Endorsed by American Association of Orthodontists

Insurance

Request for Group Insurance from:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Plan Administrator:

PEARL® INSURANCE
1200 E. Glen Ave., Peoria Heights, IL 61616
Questions: Please call 800.622.0344

Please complete this form and return to: American Association of Orthodontists Program Administrator, 1200 E. Glen Ave., 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

AAO-ENDORSED GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

Please print in ink or type. Initial and date any changes you make.

A. PERSONAL INFORMATION

Full Name (First, Middle Initial, Last)

Street Address | City | State (or Province) | ZIP

Phone Number (Daytime) | Phone Number (Work) | Fax Number

Social Security # | Email (For internal use only. Email address will never be sold or shared.)

Marital Status: ◯ Married ◯ Divorced ◯ Single ◯ Widowed

Individuals Applying for Coverage	Date of Birth	Sex
Member	/ /	❍ M ❍ F
Spouse*	/ /	❍ M ❍ F
Child**	/ /	❍ M ❍ F
Child**	/ /	❍ M ❍ F

*Member date of birth must also be provided when requesting spouse coverage only.
**See plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

B. MEMBER AFFILIATION

Membership in AAO is required for participation in this plan. **AAO Membership #** _____

C. PAYMENT OPTION SELECTION: Choose only one

❍ **Option 1: Direct Billing.** Following your intitial billing, you will be billed (choose one): ❍ Annually ❍ Semiannually (January 1 and July 1)

❍ **Option 2: Electronic Funds Transfer.** I request and authorize the AAO-Endorsed Insurance Program to make semiannual withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Accidental Death & Dismemberment Insurance plan (enclose a voided check or deposit slip, as applicable).

Signature(s) as required on checks issued/withdrawals made against this account | **Date**

Be Sure To Complete All Pages and Sign the Last Page. DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

D. INSURANCE REQUESTED: Refer to plan information for eligibility, principal sums, premium, and coverage description

I hereby apply for the following Accidental Death & Dismemberment coverage: ❍ **$25,000** ❍ **$50,000** ❍ **$75,000** ❍ **$100,000** ❍ **$125,000** ❍ **$150,000**

Family option: ❍ Member **$50,000;** Spouse **$25,000;** Children **$2,500**

❍ Member **$100,000;** Spouse **$50,000;** Children **$5,000**

❍ Member **$150,000;** Spouse **$75,000;** Children **$75,000**

E. BENEFICIARY DESIGNATION: Insert name, relationship, and social security number

I make the following beneficiary designation with respect to all the insurance on my life under this Group Accidental Death & Dismemberment 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 want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.) (1) In naming more than one beneficiary, please note if each is to be primary 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. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name (First, Middle Initial, Last) | Relationship to Insured

Date of Birth | Social Security # | Phone Number

F. AUTHORIZATION AND SIGNATURE

I hereby enroll with New York Life Insurance Company of New York, New York, for coverage under the AAO Group Accidental Death and Dismemberment Plan. I have read and understand the conditions and exclusions of the program. I understand my coverage will become effective upon the date of approval specified by New York Life Insurance.

Signature of Member | Date

Signature of Spouse (if proposed for insurance) | Date

FOR RESIDENTS OF CANADA: For purposes of the Insurance Companies Act (Canada), this Document was issued in the course of New York Life Insurance Company's insurance business in Canada.

Be Sure To Complete All Pages and Sign the Last Page. DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.