

# GROUP TERM LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE APPLICATION

For Employees of 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. Employee's Full Name, Mailing Address, and Information:** (Please print in ink or type all answers.)

Name of Employee: \_\_\_\_\_

Last	First	Initial	Social Security No.
			_____/_____/_____ ( )
Office Address	City	State	ZIP Code
			Business Phone ( )
Home Address	City	State	ZIP Code
			Home Phone
Date of Birth	Height	Weight	Sex
_____/_____/_____ Mo./Day/Yr.	ft. ___ in. ___	lbs. _____	<input type="checkbox"/> M <input type="checkbox"/> F

Name of Employer: \_\_\_\_\_

Last	First	Initial

**2. Membership Affiliation:**

- A. Are you currently insured under an AAP Sponsored Plan?  Yes  No
- B. Are you a full-time employee of an AAP member and working at least 30 hours per week?  
 Yes  No
- C. Date of employment \_\_\_\_\_

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

- A. I request group insurance coverage in the amount of:  \$100,000  \$50,000
- B. Is Accidental Death/Dismemberment coverage desired?  Yes  No
- 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assigned, terminated, changed or modified into paid up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or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
- D. Do you intend to reside outside the U.S. or Canada in the next 12 months?  
 Yes  No (Country \_\_\_\_\_) If yes, for how long? \_\_\_\_\_

**4. Smoking Status:**

Have you used tobacco or nicotine in any form within the last 24 months?

Me:  Yes  No

If "Yes," when did you last use tobacco or nicotine products? Month\_\_\_\_\_ Year\_\_\_\_\_

**5. Statement of Health:** *(Answer the following questions as they apply to you)*

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| 1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 30 or more hours per week at your usual place of business?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you disabled or receiving any disability or workers compensation or on waiver of premium for life or health insurance? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Are you now ill, receiving or contemplating medical attention or surgical treatment? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. During the past 5 years, have you 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"/> |
| 5. Are you taking any kind of medication or so far as you know in impaired physical or mental health? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Are you pregnant? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. During the past 5 years, have you 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	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

**6. Beneficiary Designation:** *(Insert name, relationship and address.)*

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if already covered under the Plan, I hereby revoke any prior beneficiary designations. With respect to insurance on my life:

Primary Beneficiary Name	Beneficiary's Relationship to Applicant
Secondary Beneficiary Name	Beneficiary's Relationship to Applicant

**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:** 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 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 applicant **requests** the insurance indicated; and the applicant **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 their knowledge and belief, the answers provided to the questions are true and complete.

Applicant's Signature \* \_\_\_\_\_ Date \_\_\_\_\_  
(Please sign and date in ink)

**Owner Information-Required if owner is other than applicant**

(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 applicant)

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-G46330-1

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.