Group Term Life Insurance Application for Members & Employees 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 APXJAAVCH
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

1. APPLICANT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____
Home Phone Number Office Phone Number Mobile Phone Number

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

Social Security #: ____ - ____ - _____ Date of Birth: ____ /____ / ____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union is determined by state law.

I am applying as (please check only one):

☐ a member of the American Academy of Pediatrics ID#: _____

☐ an employee of an American Academy of Pediatrics member
Member/Firm Name: _____ Employment Date: _____

Policy eligibility is contingent upon maintaining membership in the AAP.

Are you presently insured by any other AAP-sponsored coverage? ☐ Yes ☐ No

If yes, provide details: _____

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

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

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

2. DEPENDENT INFORMATION (This section is for association members only, employees of members skip to next section):

MEMBERS ONLY: If you intend to apply for spouse or dependent child coverage, please fill out the following:

Full Name (First, MI, Last)	DOB (mm/dd/yy)	Height (ft. in.)	Weight (lbs.)	Sex
Spouse:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female

3. PAYMENT OPTION (Choose only one):

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

I request and authorize AAP Insurance Program, administered by USI Affinity, to make semi-annual charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this coverage. 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 HEREBY APPLY FOR THE FOLLOWING COVERAGE: **GROUP TERM LIFE INSURANCE**

a) ☐ **Total Amount* Desired for Member Coverage:** $_____

b) ☐ **Total Amount* Desired for Spouse Coverage:** $_____

c) ☐ **Total Amount* Desired for Employee Coverage:** ☐ $50,000 ☐ $100,000

*NOTE: If you are increasing or altering present coverage in any way, do NOT indicate just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting. For member coverage, choose an amount between $10,000 and $745,000 in $5,000 increments; between $750,000 and $2,000,000 in $50,000 increments. For spouse coverage, choose an amount between $2,500 and $750,000 in $5,000 increments; between $750,000 and 2,000,000 in $50,000 increments. Spouse coverage cannot exceed member coverage.

d) ☐ **Dependent Child Coverage** ☐ $750 ☐ $1,500 for ages 14 days to 6 months
☐ $7,500 ☐ $15,000 for ages 7 months to 23 years

e) Optional Benefit Rider: Accidental Death & Dismemberment ☐ Member ☐ Employee

f) **Other Insurance:** Do you have other life insurance in force? ☐ Yes ☐ No

If yes, total amount in all companies: Applicant: $ _____ Spouse: $ _____

Do you have other life insurance applications pending? ☐ Yes ☐ No If yes, indicate amount and company:

Applicant: $ _____ Company:_____

Spouse: $ _____ Company:_____

g) **Tobacco/Nicotine Use:** Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member _____ _____ Spouse _____ _____
MO/YR Product MO/YR Product

h) **RESIDENTS OF NEW YORK—IMPORTANT REPLACEMENT INFORMATION: 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 NY: I have read the Important Replacement Information above. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life 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	

6. MEDICAL HISTORY:

Please indicate the best contact number for a Service Provider to contact you and/or your spouse/Domestic partner on behalf of New York Life Insurance Company for Medical History. (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

You may be contacted by a service provider on behalf of New York Life Insurance Company to ask about your medical history.

	Preferred Telephone	Preferred E-mail Address
Member:	( )	☐ **Residence** ☐ **Business** ☐ **Mobile**
Spouse:	( )	☐ **Residence** ☐ **Business** ☐ **Mobile**

Medical Requirements: Some, not all, members may need a physical exam, blood test, or EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly—at your convenience and without any cost to you—through our professional paramedic service. A paramedic will contact you to make an appointment.

7. AUTHORIZATIONS AND SIGNATURES:

I understand that New York Life Insurance Company 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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health 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 reinsurers, 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 for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, 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. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

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, including making a brief report of our protected health information to MIB, Inc.; and **attests** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

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

Spouse 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). For applicants not yet insured under this Group Policy, who wish to have initial ownership of any Certificate of Insurance resulting from this application owned by an individual or entity other than him/herself, complete this section.

Full Name (Last, First MI)	Relationship		Daytime Phone
Mailing Address	City	State	Zip Code
Tax ID	DOB		Social Security #
Owner's Signature (Necessary only if other than applicant.)			Date
Agent Signature			Date

FRAUD NOTICE – *For Residents of all states except those listed below and NY:* 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 AL/AR/LA/RI: 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 CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 member.

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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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 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 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 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.