

ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE ENROLLMENT FORM



Request for Group Insurance from:
 New York Life Insurance Co.
 51 Madison Avenue
 New York, NY 10010



To apply:
 Complete Form
 Mail To:
 Pediatrics Insurance Consultants, Inc.
 300 S. Wacker Dr.
 Suite 2800
 Chicago, IL 60606-6703

Any Questions?
 Please Call
 1-800-257-3220 or
 1-312-419-9700

American Academy of Pediatrics



Enrollment form for members of the American Academy of Pediatrics.

DEDICATED TO THE HEALTH OF ALL CHILDREN™

1. Member Information *(Please print in ink or type all answers.)*

Group Policy Number: **G29190**

Last		First	Initial	Social Security No.	
Billing Address: Street		City	State	ZIP Code	
Home Address: Street		City	State	ZIP Code	
Home Phone Number		Office Phone Number	Fax Number		
Date of Birth					

Send correspondence to: Home Address Billing Address

2. Dependent Information

If dependent coverage is requested, list eligible dependents such as lawful spouse and unmarried, dependent children under age 23 (under age 25 if full time student). California residents who wish to request coverage for a Domestic Partner should contact the Administrator for a Declaration of Domestic Partnership.

Proposed For Insurance (First, Middle Initial, Last)	Country of Residence	Date of Birth			Sex	
		Mo.	Day	Yr.		
Spouse:					<input type="checkbox"/> M	<input type="checkbox"/> F
Child:					<input type="checkbox"/> M	<input type="checkbox"/> F
Child:					<input type="checkbox"/> M	<input type="checkbox"/> F

3. Insurance Requested

(Refer to the brochure for eligibility, options and coverage description)

I hereby apply for the following coverage: Group Accidental Death and Dismemberment Insurance

- a) Total Member amount desired: \$
 Member coverage is available from \$100,000 to \$500,000 in \$25,000 increments.
- b) Family Coverage: Yes No
 Spouse coverage 50% of insured member coverage and/or
 Child coverage \$10,000 each child. Six months to age 23 (25 if full time student)

Does any person proposed for insurance intend to reside outside the U.S. or Canada in the next 12 months?
 Member Yes No (Country _____) Spouse Yes No (Country _____)
 If yes, for how long? _____

4. Beneficiary Designation - California residents do not enter social security number below.

I make the following beneficiary designation with respect to all the insurance on my life under this Group AD&D Insurance Plan. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy(ies). (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 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: Last First Middle Initial Relationship Social Security No.

Beneficiary's Address: Street City State/Province ZIP Code

I request the group insurance shown on this form. 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: (a) insurance will become effective on the first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I am actively performing any and all duties of my occupation and any approved dependents are actively performing the normal activities of a person in good health of like age on the approval date (with respect to N.C. residents performing the normal activities of a person of like age); (b) any person who is not performing such duties/activities as required will not become insured until the day he/she is performing such duties/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 (c) any dividend apportioned to the group policy will be paid to the Trustee of the American Academy of Pediatrics.

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 D.C.,** 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 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 LA:** 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 NY:** For AD&D 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 state value of the claim for each such violation. **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 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.

Member's Signature X _____ Date ____/____/____
(Please sign and date in ink)

Spouse's Signature X _____ Date ____/____/____
(Necessary only if spouse coverage is requested)

Arkansas Insurance Producer License Number 235028
California Insurance Producer License Number 0F52897

For the purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada.