AVMA | LIFE
Veterinarian Inspired Coverage

NEW YORK LIFE

Application • Enrollment Form for SAVMA Graduating Student Members

Limited-time Offer: Open enrollment begins 60 days prior to graduation and ends 30 days after graduation.

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

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	**Group Policies** G-14884-0 G-14884-6 G-14884-7	GROUP INSURANCE CERTIFICATE #
	SOCIAL SECURITY NO.	

MEMBER'S FULL NAME	DATE OF BIRTH	❒ MALE ❒ FEMALE

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

CITY	STATE	ZIP CODE	HOME PHONE
BILLING ADDRESS			
CITY	STATE	ZIP CODE	MOBILE PHONE

FAX NUMBER	EMAIL ADDRESS	BUSINESS PHONE

SEND CORRESPONDENCE TO: (bills, certificates and other correspondence) ❒ Home ❒ Billing

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 – STUDENT STATUS

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

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:	**DATE OF BIRTH** MM / DD / YYYY	**SEX**
Spouse/DP		❒ MALE ❒ FEMALE

Child (Name)	Date of Birth		Child (Name)	Date of Birth	
1.		❒ MALE ❒ FEMALE	3.		❒ MALE ❒ FEMALE
Child (Name)	Date of Birth		Child (Name)	Date of Birth	
2.		❒ MALE ❒ FEMALE	4.		❒ MALE ❒ FEMALE

BENEFICIARY DESIGNATION

(if necessary attach a 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 Term Life Insurance and Accidental Death & Dismemberment Plan(s) being applied for on this application form, 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. 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, 7 AM – 7 PM Central, 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(s) for eligibility, options and coverage descriptions.

☐ Disability Income Insurance (Select Coverage and complete all requested information)

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

- Waiting Period (**Plan 2:** 30 day, **Plan 3:** 90 day, **Plan 4:** 180 day, **Plan 5:** 60 day) **Plan** _____

- Monthly Benefit ($1,000 to $2,500 in $100 units**)** $_____

- Optional LTD Benefits - By checking the boxes below, I hereby apply for the following Optional Benefits

- ❒ Future Purchase Option (FPO) - $1,500/month (not to exceed monthly LTD benefit)
- ❒ Cost of Living Adjustment (COLA) Option
- ❒ "Own Occupation Plus" Definition Option

☐ **Short Term Disability (STD) Insurance – Up to $500 Monthly Benefit ♦ 6 month Benefit Period**

- Waiting Period (**Plan 1:** 1st Day Accident/8th Day Sickness, **Plan 2:** 30 Day) **Plan** _____

- Monthly Benefit ($200 to $500 in $100 units**)** $_____

☐ Basic Protection Package (only available if applying for Long-Term Disability*)

The Basic Protection Package includes:

Decreasing Term Life ♦ Accidental Death & Dismemberment ♦ Rabies Prophylaxis Benefits ♦ and Monthly Long-Term Disability Income*

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

☐ Family Group Term Life Insurance (check all that apply)

- ❒ **Member** Coverage: $100,000
- ❒ **Spouse/Domestic Partner** coverage: $50,000 (only available if member coverage is selected)
- ❒ **Dependent Child(ren)** coverage: (select one) ❒ $5,000 ❒$10,000 (only available if member coverage is selected)

☐ Large Scale Accidental Death and Dismemberment Insurance (check all that apply)

- ❒ **Member** coverage: $100,000 principal sum
- ❒ **Spouse/Domestic Partner** coverage: $50,000 principal sum (only available if member coverage is selected)

☐ Hospital Indemnity Insurance (Check Boxes to indicate who will be covered)

$100/day for graduate and eligible dependent

NOTE: Daily benefits for hospitalization for Normal Pregnancy will not be paid until the covered person has been insured under the policy for at least nine consecutive months.

❒ **Member** ❒ **Spouse/Domestic Partner*** ❒ **Child(ren)*** ***only available if member coverage is selected**

☐ Critical Illness Insurance (Check Boxes to indicate who will be covered)

- ❒ **Member** coverage: $10,000 principal sum
- ❒ **Spouse/Domestic Partner** coverage: $5,000 principal sum (only available if member coverage is selected)

☐ Professional Overhead Expense (POE) Insurance - $300 Monthly Benefit

Maximum Benefit Period (**Plan 1:** 15 day/12 month, **Plan 2**: 30 Day/24-month) **Plan** _____

☐ Supplemental Disability Income Insurance (for Educational Expense Obligations)

Monthly Benefit Amount from $200 to $500 in $100 units $_____

(Total Monthly Benefit amount may not exceed required Monthly Payment rounded up to the next higher $100)

Maximum Benefit Period (Must Attach Copy of Financial Statement for Loan if applying for 10 year Plan) ❒ 5 Years ❒ 10 Years

Name of Financial Institution: _____

Date Loan Initiated:_____ Length of Loan Repayment: _____months

Required Monthly Payment: $_____

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

Please Initial and date any changes you make on this form **and sign page 3**

Application continued – see following page

TOBACCO / NICOTINE USE: Must be completed if applying for Life and Disability Insurance (Including Basic Protection and Supplemental DI)

Have you or your spouse/domestic partner (if applying for coverage) used tobacco or any nicotine substitute **in any form** within the past 24 months (including nicotine patches, nicotine chewing gum and electronic cigarettes)? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

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

Member:_____ _____ Spouse/Domestic Partner:_____ _____
month/year Product month/year Product

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/Domestic Partner:** ❒ 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/Domestic Partner:** ❒ 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.

I request the group insurance shown on Page 2. 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 insurance will become effective the later of the date of graduation or the date approved by New York Life, 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.

HOSPITAL INDEMNITY INSURANCE AND CRITICAL ILLNESS 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.

By signing and dating this application, the member and any person proposed for insurance **request** the insurance indicated; **understand** the effective date criteria; and **attest** to having read the Fraud Notices indicated on page 4; and that to the best of my/our knowledge and belief, the answers to the questions are true and complete.

IF I AM APPLYING FOR HOSPITAL INDEMNITY INSURANCE I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY 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)

Application continued – see following page

AGENT'S NAME_____ AGENT'S NUMBER_____

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

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 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.