AAD INSURANCE
Powered by Aon

PREFERRED PROVIDER

Application for Group Term Life Insurance *for AAD Members*

Complete this form and return to:
AAD Plan Administrator ♦ Affinity Insurance Services, Inc. ♦ 1100 Virginia Drive, Suite 250 ♦ Fort Washington PA 19040
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-30377-0

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 **Spouse:** ☐ 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 (person(s) insured and amount)__________________________________

____

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS lawful Spouse under age 65 and unmarried, dependent children from 15 days through age 18 (through age 22 if a full-time student) - *attach a separate signed and dated sheet to provide additional dependents*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	☐ MALE ☐ FEMALE	HEIGHT ft. in.	WEIGHT lbs.

Child (Name)	Date of Birth		Child (Name)	Date of Birth	
1.	/ /	☐ MALE ☐ FEMALE	3.	/ /	☐ MALE ☐ FEMALE
2.	/ /	☐ MALE ☐ FEMALE	4.	/ /	☐ MALE ☐ FEMALE

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

Application continued – see following page

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

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

Term Life Insurance (Members/Spouses coverage amounts available: from $50,000 up to $500,000 in $50,000 increments)

NOTE 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. The maximum amount of coverage any one person can have under all AAD Life Insurance plans combined is $1,000,000

Member Amount Desired………………………………………………………………………………. $______________

Spouse Amount Desired (not exceed member amount)……………………………………………. $______________

Child(ren) $10,000 each (limited to $1,000 from 15 days to 6 months)……………………………….. ☐ Yes ☐ No

LIFE INSURANCE QUESTIONS Must Be Completed

Do you have other life insurance in force? .... **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

If "Yes," total amount in all companies: Member: $_________________________ Spouse: $___________________________

Do you have other insurance applications pending? If "Yes," indicate amount and company:

Member: ☐ Yes ☐ No Amount $_____________________ Company________________________________

Spouse: ☐ Yes ☐ No Amount $_____________________ Company________________________________

REPLACEMENT INFORMATION Must Be Completed

Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? .... **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

Residents of New York: 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? ………….. **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK 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.

BENEFICIARY DESIGNATION *(If necessary, attach separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect all insurance on my life under the Group Term Life Insurance plan and if I am already covered I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy

NOTE: 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. If naming a trust, please indicate the full name and date of the trust.

☐ **Primary** ☐ **Secondary** **Percent of Proceeds** ___________%

BENEFICIARY NAME		BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY DATE OF BIRTH / /	
BENEFICIARY STREET ADDRESS	CITY		STATE	ZIP CODE

☐ **Primary** ☐ **Secondary** **Percent of Proceeds** ___________%

BENEFICIARY NAME		BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY DATE OF BIRTH / /	
BENEFICIARY STREET ADDRESS	CITY		STATE	ZIP CODE

Please Initial and date any changes you make on this form

If you have any questions, call toll free at **1-888-747-6866**

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

1. Is any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
3. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
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? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
5. Is any person to be insured now pregnant? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
6. During the past five 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 chest? **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   b. Arthritis, back trouble, bone or joint disorder? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   c. Fainting spells, convulsions or epilepsy? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   d. Sugar, blood, albumin or pus in urine? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   e. Diabetes, kidney trouble, ulcers or digestive disorder? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   f. Disorder of breast or reproductive organs or functions? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   g. Nervous or mental disorder, emotional conditions or psychiatric care? **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   h. Cancer, tumor or cyst? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   i. Varicose veins, hemorrhoids or hernia? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   j. Disorder of eyes, ears, nose or sinuses? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   k. Thyroid, liver or respiratory disorder? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   l. Alcoholism or drug habit? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   m. Disorder of the blood? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
   n. Other Health or physical impairment including:
      i. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
      ii. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
      iii. Any other impairment? .... **Member** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
7. Except for residents of Maryland, has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuro-muscular or mental illness? **Member** ☐ Yes ☐ No **Spouse** ☐ 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:

Application continued – see following page

Have all questions been answered? Have you initialed any changes you made on this form?
Have you provided names and addresses for all physicians or other Medical care Practitioners and Hospitals where you were treated? Attach a separate signed and dated sheet for any additional information you need to provide.

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 (b) I and any approved dependents must be actively performing the activities of a person in good health of like age and sex on the date coverage is effective. *(Residents of NC: Any reference to "performing normal activities" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application).*

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; 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 my/our protected health information to MIB; and **attest** 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/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature______________________________ Date__________________

Spouse's Signature ______________________________ Date__________________
(Necessary only if Spouse coverage is requested)

Application continued – see following page

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.

BEFORE YOU MAIL THIS APPLICATION it will greatly speed action on your application if you review it carefully, Corrections or strikeouts must be initialed by the member.

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

Affinity Insurance Services, Inc.

1100 Virginia Drive, Suite 250 ♦ Fort Washington,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

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 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.

GMA-PR1

Last Page of Application
G-30377-0
TLWEB-0717

The AAD Insurance Program is administered by Affinity Insurance Services, Inc. (TX 13695); (AR 100106022); in CA & MN, AIS Affinity Insurance Agency, Inc. (CA 0795465); in OK, AIS Affinity Insurance Services Inc.; in CA, Aon Affinity Insurance Services, Inc. (CA 0G94493); Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY, AIS Affinity Insurance Agency.

CA Insurance License # 0795465

(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