AVMA | LIFE
Veterinarian Inspired Coverage

NEW YORK LIFE

Application • Enrollment Form for AVMA LIFE Trust Group Insurance Program

Complete this form and return to:
AVMA LIFE Trust Program Administrator ♦ 1200 E. Glen Ave. ♦ Peoria Heights, IL 61616-5384
Please print in ink or type all answers – initial and date any changes you make to this form **Questions? Call 1-800-621-6360**

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	**Group Policies** G-14884/14885/14886	GROUP INSURANCE CERTIFICATE #
	SOCIAL SECURITY NO.	DATE OF BIRTH (mm/dd/yyyy)

MEMBER'S FULL NAME	❒ MALE ❒ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.

BILLING ADDRESS	MARITAL STATUS: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner Maiden Name_____ Date of Marriage_____

CITY	STATE	ZIP CODE	OFFICE PHONE

FAX NUMBER	E-MAIL ADDRESS	HOME PHONE

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: ❒ Yes ❒ No **Spouse/Domestic Partner:** ❒ Yes ❒ No If yes, Country _____ How Long?_____

MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS

ANNUAL EARNED INCOME $	OCCUPATION (Please specify type of practice or other occupation if not practicing)	
VETERINARY COLLEGE	YEAR OF GRADUATION	AVMA MEMBERSHIP #

ATTENTION STUDENT MEMBERS: Are you enrolled for and attending a full schedule of classes? ❒ Yes ❒ No
If No, please explain_____

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS lawful Spouse/Domestic Partner (DP) and unmarried, dependent children less than age 23 (age 26 for Hospital Indemnity Insurance) *Attach a separate signed and dated sheet to provide additional dependents*

FULL NAME: Spouse/DP SS#:_____	DATE OF BIRTH	SEX	HEIGHT	WEIGHT
Spouse/DP		☐ Male ☐ Female	FT. IN.	LBS.
Child 1		☐ Male ☐ Female	FT. IN.	LBS.
Child 2		☐ Male ☐ Female	FT. IN.	LBS.
Child 3		☐ Male ☐ Female	FT. IN.	LBS.
Child 4		☐ Male ☐ Female	FT. IN.	LBS.

BENEFICIARY DESIGNATION *(If necessary, attach separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect to a) all the insurance on my life under the Family Group Term Life, Basic Protection and/or Large Scale AD&D Insurance Plan(s) being applied for under this application, and if I am already covered under the Plan(s), I hereby revoke any prior beneficiary designation; b) ONLY the insurance issued as a result of this application for Group 10-Year Level Term Life Insurance/20-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy *(If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other 10- or 20-Year Term Life Insurance Certificate, contact the Trust Office at the number provided below). 1) If naming more than one beneficiary, note if each is to be primary and/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.*

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /

CITY	STATE	ZIP CODE

Please Bill Me:	❒ Quarterly	❒ Semi-Annually	❒ Monthly Electronic Funds Transfer (EFT)*	❒ Credit Card*

Application continued – see following page

* Upon receiving your approval letter, please login to www.AVMALife.org or contact Customer Service at 1-800-621-6360, 8 AM – 8 PM, Monday – Friday, to select your method of payment and submit your information.

I HEREBY APPLY FOR THE COVERAGE CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION: (Refer to brochure or certificate for eligibility, options and coverage descriptions)

NOTE: If you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

AGGREGATE LIFE INSURANCE LIMITS: The maximum coverage available to an individual under all (3) three life insurance plans combined may not exceed $2,000,000.

☐ **10-Year Term Life Insurance** ❒ New Application ❒ Please change my coverage

Member coverage available from $100,000 up to $2,000,000 in units of $10,000 …… $ _____

Spouse/Domestic Partner coverage available from $100,000 up to $1,000,000 in units of $10,000…… $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 .... $ _____

☐ **20-Year Term Life Insurance** ❒ New Application ❒ Please change my coverage

Member coverage available from $100,000 up to $2,000,000 in units of $10,000 …… $ _____

Spouse/Domestic Partner coverage available from $100,000 up to $1,000,000 in units of $10,000 …… $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 …….. $ _____

☐ **Family Group Term Life Insurance**

Member coverage available from $100,000 up to $2,000,000 in units of $10,000 …… $ _____

Spouse/Domestic Partner coverage available from $100,000 up to $1,000,000 in units of $10,000 …… $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 …….. $ _____

LIFE INSURANCE QUESTIONS Must Be Completed if applying for Life Insurance (including Basic Protection Package)

Do you have other life insurance in force? **Member:** ❒ Yes ❒ No **Spouse/Domestic Partner (DP):** ❒ Yes ❒ No

If "Yes," total amount in all companies: Member: $_____ Spouse/DP: $_____

Do you have other insurance applications pending? If "Yes," indicate amount and company:

Member: ❒ Yes ❒ No Amount $_____ Company_____

Spouse/Domestic Partner: ❒ Yes ❒ No Amount $_____ Company_____

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance (including Basic Protection Package)

Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

Residents of New York: I have read the Important Replacement Information below. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK

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 you decide whether the replacement is in your best interest.

Please Initial and date any changes you make on this form

Application continued – see following page

COVERAGE SELECTION (CONTINUED)

☐ Disability Income (DI) Insurance

❒ New Application ❒ Please change my coverage

☐ **Long Term Disability (LTD) Insurance**

- **Waiting Period** (**Plan 2:** 30 day, **Plan 3:** 90 day, **Plan 4:** 180 day, **Plan 5:** 60 day)…… **Plan** _____
- **LTD Monthly Benefit** ($1,000 to $12,500 in $100 units) …… $_____
- **Optional LTD Benefits** - By checking the boxes below, I hereby apply for the following Optional Benefits

❒ Future Purchase Option (FPO) – ($500 to $7,000 in $100 units)…… $_____

❒ Cost of Living Adjustment (COLA) Option

❒ "Own Occupation Plus" Definition Option

☐ **Short Term Disability (STD) Insurance**

- **Waiting Period** (**Plan 1:** 1st Day Accident/8th Day Sickness, **Plan 2:** 30 Day)…… **Plan** _____
- **STD Monthly Benefit** ($200 to $5,000 in $100 units) …… $_____

Do you have in force or are you applying for any other disability income insurance? ❒ Yes ❒ No
If so, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

☐ Basic Protection Package (only available with Long-Term Disability*)

❒ New Application ❒ Please change my coverage

The Basic Protection Package includes**: Decreasing Term Life ♦ Accidental Death & Dismemberment ♦ Rabies Prophylaxis Benefits ♦ Monthly Long-Term Disability Income***

*Please complete the Long Term Disability Income section above – (Waiting Period and Monthly Income Benefit are required fields)

☐ Professional Overhead Expense (POE) Insurance

❒ New Application ❒ Please change my coverage

- **POE Waiting Period/Maximum Benefit Period** (**Plan 1:** 15 day/12 month, **Plan 2:** 30 Day/24-month) Plan _____
- **POE Monthly Benefit** ($300 to $45,000 in $100 Units) …… $_____

1. What was your average monthly amount of eligible overhead expenses in the past 6 months? _____
2. If practicing as a partnership or corporation, for what percentage of these were you responsible? _____%
3. What was your average number of employees in the past 6 months? _____

☐ Supplemental DI Insurance (for Educational Expense Obligations)

❒ New Application ❒ Please change my coverage

Monthly Supplemental Disability Benefit Amount ($200 to $2,000 in $100 units) …… $_____
(Total Monthly Benefit amount may not exceed required Monthly Payment rounded up to the next higher $100)

Maximum Benefit Period: …… ❒ 5 Years ❒ 10 Years

Name of Financial Institution: _____

Date Loan Initiated:_____ Length of Loan Repayment: _____months

Required Monthly Payment: $_____ NOTE: Must Attach Copy of Financial Statement for Loan

(*If necessary, attach separate signed and dated sheet if more than one loan. Include all the above information for each loan)*

☐ Hospital Indemnity

❒ New Application ❒ Please change my coverage

Member Daily Benefit amount available from $100 to $400 in $50 units …… $ _____

Spouse/Domestic Partner Daily Benefit amount available from $100 to $400 in $50 units …… $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage.)

Child(ren) Daily Benefit amount available from $100 to $200 in $50 units …… $ _____

THIS QUESTION MUST BE ANSWERED FOR HOSPITAL INDEMNITY COVERAGE TO BECOME EFFECTIVE:
Do you understand that the Hospital Indemnity Plan will not pay benefits for a confinement resulting from any condition which required medical care or treatment during the 12 months preceding an insured individual's effective date unless the confinement begins after he or she has been continuously insured for at least 12 months? ❒ Yes ❒ No

☐ Large Scale Accidental Death & Dismemberment Insurance

❒ New Application ❒ Please change my coverage

Member coverage up to $200,000 principal sum …… $ _____

Spouse/Domestic Partner coverage up to $100,000 Principal Sum …… $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage at time of application.)

Please Initial and date any changes you make on this form

Application continued – see following page

MEDICAL HISTORY **Please indicate the best contact number for a Service Provider to contact you and/or your spouse on behalf of New York Life Insurance Company for Medical History.** (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)			
Member	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile	**Spouse /Domestic Partner**	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile

I request the group insurance shown on page(s) 2 and/or 3 of this application. 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. 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 on any supplemental forms, and that any material 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 insurance will become effective on the day approved by New York Life if I am alive on that date; the initial contribution is paid within 31 days after the date I am billed; I and any approved dependents are actively performing the normal activities of a person in good health of like age on the effective (residents of NC "performing normal activities" is replaced by the requirement that health status remains the same as stated on the application); and for Disability and Overhead Insurance only, I am actively working 20 or more hours per week.

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company or 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, 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.

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 plan 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 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, I acknowledge that I, or my authorized agent or representative, may request a copy of this signed AUTHORIZATION.

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 in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated on the attached; 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.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL.

IF I AM APPLYING FOR HOSPITAL INDEMNITY INSURANCE I HEREBY ATTEST THAT I AM PURCHASING THIS COVERAGE AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Member's Signature_____ Date_____

Spouse's/Domestic Partner's Signature _____ Date_____
(Necessary only if Spouse/Domestic Partner coverage is requested)

Fraud Notices

Please read before signing the application form

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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.

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 and 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 (applicable to Accident and Health Insurance only)**:** 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 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.

Please retain a copy for your records

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for AVMA LIFE Trust Group Insurance Coverage

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 a 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, of the 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 (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 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.*

New York Life Insurance Company 8.12ed