Group Accidental Death & Dismemberment Enrollment Form for Members of the American Academy of Pediatrics

aap INSURANCE PROGRAM

NEW YORK LIFE

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

TO APPLY: Complete this form and return it to USI AFFINITY, 14 Cliffwood Avenue, Suite 310, Matawan, NJ 07747
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

1. MEMBER INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Fax Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - _____ Date of Birth: ____ /____ / ____ Sex: ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*

*Eligibility of Domestic Partner/Civil Union is determined by state law. (Call administrator for Declaration of Domestic Partnership form to complete and return with application. Not applicable in OR.)

Are you now a member of the American Academy of Pediatrics? ☐ Yes ☐ No If yes, Member ID#: _____

Policy eligibility is contingent upon maintaining membership in the AAP.

Do you or your spouse plan to reside outside the U.S. or Canada within the next 12 months?

Member: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. DEPENDENT INFORMATION

If you intend to apply for spouse/domestic partner or dependent child coverage, please fill out the following:

Full Name (First, MI, Last)	Country of Residence	DOB (mm/dd/yy)	Sex
Spouse:			☐ Male ☐ Female
Child:			☐ Male ☐ Female
Child:			☐ Male ☐ Female
Child:			☐ Male ☐ Female

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually ☐ Charge My Credit Card (see below):

I request and authorize AAP Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan. Please note, the charge will be listed as "USI Insurance Services" on your statement.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

4. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I WISH TO ENROLL IN THE FOLLOWING COVERAGE: **GROUP ACCIDENTAL DEATH & DISMEMBERMENT**

a) ☐ **Total Amount* Desired for Member Only Coverage:** $_____
*Choose an amount between $100,000 and $500,000 in $25,000 increments.

b) ☐ **Spouse Coverage***
*Spouse coverage will be 50% of the member coverage

c) ☐ **Dependent Child(ren) Coverage***
*Dependent child(ren) coverage will be $10,000 per child.

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Accidental Death & Dismemberment Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation: 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. (Attach a separate sheet if necessary, then sign and date.)

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #		Benefit %
				☐ Primary ☐ Secondary	
				☐ Primary ☐ Secondary	

7. AUTHORIZATIONS AND SIGNATURES:

By **signing and dating** this application, the member and spouse (if proposed for insurance) **requests** the insurance indicated and **attests** that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

Spouse Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)