after receipt of the application by the AAO Endorsed Insurance Office and (b) all other insurance will become effective on the first day of the month on or following the day coverage is approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age and sex on the date insurance is effective. I also understand that except for medical coverage: (a) any person who was not performing his or her normal activities on the day insurance would otherwise become effective, will not be insured until the date he or she is performing such activities provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance, and (b) any dividend apportioned to the group policy will be paid to the American Association of Orthodontists, as the Group Policyholder.

**For Group Health Insurance: I also understand that in the event I cannot provide evidence that I, or if applicable, my dependent(s) had 18 months of creditable medical coverage (with no break in coverage of more than 63 days), that benefits will not be paid for up to 12 months after the effective date of coverage for losses due to a disease or condition which I or my dependent(s) now have or have had whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the effective date of the coverage.**

**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.

**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).

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by the AUTHORIZATION 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. 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, the member and any person proposed for insurance, request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information by the providers noted, and attest to having read the Fraud Notices indicated below and that to the best of my knowledge and belief, the answers to the questions are true and complete.

**Member's Signature X** \_\_\_\_\_ Date \_\_\_\_\_  
(Please sign in ink)

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

G-14242-1

5/07

Form GPA-AC1

**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-14242-1

GPA-AC1

**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 should be submitted at once to the Plan Administration Office.**  
Plan Administration Office • 159 East County Line Road • Hatboro, PA 19040 • 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. (formerly known as 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 make 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 coverage can be approved.

MIB is a not for profit, membership organization of insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member 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 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. Toll Free Number is 866-692-6901 or TTY 866-346-3642 for the hearing impaired. For Canadian residents, the address is MIB, Inc, MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416)-597-0590. **Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).**

**For NM Residents**, PROTECTED PERSONS (1) have a right of access to certain CONFIDENTIAL ABUSE INFORMATION (2) we maintain 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 of 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 that there is any insurance in force before the effective date as determined by New York Life.

NEW YORK LIFE INSURANCE COMPANY

4/03 ed rev 1/09

**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](http://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](http://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.

X-8292-0611W