

**Residents of Puerto Rico, please return application to:**

Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

# GROUP CRITICAL ILLNESS INSURANCE PLAN

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

## 1. AI PROFESSIONAL INFORMATION

Full Name \_\_\_\_\_ Social Security Number \_\_\_\_\_

Street Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Fax Number \_\_\_\_\_

Email (For internal use only. Email address will never be sold or shared.) \_\_\_\_\_

Please check one:  Home Address  Business Address Are you presently enrolled in this plan?  Yes  No

Marital Status:  Married  Divorced  Widowed  Single  Civil Union\* \*Eligibility of Civil Union partners is determined by State Law.

	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
AI Professional (Full Name):	/ /	ft. in.	LBS.	<input type="radio"/> M <input type="radio"/> F
Spouse (Full Name):	/ /	ft. in.	LBS.	<input type="radio"/> M <input type="radio"/> F

I am an AI Professional:  Yes  No If yes, Membership # \_\_\_\_\_

Do you have any existing insurance coverage through AIIT? If yes, indicate which plan(s) and provide details \_\_\_\_\_

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?  Yes  No

AI Professional: Country(ies) \_\_\_\_\_ Length of Stay \_\_\_\_\_

Spouse: Country(ies) \_\_\_\_\_ Length of Stay \_\_\_\_\_

## 2. PAYMENT OPTION (Choose only one)

OPTION 1: PERIODIC BILLING  Quarterly  Semi-Annual  Annual OPTION 2: Electronic Funds Transfer (EFT)  Monthly  Quarterly  Semi-Annual  Annual

## 3. INSURANCE REQUESTED: Refer to plan brochure for eligibility, options, and coverage descriptions.

I hereby apply for CRITICAL ILLNESS INSURANCE:  New  Addition

NOTE: If you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

A. Total Member Amount Desired (\$5,000 to \$100,000 in \$5,000 increments) \$ \_\_\_\_\_

B. Total Spouse Amount Desired (Spouse coverage cannot exceed member coverage) \$ \_\_\_\_\_

## 4. FAMILY HISTORY

Have you or your spouse had a parent, brother, or sister who, prior to age 60, had cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? If "Yes", give complete details below. (Attach a separate sheet if necessary, then sign and date it.)

Name(s) of Proposed Insured	Relative	Disease / Illness	Age at Onset	Age at Death	Age if Living

## 5. STATEMENT OF HEALTH (Please initial any changes you make on this form)

To the best of your knowledge and belief answer the following questions as they apply to you and your spouse.	AI PROFESSIONAL	SPOUSE
1. Are you or your spouse now ill, or receiving or contemplating any medical attention or surgical treatment? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
2. Are you or your spouse taking any kind of medication or, so far as you know, in impaired physical or mental health? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
3. Have you or your spouse used tobacco or nicotine in any form, including patch or gum, within the past 24 months? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
4. During the past five years, have you or your spouse ever been medically diagnosed by a physician as having or been treated for:		
A. Heart attack, heart or circulatory trouble, high blood pressure, pain or pressure in chest? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
B. Organ transplant? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
C. Stroke? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No
D. Coma? .....	<input type="radio"/> Yes <input type="radio"/> No	<input type="radio"/> Yes <input type="radio"/> No

**5. STATEMENT OF HEALTH Continued** (Please initial any changes you make on this form)

- |   |  |  |
|---|--|--|
|   | AI PROFESSIONAL                                    | SPOUSE   |
| E. Cancer, carcinoma in situ, tumor, or cyst? .....   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| F. Dementia or problems with memory or ability to think or reason? .....  | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| G. Diabetes, kidney trouble, ulcers, or digestive disorder? .....   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| H. Thyroid, liver, or respiratory disorder? .....   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| I. Alcoholism or drug habit? .....  | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| J. Disorder of the blood, except for HIV? .....   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| K. Blindness or glaucoma or partial or total loss of hearing in one or both ears; partial or total loss of speech, motor neuron disease, or paralysis? .... | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| L. Other health or physical impairment including: .....   | <input type="radio"/> Yes <input type="radio"/> No | <input type="radio"/> Yes <input type="radio"/> No |
| (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC); immune system?                            |  |  |
| (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?  |  |  |
| (iii) Any other impairment?   |  |  |

If you answered “Yes” to any of the above questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it).

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 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.

**6. FRAUD NOTICE** (please read before signing the application for insurance)

**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. **FOR 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 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. **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 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 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:** 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.

## 7. IMPORTANT NOTICE

**How New York Life obtains information and underwrites your request for AIT-Endorsed Group Critical Illness 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, LLC (“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 an 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, on this 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 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. If you have requested enrollment for critical illness coverage, New York Life may use or disclose information about you without further written authorization from you as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by your AUTHORIZATION.

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, LLC, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website at [www.mib.com](http://www.mib.com).

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean there is any insurance in force before the effective date is determined by New York Life.

For NM Residents: PROTECTED PERSONS<sup>1</sup> have a right of access to certain CONFIDENTIAL ABUSE INFORMATION<sup>2</sup> we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSONS 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.

<sup>1</sup> PROTECTED PERSONS 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.

<sup>2</sup> 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 8.12ed

## 8. AUTHORIZATION AND SIGNATURE

**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 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, 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 [below, 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.**

**THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.**

AI Professional’s Signature (Please Sign and Date in Ink)

Date

Spouse’s Signature (Please Sign and Date in Ink)

Date

(Necessary only if spouse coverage is requested)

232038