Endorsed by American Association of Orthodontists

Insurance

Please complete the application form and return to:
AAO Endorsed Insurance Program Administrator,
1200 East. Glen Avenue, Peoria Heights, IL 61616
Don't let an unanswered question delay your enrollment
Call toll free: **800.622.0344** or visit **aao-insurance.com**

GROUP DISABILITY INCOME INSURANCE PLAN FOR NONMEMBERS WHO ARE ORTHODONTIST EMPLOYEES

EMPLOYEE INFORMATION (PRINT IN INK OR TYPE ALL ANSWERS) **Group Policy: G-14260-0 Certificate No.** _____

Last Name | First Name | Middle Initial | Social Security #

Mailing Address

City | State (or Province) | Zip | Email Address

Daytime Phone Number | Evening Phone Number | Daytime Fax Number

Marital Status: ❍ Married ❍ Divorced ❍ Widowed ❍ Single ❍ Domestic Partner* ❍ Civil Union** Maiden Name: _____

Date of Birth	Height	Weight	Sex
/ /	ft. in.	lbs.	❍ M ❍ F

*Eligibility is determined by state law. Submit a Declaration of Domestic Partnership Form - Not applicable in Oregon.
**Eligibility is determined by state law.

MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS:

A. What is the name of your employer? _____ Mailing Address _____

B. What is your occupation? _____

C. Main duties? _____

D. Date of employment? _____ Annual earned income? _____

E. 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

F. Do you intend to reside outside the U.S. or Canada in the next 12 months? ❍ Yes ❍ No If yes, which country _____ How long? _____

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

NOTE: If you are increasing or altering present coverage in any way, do not only indicate the additional amount of coverage; instead indicate the TOTAL AMOUNT of coverage you are requesting: ❍ New Coverage ❍ Additional Coverage

GROUP DISABILITY INCOME COVERAGE - I HEREBY APPLY FOR THE FOLLOWING

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 66 2/3% of your basic monthly salary.

a) Monthly Benefit Option: $ _____ (from $200 to $1,000 per month, in $100 increments)

b) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? ❍ Yes ❍ No
If yes, please list below.

Company	Plan	Monthly Benefit	Benefit Period

STATEMENT OF HEALTH: To the best of my knowledge and belief:

A. Are you now taking any prescribed medication, receiving or contemplating any medical attention or surgical treatment? ❍ Yes ❍ No

B. During the past five years have you ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss? ❍ Yes ❍ No

C. During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs? ❍ Yes ❍ No

D. Are you now pregnant? ❍ Yes ❍ No

E. Are you now disabled, have you applied or are you applying for, or are you receiving any disability or Workers' Compensation benefits, or on a waiver of premium for life or health insurance? ❍ Yes ❍ No

F. **Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime, served time in prison because of a conviction, or have an arrest pending? ❍ Yes ❍ No

For residents of Minnesota and Connecticut only, have you been convicted of a crime, served time in prison because of a conviction, or been convicted for any reason during the past 15 years? ❍ Yes ❍ No

If you have answered yes to any of the above questions, please explain (attach a separate sheet if necessary, then sign and date it)

Question	Date	Name and address of physicians & hospitals	Include all information as to the nature of the illness or injury, symptoms, number of attacks, duration, treatment, and results

PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM

I understand 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 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].

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, 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 for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this 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 by 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 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.

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/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated [above, below, on the reverse of this page, on the attached, enclosed], including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Employee Signature X | **Date**

(PLEASE SIGN AND DATE IN INK)

G-14260-0

FRAUD NOTICE (PLEASE READ BEFORE SIGNING THE ENROLLMENT FORM)

FOR RESIDENTS OF ALL STATES EXCEPT THOSE LISTED BELOW:

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 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.

FOR 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, 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 bar 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.

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 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 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 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 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 and no 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.

Send no money now.
You will be billed once coverage has been approved.

IMPORTANT NOTICE (HOW NEW YORK LIFE OBTAINS INFORMATION AND UNDERWRITES YOUR REQUEST FOR GROUP TERM LIFE 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 physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance, and MIB, Inc. (formerly known as Medical Information Bureau). 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.

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 the administrator 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.

New York Life may release this information to the plan administrator, MIB, other insurance companies to whom you may apply for insurance or to whom a claim for benefits may be submitted, and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). 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 insurance can be approved.

MIB is a not-for-profit 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, telephone 866.692.6901 (TTY 866.346.3642). For Canadian residents, the address is: 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.**

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 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 a 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.*

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Request for Group Insurance from:

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

Plan Administrator:

PEARL INSURANCE®
1200 East Glen Avenue, Peoria Heights, IL 61616-5348
Questions: Please call 800.622.0344