AMERICAN OPTOMETRIC ASSOCIATION

Group Long-Term Disability Income Insurance Plans
APPLICATION
For Members of the American Optometric Association

Official Member No.: _____

Name: _____

Address: _____

City, State, Zip: _____

To Apply, Please Complete and Return to:
AOA Insurance Program
P.O. Box 26860
Phoenix, AZ 85068-9961

NEW YORK LIFE

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Ave., New York, NY 10010

Phone: 1.866.331.0180

1 Member Information:

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Member Name: (FULL NAME: FIRST - M.I. - LAST)

Address:

City, State, Zip:

Home Phone: ( ) – Office Phone: ( ) – Fax: ( ) –

Social Security #: – – Height: ft. in. Weight: lbs. Sex: ◯ Male ◯ Female

Date of Birth: – – (MONTH DAY YEAR) Email Address: (For internal use only. Email addresses will never be sold or shared.)

MEMBERSHIP AFFILIATION—OCCUPATIONAL STATUS:

a. Are you now a Member of the AOA? ◯ Yes ◯ No

Member #:

b. Are you now an Employee of a Member of the AOA? ◯ Yes ◯ No

Member #:

c. What is your occupation? Main Duties?

d. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties normally are performed, or other location to which travel is required. Are you at FULL-TIME WORK? ..... ◯ Yes ◯ No

e. Gross Annual Income from Salary: $, Bonus: $, Commission: $,

f. Self-Employment: $, Self-Employment Start Date: – – (MONTH DAY YEAR) Total: $,

Be Sure to Complete All Pages and Sign Last Page

Send no money with this application.

1 Member Information (Continued)

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? If "Yes" please list: (Attach a separate sheet if necessary, sign and date)

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

2 Insurance Requested: (refer to brochure for eligibility, options, and coverage description)

I hereby apply for the coverages checked below, based upon all my statements made in this application:
Monthly Benefit: $_____(from $500 to $10,000 per month in $100 units). Please note: You may choose any Monthly Benefit Option provided it and other disability income coverage you may have does not exceed 60% of your GROSS MONTHLY EARNED INCOME (as defined in the Brochure). Members under age 45 and in practice for 6 months or less maximum monthly benefit amount is $2,000.

Plan (check one): ○ 2-Year Plan ○ 5-Year Plan ○ To Age 65 Plus Plan
Waiting Period (check one): ○ 45 days ○ 60 days ○ 90 days ○ 180 days ○ 365 days

EMPLOYEE OF AN AOA MEMBER
2-Year Plan 90-day waiting period. Monthly Benefit: $_____ (from $100 to $3,000 per month in $100 units)

3 Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you:

	YES	NO
A. Are you now ill or taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment?	○	○
B. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:	○	○
1. heart or circulatory trouble: elevated blood pressure; chest pain or pressure; gynecological or genitourinary disorders; disorder of breast or reproductive organs or functions; ulcers or digestive disorders; cancer; tumor or cyst; diabetes; mental or nervous disorder; emotional conditions; psychiatric care or psychotherapeutic treatment; fainting spells; convulsions or epilepsy; respiratory disorder; kidney or liver disorder (including hepatitis); enlarged lymph nodes or immunodeficiency disorder; thyroid disorder; blood disorder; albumin, blood, pus or sugar in urine; back trouble/disorder; arthritis; bone or joint disorder; varicose veins; hemorrhoids or hernia; disorder of eyes, ears, nose or sinuses; unexplained weight loss or accidental injury?	○	○
2. other health or physical impairment including (in the past five years):		
a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○	○
b. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue?	○	○
c. Any other impairment?	○	○
C. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	○	○
D. Are you now pregnant?	○	○
E. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	○	○
F. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or any type of organized motorcycle racing?	○	○

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Be Sure to Complete All Pages and Sign Last Page

Send no money with this application.

3 Statement of Health: Please initial any changes you make on this form. *(Continued)*

G. Your Driver's License No.: _____ State Issued: ____

H. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations? . . . . . ○ ○

I. Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)? . . . . . ○ ○

If "Yes," Please state when you last used tobacco or nicotine products and specify the product used.

Member: Product _____ **Date** (Mo/Dy/Yr): __ – __ – ____

J. **Except for the residents of Minnesota and Connecticut,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ○ ○

K. **For residents of Minnesota and Connecticut only,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years? . . . . . ○ ○

If you have answered "Yes" to any Questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

QUESTION LETTER/#	NAME(S) OF PROPOSED INSURED	ILLNESS OR CONDITION	DATE OF ONSET	DURATION	TREATMENT/ OPERATIONS	DEGREE OF RECOVERY	DATE	NAME AND ADDRESS OF PHYSICIANS OR OTHER MEDICAL CARE PRACTITIONERS OR HOSPITALS WHERE CONFINED OR TREATED

4 Fraud Notice:

FRAUD NOTICE

FRAUD NOTICE – *For Residents of all states <u>except</u> those listed below:* 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.

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

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4 Fraud Notice: *(Continued)*

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 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.

AUTHORIZATION

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 my 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, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

X _____ **Date:** ☐☐ – ☐☐ – ☐☐☐☐
MONTH DAY YEAR

Member's Signature (PLEASE SIGN AND DATE IN INK)

G-31051-0

Be Sure to Complete All Pages and Sign This Page

Once completed and dated, this should be submitted at once to the AOA Group Insurance Office at: AOA Group Insurance Program
P.O. Box 26860, Phoenix, AZ 85068-9961 • 1-866-331-0180

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