

GROUP OFFICE OVERHEAD EXPENSE APPLICATION

For Members of the American Academy of Pediatrics Group Insurance Trust

Request for Group Insurance from:

New York Life Insurance Co.
51 Madison Ave.
New York, NY 10010



To apply:

Complete Form

Mail To:

Pediatrics Insurance Consultants, Inc.
300 S. Wacker Dr.
Suite 2000
Chicago, IL 60606-6736



Any Questions?

Call
1-800-257-3220
or
312-419-9700



1. Member's Full Name, Mailing Address, and Information: (Please print in ink or type all answers.)

Last _____ First _____ Middle _____

Street Address _____ City _____ State _____ ZIP _____

() _____ () _____

Home Phone _____ Business Phone _____

/ / _____ / / _____

Member's Date of Birth _____ Social Security Number _____

Height: _____ ft. _____ in. Weight: _____ lbs. Sex: Male Female

Do you intend to reside outside the U.S. or Canada in the next 12 months?
If yes, for how long? _____

2. Membership Application — Occupational Status

A. Are you a member of the AAP? Yes, Member ID: _____ No
Are you currently insured under the AAP program? Yes No

B. What is your occupation? _____
Main Duties _____

C. "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 20 hours per week at the place such duties are normally performed.
Are you at FULL-TIME WORK? Yes No

D. What was the average monthly total of Eligible Overhead Expenses you incurred in the preceding 12 months? (Complete the attached worksheet to determine Eligible Overhead Expenses):
\$ _____

E. What type of business? Sole Proprietor Corporation Partnership

F. If corporation or partnership, for which percent of the monthly Eligible Overhead Expenses are you responsible? _____%

3. Insurance Requested — Insurance Status: (Refer to brochure for eligibility, options and coverage descriptions)

I hereby apply for the coverage indicated below, based upon all my statements made in this application.

A. **Monthly Benefit Option** \$ _____ (\$1,000 to \$10,000 in \$100 increments)

B. Benefit Period: 12 months 24 months

C. Do you now have or are you now applying for other business/office overhead insurance which provides benefits if you are unable to work because of disability? Yes No **If Yes, Please List**

Company	Plan	Monthly Benefit	Benefit Period

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

- TO THE BEST OF YOUR KNOWLEDGE AND BELIEF, ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU.** Yes No
1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?
 2. 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:
 - a) 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?
 - b) Other Health or physical impairment including:
 - (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
 - (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?.....
 - (iii) Any other impairment?
 3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?
 4. Are you now pregnant?
 5. 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?.....
 6. During the past two years, have you participated in, or plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?
 7. Driver's License No.: _____
State in which issued: _____
 8. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?
 9. **Except for the residents of Minnesota and Connecticut**, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?
For residents of Minnesota and Connecticut only, have you 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 any of the above questions "Yes," give complete details below. (Attach a separate sheet, if necessary, sign and date.) Please avoid the use of such terms as "etc.," "various," or "miscellaneous."

Illness or Condition • Date of Onset • Duration • Treatment • Operation • Degree of Recovery and Date:	Name and Address of Physicians or Other Practitioners and Hospitals Where Confined or Treated:

FRAUD NOTICES

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 AR/LA/MD: 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.

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 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.

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.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, or insurance company 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 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member **requests** the insurance indicated; and the member **consents** to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and **attests** to having read the IMPORTANT NOTICE and Fraud Notices, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

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

Brokers for the AAP Group Insurance Trust



Pediatrics Insurance Consultants, Inc.
300 S. Wacker Drive
Suite 2000
Chicago, IL 60606-6736
800-257-3220
312-419-9700

Call toll free
☎ 1-800-257-3220



Underwritten by
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Policy Form GMR-FACE-G46622

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.