AAD INSURANCE
Powered by Aon
PREFERRED PROVIDER

Application for Group Business Overhead Expense Insurance

for AAD Members

NEW YORK LIFE

Complete this form and return to:
AAD Plan Administrator ♦ Affinity Insurance Services, Inc. ♦ 1100 Virginia Drive, Suite 250 ♦ Fort Washington, PA 19034
Please print in ink or type all answers – initial and date any changes you make to this form
Questions? Call 1-888-747-6866

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	**Group Policies** G-30379-0	GROUP INSURANCE CERTIFICATE #
	SOCIAL SECURITY NO.	DATE OF BIRTH MM / DD / YYYY

MEMBER'S FULL NAME	❒ MALE ❒ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.

HOME ADDRESS	CITY	STATE	ZIP CODE

HOME PHONE #	WORK PHONE #	FAX #
E-MAIL ADDRESS		CELL PHONE #

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
☐ Civil Union* ☐ Domestic Partnership* *Eligibility determined by State Law) Maiden Name_____

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: ☐ Yes ☐ No If yes, Country _____ How Long?_____

MEMBERSHIP AFFILIATION (Membership is required to participate in this plan)

Are you a member in good standing of the American Academy of Dermatology (AAD)? ☐ Yes ☐ No

Are you presently insured by any AAD Insurance plan? ☐ Yes ☐ No If yes, indicate which plan(s) and provide details (coverage and amount)_____

BILLING OPTION SELECTION: (If you select "Bill Me" a $5.00 billing fee will be applied to all invoices)

☐ **Electronic Funds Transfer:** ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Please attach voided check or savings account deposit slip

Authorization for Electronic Funds Transfer I request and authorize Affinity Insurance Services, Inc. (LifeHealth) to make withdrawals based on my selected payment method above against the account specified on the attached voided check or savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. **In order to process your electronic payment, both the Account # and Bank Routing # must both appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/ charges for the insurance premium from my account including any increases in premium due to age.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage at the end of the 31-day grace period, effective as of the due date if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

_____ _____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

☐ **"Bill Me" Periodic Billing:** ☐ Quarterly ☐ Semi-Annual ☐ Annual

I HEREBY APPLY FOR THE COVERAGE CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE ON THIS APPLICATION:

(Refer to www.aad-insurance.com, the brochure or your certificate for eligibility, options and coverage descriptions)

Business Overhead Expense Insurance

NOTE1 If you are increasing or altering present coverage in any way, only indicate the additional amount of coverage you are applying for. Exclude the amount you may already have under the plan.

NOTE2 If you have partners, share office facilities, or are a member of a professional corporation, request a Monthly Benefit Amount equal to only your share of expenses.

Benefit Period: 24 Months **Waiting Period:** 30-day

Monthly Benefit Amount Desired (from $500 to $10,000 in $100 increments)**:** $ _____

1. What was your average monthly amount of eligible overhead expenses in past 6 months? $ _____
2. If practicing as partnership or corporation, for what percentage of these were you responsible? _____
3. What was your average number of employees in the past 6 months? $ _____
4. Do you have in force or are you applying for any other business overhead expense insurance? ☐ Yes ☐ No

If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above? ☐ Yes ☐ No If yes, indicate which, and date it will be terminated_____

OCCUPATIONAL STATUS Must be completed

What is your occupation?_____ Main Duties_____

FULL-TIME WORK means actively performing the regular deities of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ☐ Yes ☐ No

STATEMENT OF HEALTH To the best of your knowledge and belief: (please initial any changes)

1. Is any person to be insured now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	Yes ☐ No ☐
2. During the past five years, has any person to be insured 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?	Yes ☐ No ☐
b. Other Health or physical impairment including: i. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ?	Yes ☐ No ☐
ii. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	Yes ☐ No ☐
iii. Any other impairment?	Yes ☐ No ☐
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	Yes ☐ No ☐
4. Is any person to be insured now pregnant?	Yes ☐ No ☐

STATEMENT OF HEALTH (Continued)

5. Is any person to be insured 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?	Yes ☐ No ☐
6. During the past two years, has any person to be insured participated in, or does any person 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?	Yes ☐ No ☐
7. Driver's License No.: _____State in which issued: _____	
8. During the past five years, has any person to be insured had his or her driver's license suspended, or revoked, or had any moving violations?	Yes ☐ No ☐
9. Except **for the residents of Minnesota and Connecticut,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	Yes ☐ No ☐
For residents of Minnesota and Connecticut only, has any person to be insured 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?	Yes ☐ No ☐

If you have answered "Yes" to any of the questions on the previous page please give complete details below.

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 request the group insurance shown on page 2 of this application. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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.

I understand that insurance will become effective the first of the month on or following the date approved by New York Life if (a) I am alive on that date; (b) the initial contribution is paid; and (c) I and am actively working 30 or more hours per week on such date.

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

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 as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member **requests** the insurance indicated; **consents** to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB; and **attests** to having read the IMPORTANT NOTICE and Fraud Notices indicated on the attached; including how my/our information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature_____ Date_____

SEND NO MONEY NOW! If approved for coverage, you will be billed at the premium contribution level determined by medical underwriting of your application. We will notify you of your effective date and premium contribution due. Payment of premium with your application does not mean insurance is in force before the effective date determined by New York Life.

Fraud Notices *Please read before signing the application form*

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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 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 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 MD: Any person who knowingly or willfully presents a false and 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 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 (applicable to Accident and Health coverage 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.

GPA-DI-FMU

Last Page of Application
G-30379-0 OEWEB-0717

Please complete the application form and return it to the AAD Plan Administrator:*

Affinity Insurance Services, Inc. ♦ 1100 Virginia Drive, Suite 250 ♦ Fort Washington, PA 19034

*Residents of Puerto Rico - Please send your application to:
Global Insurance Agency, Inc., P.O. Box 9023918, San Juan, Puerto Rico 00902-3918.

Don't let an unanswered question delay your enrollment

Call toll free: 1-888-747-6866 ♦ **Visit:** www.aad-insurance.com

(Please retain this notice for your records)

IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request for AAD endorsed Group Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, or a claim for benefits is submitted to a MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, of the application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866- 692-6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: ***PROTECTED PERSONS***[1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION***[2] *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1] ***PROTECTED PERSON*** *means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.*

[2]***CONFIDENTIAL ABUSE INFORMATION*** *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company 7.15ed