AVMA | LIFE
Veterinarian Inspired Coverage

NEW YORK LIFE

Application • 45+ Term Life Advanced Insurance 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-14884-5	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 ❒ Domestic Partner ❒ Divorced ❒ Widowed 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 #

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

lawful Spouse/Domestic Partner (DP) from age 45 through 74

FULL NAME: Spouse/DP SS#:_____	DATE OF BIRTH	SEX	HEIGHT	WEIGHT
Spouse/DP		☐ 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 all the insurance on my life under the Group 45+ Term Life Advanced Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation; The automatic beneficiary for spouse/domestic partner is the insured member.
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

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.

☐ **Group 45+ Term Life Advanced Insurance** New Application ❒ Please change my coverage

Member coverage available from $25,000 up to $100,000 in units of $1,000 $ _____

Spouse/Domestic Partner coverage available from $25,000 up to $100,000 in units of $1,000 $ _____
(Your spouse/domestic partner coverage may not exceed 100% your own coverage at time of application)

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.**

TOBACCO / NICOTINE USE: Must Be Completed

Have you used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)? **Spouse/Domestic Partner:** ❒ Yes ❒ No

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

Member: ❒ Yes ❒ No If yes, month/year last used _____ Product _____

Spouse/Domestic Partner: ❒ Yes ❒ No If yes, month/year last used _____ Product _____

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.

STATEMENT OF HEALTH: To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse/domestic partner (if applying for coverage)

A. Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? …….. ❒ Yes ❒ No

B. During the past five years has any person proposed for insurance 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, or unexplained weight loss? ……. ❒ Yes ❒ No

C. During the past five years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs? ……..... ❒ Yes ❒ No

D. During the past five years has any person proposed for insurance suffered from incontinence or required assistance in bathing, toileting, dressing, eating, cooking or transferring? ……. ❒ Yes ❒ No

E. Has any person proposed for insurance had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for: cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? ……. ❒ Yes ❒ No

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

Proposed Insured?	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

Please Initial and date any changes you make on this form

Application continued – see following page

Applicants Age 60 and over who are applying for a coverage amount of $50,000 or more - Please indicate the best number for a Service Provider to contact you on behalf of New York Life Insurance Company to ask questions about your Medical History.	
Member	Contact #_____ (choose one) ☐ Residence ☐ Business ☐ Cell Phone
Spouse /Domestic Partner (if applying for coverage)	Contact #_____ (choose one) ☐ Residence ☐ Business ☐ Cell Phone

I **request** the group insurance shown on page 1. 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.

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 **attests** 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 knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature_____ Date_____

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

Application continued – see following page

Once completed and dated, this should be submitted at once to*:
AVMA LIFE Trust Program Administrator
1200 E. Glen Ave. ♦ Peoria Heights, IL 61616-5384 • Phone: 1-800-621-6360

*Residents of Puerto Rico - please send your completed application to
Global Insurance Agency, Inc., P.O. Box 9023919, San Juan, PR 00902-3918

AGENT'S NAME_____ AGENT'S NUMBER_____

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 ALAR/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 (for 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