

Group Business Overhead Expense Insurance APPLICATION

For Members of the American Optometric Association

/	,	1
Official Me	nber No.:	
Name:		
Address: _		
City, State,	Zip:	

To Apply, Please Complete and Return to:

AOA Insurance Program P.O. Box 26860 Phoenix, AZ 85068-9961

Phone: 1.866.331.0180



Request for Group Insurance from: New York Life Insurance Company 51 Madison Ave., New York, NY 10010

Member Information: Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.							
Member Name: (FULL NAME: FIRST - M.I LAST)							
Address:							
City, State, Zip:							
Home Phone: () Fax: () - Fa							
Social Security #: Height: ft. in. Weight: Ibs. Sex: Male Female							
Date of Birth: ————————————————————————————————————							
MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS:							
a. Are you now a Member of the AOA? Yes No Member #:							
b. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties normally are performed, or other location to which travel is required. Are you at							
FULL-TIME WORK?							
c. Gross Annual Income from Salary: \$, Bonus: \$, Commission: \$,							
d. Self-Employment: \$ Self-Employment Start Date: MONTH DAY YEAR Total: \$, , ,							

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Send no money with this application.

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COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD	
Insurance Requeste	d: (refer to brochure for e	ligibility, options, an	d coverage descript	ion)
	checked below, based upon all my sta (from \$100 to \$15,000 per		ion:	
Vaiting Period (check one): 15 d	ays 🔾 30 days			
Practicing as: Ocorporation Average number of Employees	•	•		
Statement of Healtl	ո։ Please initial any chanց	jes you make on this	form.	
o the best of your knowledg	e and belief, please answer the fo	llowing questions as they		. IN
A. Are you now ill or taking any բ surgical treatment?	prescribed medications or receiving o	r contemplating any medical a	YES attention or	S N
A. Are you now ill or taking any p surgical treatment? B. During the past five years, hav practitioner as having or been	orescribed medications or receiving o ve you ever been medically diagnosed treated for:	r contemplating any medical a	YES attention or cal care	
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Statement	of Health: P	lease i	nitial a	ny changes	you m	ake on t	this form. <i>(Continued)</i>
G. Your Driver's Lic	ense No:						State Issued:
H. During the past	five years, have you	had your	driver's li	cense suspende	d, or revoke	ed, or had a	any moving violations? \bigcirc
I. Tobacco/Nicotine	Use: Have you or y	our spous	e (if prop	osed for covera	ge) used tol	bacco or ar	ny nicotine substitute in
any form (includi	ng nicotine patches	and nicoti	ne chewi	ng gum and elec	tronic cigar	ettes)?	
If "Yes," Please s	tate when you last u	sed tobaco	co or nicc	tine products ar	nd specify th	ne product	used.
Member: Product				Date (Mo/Dy/Y	′r):		
prison because	of a conviction or ha	ive an arre	st pendin	ıg?			onvicted of a crime or served time in
	Minnesota and Con prison because of a contract						st 15 years?
	nswered "Yes" ssary, sign and		Questi	ons, give co	omplete	details	below. (Attach a separate
QUESTION NAME(S) OF PROPOSED INSURE	D ILLNESS OR CONDITION	DATE OF ONSET	DURATION	TREATMENT/ OPERATIONS	DEGREE OF RECOVERY	DATE	NAME AND ADDRESS OF PHYSICIANS OR OTHER MEDICAL CARE Practitioners or hospitals where confined or treated
	-						
Fraud Not	ice:						

FRAUD NOTICE

FRAUD NOTICE – *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 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: For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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 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.

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Fraud Notice: (Continued)

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: <u>For accident and health insurance only</u>, 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.

AUTHORIZATION

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, LLC ("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 NewYork 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, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. 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 above and in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, LLC; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the guestions are true and complete.

Member's Signature (PLEASE SIGN AND DATE IN INK

X	Date:		_	_			Τ
Once completed and dated, this should be submitted at once t	0	MONTH	I DAY	-	,	YEAF	ł

the AOA Group Insurance Office at the address below.

AOA Group Insurance Program • P.O. Box 26860 • Phoenix, AZ 85068-9961 • 1-866-331-0180

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