

GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE 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	Initial	Social Security No. / /
Mailing Address ()	City	State ()	ZIP Code
Age	Home Phone	Business Phone	
Name if Proposed for Insurance		Date of Birth Mo./Day/Yr.	Height
			Weight lbs.
Member: _____		/ /	__ ft. __ in. _____
Spouse: _____		/ /	__ ft. __ in. _____
Child(ren): _____		/ /	__ ft. __ in. _____
_____		/ /	__ ft. __ in. _____

If more than two children are proposed for insurance, attach a separate sheet.

2. Membership Affiliation:

- A. Are you now a member of the AAP? Yes, Member ID: _____ No
- B. Are you currently insured with the AAP? Yes No

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

- A. Total amount of coverage desired:
- | | | | | | |
|----------|--------------------------------------|------------------------------------|--|--------------------------------------|------------------------------------|
| Member | <input type="checkbox"/> \$1,000,000 | <input type="checkbox"/> \$100,000 | *Spouse | <input type="checkbox"/> \$1,000,000 | <input type="checkbox"/> \$100,000 |
| | <input type="checkbox"/> \$750,000 | <input type="checkbox"/> \$50,000 | | <input type="checkbox"/> \$500,000 | <input type="checkbox"/> \$50,000 |
| | <input type="checkbox"/> \$500,000 | <input type="checkbox"/> \$ _____ | | <input type="checkbox"/> \$375,000 | <input type="checkbox"/> \$25,000 |
| | <input type="checkbox"/> \$250,000 | | | <input type="checkbox"/> \$250,000 | <input type="checkbox"/> \$ _____ |
| Children | <input type="checkbox"/> \$15,000 | <input type="checkbox"/> \$7,500 | *Spouse coverage cannot exceed 100% of member coverage | | |

California and Nevada residents who wish to request coverage for a Domestic Partner should contact the Administrator for a Declaration of Domestic Partnership form.

- B. Is Accidental Death/Dismemberment coverage** desired? Yes No
**Available for Member only.
- C. **Residents of NY:** 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? Yes No
IMPORTANT REPLACEMENT INFORMATION FOR NEW YORK RESIDENTS 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.

Residents of all other states: Is the insurance applied for intended to replace, discontinue or change an existing policy? Yes No

- E. 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. Smoking Status:

Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form within the last 24 months?

Me: Yes No My Spouse: Yes No

If "Yes," when did you last use tobacco or nicotine products?

Member: Month_____ Year_____ Spouse: Month_____ Year_____

5. Statement of Health: (Answer the following questions as they apply to you and all dependents to be insured)

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. Are you or any person to be insured disabled or receiving any disability or workers compensation or on waiver of premium for life or health insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any person to be insured now ill, receiving or contemplating medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past 5 years, have you or any person to be insured consulted any physician or other medical care practitioner, other than for routine physical examination or checkup, been hospitalized or had an operation or had any illness, disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any other person to be insured taking any kind of medication or so far as you know in impaired physical or mental health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Are you or any person to be insured pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 5 years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for: | | |
| A. Heart or circulatory trouble, high blood pressure, pain or pressure in the chest?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Arthritis, back trouble, bone or joint disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Fainting spells, convulsions, or epilepsy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Sugar, blood, albumin or pus in urine?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Diabetes, kidney trouble, ulcers or digestive disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Disorder of the breasts, or reproductive organs or functions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| G. Nervous or mental disorder, emotional condition or psychiatric care?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| H. Cancer, tumor or cyst?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| I. Varicose veins, hemorrhoids or hernia?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| J. Disorder of eyes, ears, nose or sinuses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| K. Thyroid, liver or respiratory disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| L. Alcoholism or drug habit?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| M. Disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| N. Other health or physical impairment including: | | |
| (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past 5 years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Any other impairment?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered any of the questions "Yes," please give complete details below.
(Attach a separate sheet if necessary, sign and date)

Question No./Letter	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 Medical Care Practitioners and Hospitals where confined or treated

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 and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices on page 3, and that to the best of their knowledge and belief, the answers provided to the questions are true and complete.

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

Spouse's Signature * _____ Date _____
(Necessary only if spouse coverage is requested)

Owner Information-Required if owner is other than member

(If owner is a trust, please submit a copy of the document with this application)

Name: Last First Middle Initial Relationship to Proposed Insured Daytime Phone

Mailing Address City State/Province Zip Code Country of Residence Tax ID #

Date of Birth Social Security # Owner's Signature * _____ Date _____
(Necessary only if other than member)

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-G46330-0

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.