

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 TERM LIFE 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.	<input type="radio"/> M <input type="radio"/> 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. Date of employment _____ Annual earned income _____

D. Are you actively engaged in your occupation on a full-time basis (at least 30 hours per week)? Yes No

E. 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 indicate just the additional amount of coverage, instead indicate the TOTAL AMOUNT of coverage you are requesting: New Coverage Additional Coverage

I HEREBY APPLY FOR THE FOLLOWING GROUP TERM LIFE COVERAGE: (up to \$30,000 in \$5,000 increments) \$ _____

NEW YORK RESIDENTS - IMPORTANT REPLACEMENT INFORMATION:

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value, by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue, or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help decide whether the replacement is in your best interest.

INSURANCE REPLACEMENT - RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Yes No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing policy? Yes No

BENEFICIARY DESIGNATION: I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation.

Beneficiary's Name: _____ Complete Address _____ Relationship _____ Social Security # _____ % _____

Beneficiary's Name: _____ Complete Address _____ Relationship _____ Social Security # _____ % _____

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 trouble, elevated blood 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, unexplained weight loss, or other illness disease or injury? Yes No
- C. During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs? 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)

**To Request Employee Life Insurance:
Complete this form in ink, indicate your choice of coverage; and mail to:**

**AAO Endorsed Insurance
Program Administrator**
1200 East. Glen Avenue,
Peoria Heights, IL 61616

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

FOR RESIDENTS OF ALL STATES EXCEPT THOSE LISTED BELOW:

RESIDENTS OF NEW YORK: 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.

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.

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 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.

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 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 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.*

¹PROTECTED 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.

²CONFIDENTIAL 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