

Request for Group Insurance From:



Plan Administrator:



Please complete the information below and return to: American Association of Orthodontists Program Administrator, 1200 E. Glen Avenue, Peoria Heights, IL 61616-5348

Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

AMERICAN ASSOCIATION OF ORTHODONTISTS ENDORSED GROUP DISABILITY INCOME INSURANCE APPLICATION

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. MEMBER INFORM	ATION							
Name								
Street Address								
City			State (or Province)			Zip Code		
Home Phone		Work Pho	Work Phone					
Home Email						Foi	r internal use only. Email address will never be sold or shared.	
_					_	1		
Age	Date Of Birth	Height		Weight	Sex	_		
	/ /	ft.	in.	lbs.	OM OF			
I am a Member of AAO								
Are you a student? O		pership is required					Year Graduated	
Are you presently insur								
If Yes, indicate which p								
ii ies, iliulcate willcii p	nan(s) and provide de	talis						
In the next 12 months,								
Country(ies)						Length of S	tay	
OPTION 1: Direct Ri	ill O Quarterly O S	emi₋Annual () Annual	OPTION 2: Flor	etronic Funde Transfa	r (FFT) O Monthly	y 🔾 Quarterly 🔾 Semi-Annual 🔾 Annual	
of flort 1. billoot bi	m Squarterly So	Cilii Ailiiddi C	Milliadi	Of HOR E. Elec	oromo ranas transic		Quarterly Seria Aminual Shimaan	
2. OCCUPATIONAL ST	ATUS	_	-		_	_		
What is your occupation					Main duties:			
FULL-TIME WORK mean		ho rogular dutic	oc of your n	ermal accumation for		cic of at loast 20 hou	urs aach wook	
at the place such duties	, .	-	•	•	. , .	SIS OF ALTERST ZO HOL	is each week	
Gross Annual Income: Salary \$ Self-employment \$ (Self-employment start date: / /)								
Bonus \$ Commission \$ TOTAL \$								
3. INSURANCE REQU	ESTED—INSURANCE ST	FATUS: Refer to e	enclosed lett	er or website aaoplans	.com/DInow for eligibili	ty, options, and cover	age descriptions	
I hereby apply for the	e long term plan cov	erage: 🔘 Ne	ew Ado	ditional				
Note: If you are increasi		- ,		Γ indicate just the ad	ditional amount of cov	erage.		
Instead, indicate the TO			•					
A. Principal Mont	•		•	•		_		
_	l (choose one): P	•	٠.	od) Plan 2 (90-c	lay waiting period)	Plan 3 (180-day v	vaiting period)	
C. Cost-of-Living	Adjustment (COLA) O	ption: Yes	○ No					
	se Option (FPO):							
Available only if long-te Amount Desired:	rm plan is selected and you	are under age 50.	/ E	rom \$500 \$2.500 in	¢100 units Not to ove	ood monthly disabil	ity benefit and plan maximum amount.)	
Amount Desireu.	>		(Г	10111 5500 - 52,500 111	\$ 100 units. Not to exc	eed monthly disabil	ty benefit and plan maximum amount.)	
Do you now have or are	you applying for other	insurance whic	h provides l	benefits if you are un	able to work because o	of a disability? ()	Yes No If "Yes," please list:	
COM	PANY		PLAN		MONTHI	Y BENEFIT	BENEFIT PERIOD	
							- SENETT PENIOD	
Will the coverage and	ad for with us if annex	od roplace and	of the abov	vo? Over ONe			-	
Will the coverage applied If "Yes," please indicate								

G-14242-3

2. During the past five years, how you were been medically disagnosed by a physician or other medical care practitioner as howing or these interact of the analysis of the control of the past five years and the past five years and the past five years and years of the past five years of the years and years of the years of	1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?		4. STATEMENT OF HEALTH (PLEASE INITIAL ANY CHA	INGES YOU MAKE ON THIS FORM)	
2. During the past five years, have you over been medically diagnosed by a physician or other medical care partitioners a sharing and their or circulatory trouble, elevated blood pressure, chet plan or pressure, specially and pressure or productions of stories, sites or digetive disorders, specially on the pressure of the pressure o	2. During the past five years, have you ever been medically diagnosed by a physician or other medical care proctinener as having of been treased for a functions, ulcors or digitally every complete discovery. The past of th	To	the best of your knowledge and belief, answ	ver the following questions as they apply to you to be insured	I.
a) Bear or circulationy touble, elevated blood pressue, chest pain or pressue, generalizing and including surface of the control of the contr	a) Near to circulatory totable, elevated blood pressure, deet pain or pressure, genealogical or epitioumary disorders, aborder to threats or repoductive engans or functions, used or advisords, but one or specific productions, and the productive control of the productive control	1.	Are you now ill or taking any prescribed medicat	ion or receiving or contemplating any medical attention or surgical tr	reatment? Yes
b) Other health or physical impairment, including: (i) Being medically diagnosed as having Acquired immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (iii) Any other impairment? 3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? 4. Are you pregnant? 5. Are you disabled, or have you applied, or are you applying for, or receiving any disability or workers Compensation benefits, or ownered or former in or life or health instruance? 6. Except for residents of Minnesota and Connecticuturi, in the past seven years, have you been convicted of a clinic or severed time in pirison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticuturi, in the past seven years, have you been convicted of a clinic or served time in pirison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticuturi, Have you been convicted of a clinic or served time in pirison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticuturi, Have you been convicted of a clinic or served time in pirison because of a conviction or here nonvicted for any reason during the past seven years? Yes If you 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: Name(s) of Proposed Insured: University of the proposed Insured:	b) Other health or physical impairment, including: (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (ii) Chronic Cough, persistent diadnose, aclayed hymph glands, chronic faltague in the past five years? (iii) Any other impairment? 3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? 4. Are you pregnant? 5. Are you gold, or have you applied, or are you applying for, or receiving any disability or workers' compensation benefits, or no waiver of preminen for five or health immane? 6. Except for residents of Minnesota and Connecticut, in the past seven years, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticut, in the past seven years, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticut only: Revue observed of a crime or served time in prison because of a conviction or been convicted for any reason during the past seven years? If you answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.) 18 you answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.) 18 you answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.) 19 you answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.) 18 you answered "Yes" to any of the above questions, give complete details below. (Attach as separate sheet if necessary, then sign and date it.) 19 you answered "Yes" to any of the above questions, give complete details below. (Attach as separate sheet if necessary, an examinati	2.	 a) Heart or circulatory trouble, elevated blood p or functions, ulcers or digestive disorders, car treatment, fainting spells, convulsions or epil disorder, thyroid disorder, blood disorder, albu 	ressure, chest pain or pressure, gynecological or genitourinary disorder ncer, tumor or cyst, diabetes, mental or nervous disorder, emotional con epsy, respiratory disorder, kidney or liver disorder, (including hepatitis), ımin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone	s, disorder of breast or reproductive organs Iditions, psychiatric care or psychotherapeutic , enlarged lymph nodes or immunodeficiency or joint disorder, varicose veins, hemorrhoids
3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? 4. Are you pregnant? 5. Are you disabled, or have you applied, or are you applying for, or receiving any disability or workers' compensation benefits, or on waiver of premium for life or health insurance? 6. Except for residents of Minnesota and Connecticut, in the past seven years, have you been consicted of a crime or served time in prison because of a conviction or howe an arrest pending? For residents of Minnesota and Connecticut, in the past seven years, have you been consicted of a crime or served time in prison because of a conviction or howe an arrest pending? For residents of Minnesota and Connecticut, in the you been convicted of a crime or served time in prison because of a conviction or been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past seven years? If you 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: Name and Address of Physicians or other Medical Care Practitioners and Hospitals Where Confined or Treated: Operations Degree of Recovery and Date:	3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? 4. Are you pregnant? 5. Are you disabled, or have you applying for, or receiving any disability or workers' compensation benefits, or on waiver of premium for life or health insurance? 6. Except for residents of Minnesota and Connecticut, in the past seven years, have you been convicted or far are in prison because of a conviction or have an arrest pending? For residents of Minnesota and Connecticut only: have you been convicted of a crime or served time in prison because of a conviction or have not an arrest pending? For residents of Minnesota and Connecticut only: have you been convicted of a crime or served time in prison because of a conviction or here convicted for any reason during the past seven years? If you 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 Tiesated: Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history. What time and telephone number would you like to be contacted at? 5. Authorization And DECLARATION of PRESON CHIMICA STATEMENT OF INSURABILITY 1. Inderstand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on such statements reade 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 answer and statements set forth above. AUTHORIZATION: I hereby authorize any liceased physician, medical practitioner, hospital, pharmacy,		 b) Other health or physical impairment, include (i) Being medically diagnosed as having Acc (ii) Chronic cough, persistent diarrhea, enla 	ling: quired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex rged lymph glands, chronic fatigue in the past five years?	((ARC)? Yes Yes Yes Yes
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If you 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:	If you 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:				Yes 🔘
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AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collect 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. By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of [my] protected health information MIB, Inc.; and attest to having read the IMPORTANT NOTICE and FRAUD NOTICES indicated [below], including how [my] information is exchanged with MIB, that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.	AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collect 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. By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of [my] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and FRAUD NOTICES indicated [below], including how [my] information is exchanged with MIB, at that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete. Date	dru Pla ps lav In	mpany, MIB, Inc. ("MIB"), or other organization ag records maintained by physicians, pharmacy an Administrator about the physical and mental ychotherapy notes for the purpose of evaluating y, in which case it may not be protected under fe this case, the information may no longer be pro	on, institution, or person that has any records or knowledge of benefit managers, and other sources of information to New Yorld health of any persons proposed for insurance, including signify my application for insurance. Health information obtained will n deral privacy rules. For example, New York Life may be required to tected by the rules governing your AUTHORIZATION.	me or my health to release information, including prescript k Life Insurance Company, its reinsurers, its subsidiaries, or ficant history, findings, diagnosis, and treatment, but exclud to be re-disclosed without my authorization unless permitted provide it to insurance, regulatory, or other government agenci
that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.	that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete. Member Signature X Date	AU ser inf By dis	THORIZATION. This AUTHORIZATION shall be vanding written notice to New York Life Insurance (ormation or taken other action in reliance on it, signing and dating this application, the meroclosure of information to and from the prov	lid for a period of 24 months from the date signed, unless soon Company. My revocation will not be effective to the extent that New or to the extent that New York Life has a legal right to contest a comber requests the insurance indicated; and the member and riders noted above and in the IMPORTANT NOTICE, including	er revoked. The AUTHORIZATION may be revoked at any time w York Life or any other person already has disclosed or collect claim under an insurance certificate or the certificate itself. any person proposed for insurance consent to authorize to making a brief report of [my] protected health information.
Member Signature X	<u> </u>				
	PLEASE SIGN AND DATE IN INK	Me	ember Signature X		Date
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FRAUD NOTICE (PLEASE READ BEFORE SIGNING THE APPLICATION FOR INSURANCE)

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 any 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 AL/AR/ LA/RI: 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 CA:** 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 any 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. The falsity of any statement in the application for any policy shall not bear the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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/she is facilitating a fraud against an insurer, submits an application, or files a claim containing false or deceptive statements may have violated state law.

7.2013 ed.

IMPORTANT NOTICE

How New York Life obtains information and underwrites your request for AAO Group Disability Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance, and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical, or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your 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 your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries, or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law. New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. 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. 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, telephone 866.692.6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: PROTECTED PERSONS¹ have a right of access to certain CONFIDENTIAL ABUSE INFORMATION² we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSONS 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 PERSONS 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 person or prospective insured person.
- 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 relationship.