


Enrollment Form

AVMA GHLIT Student Group Insurance Program

 Request For Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010		Group Policy G-14884		CERTIFICATE NO.	
		SOCIAL SECURITY NO.			
		DATE OF BIRTH / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
MEMBER'S FULL NAME		MARITAL STATUS		DATE OF MARRIAGE / /	
BILLING ADDRESS					
CITY		STATE		ZIP CODE	
MAILING ADDRESS					
CITY		STATE		ZIP CODE	
HOME PHONE		FAX NUMBER		E-MAIL ADDRESS	
IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS (i.e. lawful spouse/domestic partner and unmarried, dependent children under age 26):					
SPOUSE'S/DOMESTIC PARTNER'S NAME		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
CHILD (NAME)		DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT
MEMBERSHIP AFFILIATION-STUDENT STATUS:					
		Membership Number _____			
Veterinary College _____		Year of Graduation _____			
BENEFICIARY DESIGNATION: (Complete this section only if applying for Life Insurance and Long Term Disability Insurance.) I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan.					
BENEFICIARY NAME					
BENEFICIARY'S RELATIONSHIP TO YOU			SOCIAL SECURITY NO.		
BENEFICIARY'S STREET ADDRESS					
CITY		STATE		ZIP CODE	

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Application continued – see following page

I HEREBY APPLY FOR THE COVERAGE(S) CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:

☐ **STUDENT PPO MAJOR MEDICAL PLAN:**

Please check if you wish to select Optional Maternity Benefits: ☐ Yes ☐ No

(Not applicable in CA, MN, and MT; Maternity is already covered as any other illness.)

COVERAGE DESIRED: ☐ Member ☐ Spouse/Domestic Partner ☐ Child(ren)

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.

☐ **HOSPITAL INDEMNITY PLAN:**

(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 10 only.

☐ Member Daily Benefit \$ _____

☐ Spouse/Domestic Partner Daily Benefit \$ _____

☐ Child(ren) Daily Benefit \$ _____

☐ **\$100,000 GROUP TERM LIFE INSURANCE PLAN and \$500/MONTH LONG TERM DISABILITY INCOME PLAN (Maximum Benefit Period 5 Years • 30 Day Waiting Period):**

Residents of New York:

I have read the Important Replacement Information on page 4 of this application.

Is the Life insurance applied for intended to replace in whole or in part, any existing life insurance or annuity? ☐ Yes ☐ No

Residents of all other states:

Is the insurance applied for intended to replace, discontinue or change an existing life insurance policy? ☐ Yes ☐ No

STUDENT MEMBER DECLARATION: I declare that I am (a) a student member of the American Veterinary Medical Association, (b) attending veterinary school as a full-time student, (c) under age 65 and not currently insured for Life or Disability Income insurance under the AVMA GHLIT Insurance Program. I understand that insurance will become effective on the date my request for insurance is received by the AVMA GHLIT Trust Office provided, (a) I am performing the normal activities of a person in good health of like age on the date such insurance would take effect, and (b) the initial contribution is paid within 31 days of the date I am billed. I also understand that 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 understand that for Disability Income coverage, benefits will not be paid during the first six months of coverage following the effective date for a disability resulting from a disease, injury or condition for which I consulted a doctor, received medical services or supplies or took medication during the six month period immediately preceding the effective date of this coverage.

(Please sign in ink)

Member's Signature X

Date _____

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

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Form GPA-AC-1 as amended by GMA-5-NYFR

PLEASE BILL ME: ☐ Quarterly ☐ Semi-Annually ☐ Monthly (Electronic Funds Transfer (EFT) only).

Application continued – see following page

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

	Yes	No		Yes	No
1. Are you now enrolled for and attending a full-schedule of classes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
2. 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?	<input type="checkbox"/>	<input type="checkbox"/>	i. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you or any other person to be insured now ill, receiving or contemplating medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	j. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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?	<input type="checkbox"/>	<input type="checkbox"/>	k. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. 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?	<input type="checkbox"/>	<input type="checkbox"/>	l. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	m. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past 5 years, has any person to be insured had:			n. Other health or physical impairment including:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>	(i) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Condition (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
b. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>	(ii) Any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
c. Fainting spells, convulsions, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
d. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>	(iv) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
e. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	8. 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 12 months?		
f. Disorder of breasts or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>	Member	<input type="checkbox"/>	<input type="checkbox"/>
g. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	Spouse/Domestic Partner	<input type="checkbox"/>	<input type="checkbox"/>
			If yes, when did you last use tobacco or nicotine products?		
			Member _____ Spouse/Domestic Partner _____		
			Mo/Yr _____ Mo/Yr _____		

9. If you have answered Question 1 "No," or any of the other Questions "Yes," give complete details below. (Attach a separate sheet if necessary, sign and date.)

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:

10. 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

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.

I **request** the group insurance shown on the previous page. 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 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 Student PPO 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, if the initial contribution is paid within 31 days after the date I am billed and all other coverages will be effective on the date of receipt of the application. I also understand that 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 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 the 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. 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, or insurance company 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. 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). New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. I understand that the information provided may include information that may predate the timeframe stated in the medical questions section on this application. New York Life may release information covered by this 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 I or my authorized agent will receive a copy of this signed AUTHORIZATION.

FOR NY RESIDENTS ONLY

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 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.

FRAUD WARNING STATEMENT FOR NY RESIDENTS: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(Please sign in ink)

Member's Signature X Date _____

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

Form GPA-AC-1 as amended by GMA-5-NYFR

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, 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.

AGENT'S NAME _____ AGENT'S NUMBER _____

ENROLLMENT FORM MUST BE COMPLETED, DATED, AND SIGNED.

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

02-1210