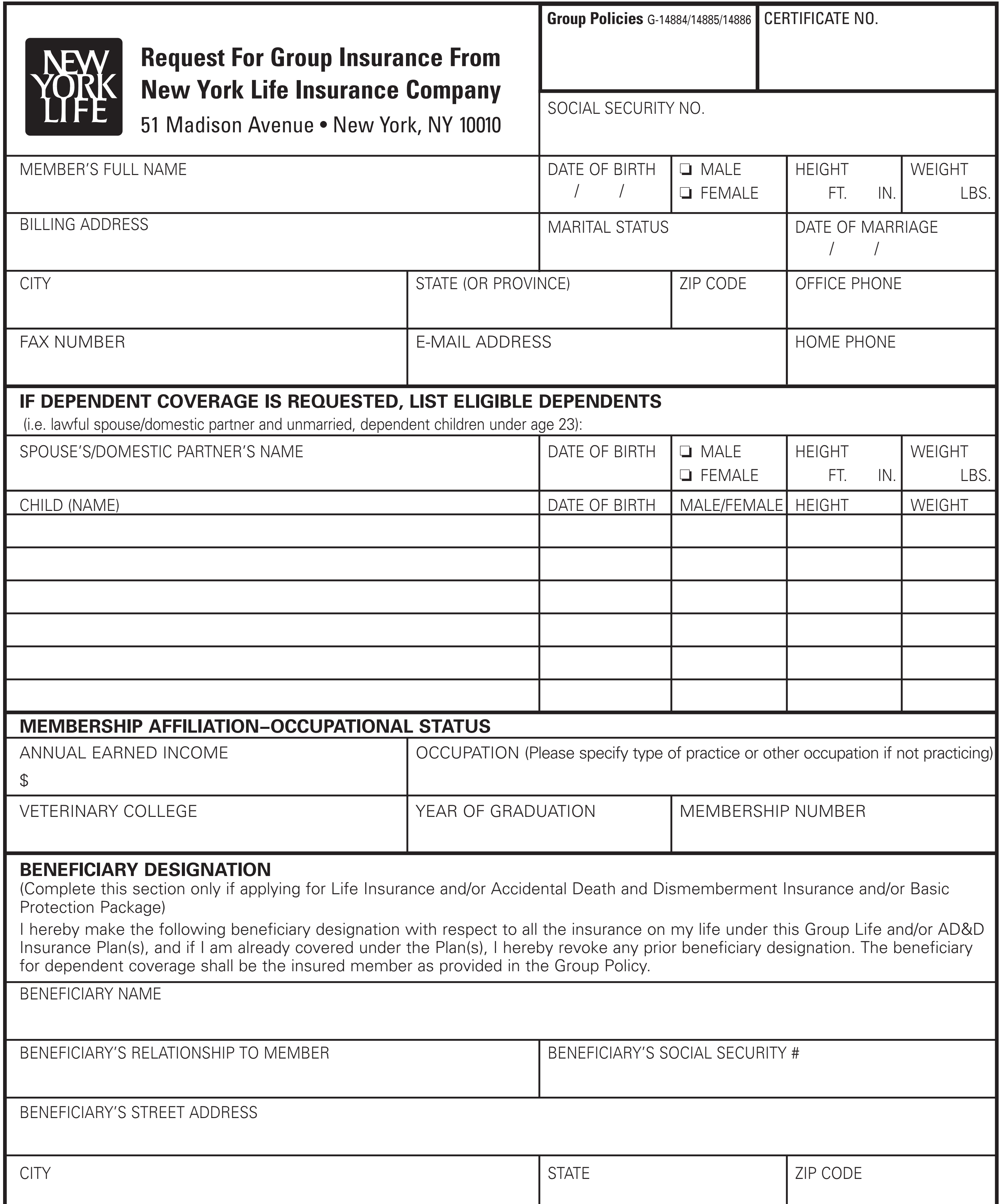
Over 50 Years of Service

AVMAGHLIT

Group Health & Life Insurance Trust Programs

Application • Enrollment Form For AVMA GHLIT Group Insurance Program



Request For Group Insurance From New York Life Insurance Company

51 Madison Avenue • New York, NY 10010

Group Policies G-14884/14885/14886	CERTIFICATE NO.
SOCIAL SECURITY NO.	

MEMBER'S FULL NAME	DATE OF BIRTH / /	❏ MALE ❏ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
BILLING ADDRESS	MARITAL STATUS		DATE OF MARRIAGE / /	

CITY	STATE (OR PROVINCE)	ZIP CODE	OFFICE PHONE
FAX NUMBER	E-MAIL ADDRESS		HOME PHONE

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS
(i.e. lawful spouse/domestic partner and unmarried, dependent children under age 23):

SPOUSE'S/DOMESTIC PARTNER'S NAME	DATE OF BIRTH	❏ MALE ❏ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
CHILD (NAME)	DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT

MEMBERSHIP AFFILIATION–OCCUPATIONAL STATUS

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

BENEFICIARY DESIGNATION
(Complete this section only if applying for Life Insurance and/or Accidental Death and Dismemberment Insurance and/or Basic Protection Package)

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life and/or AD&D Insurance Plan(s), and if I am already covered under the Plan(s), I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy.

BENEFICIARY NAME		
BENEFICIARY'S RELATIONSHIP TO MEMBER	BENEFICIARY'S SOCIAL SECURITY #	
BENEFICIARY'S STREET ADDRESS		
CITY	STATE	ZIP CODE

G-14884/14885/14886 (NC)

Application continued – see following page

Once completed and dated, this should be submitted at once to:
AVMA Group Health & Life Insurance Trust
P.O. Box 30475 • Tampa, FL 33630-3475 • Phone: 1-800-621-6360

Form GPA-AC-1

15121 GEN 6410 5/08

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)

☐ **New Application** ☐ **Please change my coverage**

☐ Health Coverage Plans (please check only one)

Traditional Major Medical Plan

Please check deductible desired:

Plan D ❑ $750 **Plan X** ❑ $1,500 **Plan Y** ❑ $5,000

Check Whom to Cover: ❑ Member ❑ Spouse/Domestic Partner ❑ Children

PPO Plans

Please check deductible desired:

Gold Plan I ❑ $500 **Bronze Plan J** ❑ $1,000

Check Whom to Cover: ❑ Member ❑ Spouse/Domestic Partner ❑ Children

Please Check if you wish to select Optional Maternity Benefits: ❑ Yes ❑ No

PPO Value Plans

Please check deductible desired:

Plan K ❑ $500 **Plan L** ❑ $1,000 **Plan R** ❑ $2,500 **Plan T** ❑ $5,000

Check Whom to Cover: ❑ Member ❑ Spouse/Domestic Partner ❑ Children

Please Check if you wish to select Optional Maternity Benefits: ❑ Yes ❑ No

High Deductible HSA-Qualified Plans

Please check deductible desired:

❑ $1,500 Deductible (member only) ❑ $3,000 Deductible (family including member)
❑ $2,600 Deductible (member only) ❑ $5,200 Deductible (family including member)
❑ $3,500 Deductible (member only) ❑ $7,000 Deductible (family including member)
❑ $5,000 Deductible (member only) ❑ $10,000 Deductible (family including member)

Check Whom to Cover: ❑ Member ❑ Spouse/Domestic Partner ❑ Children

Requested Effective Date:
If you have a preference please indicate effective date of coverage (In no event will coverage become effective on a date (a) earlier than the date the application is received by the Trust Office or (b) later than 60 days after the application has been signed) ____________ Mo/Day/Year

Is this coverage meant to replace any other medical care insurance which is in force for at least 18 months (with no break in coverage of more than 63 days) on yourself or any other person to be insured? ❑ **Yes** ❑ **No**

If yes, please attach a copy of the Certificate of Creditable Coverage from the previous insurance plan.

❑ Disability Insurance

❑ Disability Income Plan Waiting Period (**Plan 2** — 30 day, **Plan 3** — 90 day, **Plan 4** — 180 day) Plan ____________
❑ Monthly Long Term Disability Income Benefits ($1,000 to $10,000 in $100 Units) $____________
❑ Future Purchase Option ($500 to $2,000 in $100 Units) $____________
❑ Long Term Disability Cost of Living Adjustment (COLA) Option
❑ Long Term Disability “Own Occupation Plus” Definition Option

❑ Short Term Disability Plan Waiting Period (**Plan 1** — 1st Day Accident/8th Day Sickness, **Plan 2** — 30 Day) Plan ____________
❑ Short Term Monthly Income Benefit ($200 to $5,000 in $100 Units) $____________

❑ Basic Protection Package

Monthly Long Term Disability Income, Decreasing Term Life, Accidental Death & Dismemberment and Rabies Prophylaxis Benefits.

Please complete the Monthly Long Term Disability Income (amount and waiting period) sections above.

Is the insurance applied for intended to replace, discontinue or change (does not include increases to existing coverage) an existing policy? ❑ Yes ❑ No

G-14884/14885/14886 (NC)

Application continued – see following page

Life Insurance

Total life insurance issued under AVMA GHLIT cannot exceed $1,000,000 on one individual. Total dependent children life insurance cannot exceed $10,000 on any one child.

Residents of New York: Please contact AVMA Trust office if applying for GHLIT Life Insurance for the appropriate application form.

Residents of all other states: Is the Life insurance applied for intended to replace, discontinue or change (does not include increases to existing coverage) an existing policy? ❏ Yes ❏ No

❏ **10-Year Term Life Insurance***

Member

Member coverage available from $100,000 up to $1,000,000 in units of $10,000 $ ___________

Spouse/Domestic Partner

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.

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***

Member

Member coverage available from $100,000 up to $1,000,000 in units of $10,000 $ ___________

Spouse/Domestic Partner

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.

Child(ren)

Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 $ ___________

*Applicants for this coverage must complete questions on page 6.

❏ **Family Group Life Insurance** – Only available to SAVMA members and graduating student members.

MEMBER: ❏ Non-Smoker ❏ Smoker SPOUSE/DOMESTIC PARTNER: ❏ Non-Smoker ❏ Smoker

$100,000 of Member Coverage and $___________

Spouse/Domestic Partner coverage ($50,000) $___________

Either $5,000 or $10,000 for each child $___________

For graduating student members: if coverage amounts are desired in excess of these maximum amounts, 10-Year or 20-Year Term Life Insurance must be applied for.

❏ **Large Scale Accidental Death and Dismemberment Insurance**

Up to $200,000 Principal Sum for Member and up to $100,000 for Spouse/Domestic Partner not to exceed amount on Member (in $10,000 Units)

❏ Member Principal Sum $___________

❏ Spouse/Domestic Partner Principal Sum $___________

❏ **Professional Overhead Expense Insurance**

❏ POE Plan Maximum Benefit Period (**Plan 1** – 15-day/12-month, **Plan 2** – 30-day/24-month) Plan ___________

❏ POE monthly benefit amount ($300 to $20,000 in $100 units) $___________

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

❏ **Hospital Indemnity** (From $100 Daily Benefit to $400 Daily Benefit in $50 Units)
Amount on Spouse/Domestic Partner and Children may not exceed amount on Member (Children maximum Daily Benefit is $200)
NOTE: If only applying for this coverage answer question 11 only.

❏ Member Daily Benefit $___________

❏ Spouse/Domestic Partner Daily Benefit $___________

❏ Child(ren) Daily Benefit $___________

G-14884/14885/14886 (NC)

Form GPA-AC-1

Please Bill Me: ❏ Quarterly ❏ Semi-Annually ❏ Monthly Electronic Funds Transfer (EFT)

Application continued – see following page

ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED:

(NOTICE TO MAINE RESIDENTS: You are not required to disclose whether you have been tested for HIV if you have not developed symptoms of the disease, AIDS or AIDS Related Complex (ARC).)

Question	Yes	No
1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 20 or more hours per week at your usual place of business?	❑	❑
2. Do you have in force or are you applying for any other disability income insurance? If so, indicate companies, type and amounts below: Company ______ Benefit Amount ______ ______ ______ ______ ______	❑	❑
3. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	❑	❑
4. Are you or any other person to be insured now ill, receiving or contemplating medical attention or surgical treatment?	❑	❑
5. During the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury?	❑	❑
6. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health?	❑	❑
7. Is any person to be insured now pregnant?	❑	❑
8. During the past 5 years, has any person to be insured had: a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	❑	❑
b. Arthritis, back trouble, bone or joint disorder?	❑	❑
c. Fainting spells, convulsions, or epilepsy?	❑	❑
d. Sugar, blood, albumin or pus in urine?	❑	❑
e. Diabetes, kidney trouble, ulcers or digestive disorder?	❑	❑
f. Disorder of breasts or reproductive organs or functions?	❑	❑
g. Nervous or mental disorder, emotional condition or psychiatric care?	❑	❑
h. Cancer, tumor or cyst?	❑	❑
i. Varicose veins, hemorrhoids or hernia?	❑	❑
j. Disorder of eyes, ears, nose or sinuses?	❑	❑
k. Thyroid, liver or respiratory disorder?	❑	❑
l. Alcoholism or drug habit?	❑	❑
m. Disorder of the blood? *"Disorder of the blood" includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease).*	❑	❑
n. Other health or physical impairment including: (i) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Condition (ARC)? *ARC (AIDS RELATED COMPLEX) is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression, or other psychoneurotic disorders with no known cause.*	❑	❑
(ii) Any other disorder of the immune system? *"Disorder of the immune system" includes hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, the immune-deficiency disorders, both congenital and acquired. Also included are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others.*	❑	❑
(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years?	❑	❑
(iv) Any other impairment?	❑	❑

9. Have you or your spouse/domestic partner (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?

Member ❑ Yes ❑ No Spouse/Domestic Partner ❑ Yes ❑ No

If yes, when did you last use tobacco or nicotine products?

Member ______________________ (Mo/Yr) Spouse/Domestic Partner ______________________ (Mo/Yr)

10. If you have answered Question 1 "No," or any of the other Questions "Yes," give complete details below. (Attach a separate sheet if necessary, and 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 Practitioners and Hospitals where confined or treated

11. NOTE: 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

ATTENTION: STUDENT MEMBERS

ARE YOU NOW ENROLLED FOR AND ATTENDING A FULL SCHEDULE OF CLASSES? ❑ Yes ❑ No

IF NO, PLEASE EXPLAIN: ______________________________

NOTICE TO CALIFORNIA RESIDENTS: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

G-14884/14885/14886 (NC)

Application continued – see following page

I request the group insurance shown on pages 2 and 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, and that such insurance may be subject to any impairment restriction(s) established by New York Life. 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 that any 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 (a) medical insurance will become effective on the first of the month following 30 days after the date of receipt of the application by the Trust Office unless a Requested Effective Date is indicated on page 2 of this form, in which case the effective date will be the later of the Requested Effective Date indicated (provided it does not exceed 60 days after the date the application is signed) or the date received by the Trust Office. (b) all other insurance will become effective on the day approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age and sex on the date insurance is effective. I also understand that except for major medical coverage: (a) any person who was not performing his or her normal activities on the day insurance would otherwise become effective, will not become insured until the date he or she is performing such activities provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance, and (b) any dividend apportioned to the group policy will be paid to the Trustees of the American Veterinary Medical Association Group Health and Life Insurance Trust.

I also understand that for major medical insurance in the event I cannot provide evidence that I, or if applicable, my dependent(s) had 18 months of creditable medical coverage (with no break in coverage of more than 63 days), that benefits will not be paid for up to 12 months after the effective date of coverage for losses due to a disease or condition which I or my dependent(s) now have or have had whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the effective date of this coverage.

I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). **I understand** that the information provided may include information that may predate the time frame stated on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without any further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by the AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

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 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 agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage I or my authorized agent will receive a copy of this signed AUTHORIZATION, and that in all circumstances, I or my authorized agent may request a copy of this AUTHORIZATION.

Member's Signature X ______________________________ Date ______________

(Please sign in ink)

To the best of my knowledge and belief the statements made regarding my health are true and complete.

Spouse's/Domestic Partner's Signature X ______________________________ Date ______________

(Necessary only if spouse/domestic partner coverage is requested)

G-14884/14885/14886 (NC)

Form GPA-AC-1

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 in the third degree.

Residents of AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH & PA: 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 is a crime and subjects such person to criminal and civil penalties. **For 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. **For residents of DC**, the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **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. **Residents of PR:** 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 extenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

BEFORE YOU MAIL THIS APPLICATION, it will greatly speed action on your application if you will review it carefully. Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strike-outs, these must be initialed by the member.

AGENT'S NAME Bert Jacobs AGENT'S NUMBER 638

NEW YORK LIFE

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

Supplemental Application For AVMA GHLIT 10-YEAR and 20-YEAR TERM LIFE INSURANCE PLANS

Request for Group Insurance From *New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010*
(NOT APPLICABLE TO RESIDENTS OF NEW YORK)

For PREFERRED RATE consideration answer all of the following questions:

1. Have one or more of your or any person to be insured's parents, brothers, or sisters experienced angina, stroke or heart trouble prior to age 60? ❑ Yes ❑ No
If yes, give relationship, age at onset, details of history.
____
____
____

2. Within the past two years have you or any person to be insured participated in, or do you or any person to be insured participate in, aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, motorcycle racing, rodeo riding, snowmobiling, any type of motorized racing, hang gliding, parasailing or bungee jumping? ❑ Yes ❑ No
Driver's license number: ______________________ State which issued ______________
Spouse's/Domestic Partner's driver's license number: ______________ State which issued ______________
(necessary if applying for spouse/domestic partner coverage)

3. Has your, or any person to be insured, driver's license been suspended or revoked within the last five years? ❑ Yes ❑ No
If yes, give date(s) and reason(s)
____
____
____

4. In the last seven years have you or any person to be insured been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? ❑ Yes ❑ No
If yes, give details
____
____
____

I hereby declare that to the best of my knowledge, the statements made above are true and complete. I authorize New York Life Insurance Company or the plan administrator to obtain my, and my spouse's/domestic partner's, (if applying for coverage) Motor Vehicle Record for the sole purpose of underwriting this application for insurance coverage. This authorization shall be valid until two years after the effective date of any insurance coverage for which this authorization was required and can be revoked at any time by writing the Administrator at the address shown on the primary application. A photocopy of this authorization shall be as valid as the original. I understand that I may request a copy of this authorization.

Member's Name ______________________ Social Security No. ______________
First MI Last

Spouse's/Domestic Partner's Name ______________________ Social Security No. ______________
First MI Last
(necessary if applying for spouse/domestic partner coverage)

To the best of my knowledge and belief the statements above are true and complete.
Member's Signature ______________________ Date ______________

To the best of my knowledge and belief the statements above are true and complete.
Spouse's/Domestic Partner's Signature ______________________ Date ______________
(necessary if applying for spouse/domestic partner coverage)

G-14885/14886

SEND NO MONEY NOW!
Complete this Supplemental Application, only if applying for Preferred Rates.

GMA-Pref