



Complete this form and return to: **Vivian R. Wright, 508 Ashcroft, Spring Creek, NV 89815**

Please print in ink or type all answers – initial and date any changes you make to this form **Questions? Call: 877.224.0925**

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010		Group Policies G-14884-6		GROUP INSURANCE CERTIFICATE #	
		SOCIAL SECURITY NO.		DATE OF BIRTH (mm/dd/yyyy)	
MEMBER'S FULL NAME			<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
BILLING ADDRESS		MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Domestic Partner Maiden Name _____ Date of Marriage _____			
CITY		STATE	ZIP CODE	OFFICE PHONE	
FAX NUMBER	E-MAIL ADDRESS			HOME PHONE	
Do you intend to reside outside the U.S. or Canada in the next 12 months? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse/Domestic Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, Country _____ How Long? _____					
MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS					
ANNUAL EARNED INCOME \$		OCCUPATION (Please specify type of practice or other occupation if not practicing)			
VETERINARY COLLEGE		YEAR OF GRADUATION	AVMA MEMBERSHIP #		
ATTENTION STUDENT MEMBERS: Are you enrolled for and attending a full schedule of classes? <input type="checkbox"/> Yes <input type="checkbox"/> No If No, please explain _____					
SPOUSE/DOMESTIC PARTNER INFORMATION					
FULL NAME		DATE OF BIRTH	SEX <input type="checkbox"/> Male <input type="checkbox"/> Female	HEIGHT FT. IN.	WEIGHT LBS.
PROTECTION AGAINST UNINTENDED LAPSE					
I UNDERSTAND THAT I HAVE THE RIGHT TO DESIGNATE AT LEAST ONE PERSON OTHER THAN MYSELF TO RECEIVE NOTICE OF LAPSE OR TERMINATION OF THIS POLICY I UNDERSTAND THAT SUCH NOTICE WILL NOT BE GIVEN UNTIL, 30 DAYS AFTER A PREMIUM IS DUE AND UNPAID. <input type="checkbox"/> I designate the following person to receive such notice <input type="checkbox"/> I elect NOT to designate any person to receive such notice Name _____ Address _____ Phone _____					
INSURANCE REQUESTED (Refer to brochure or certificate for eligibility, options and coverage descriptions)					
I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): <input type="checkbox"/> New Application <input type="checkbox"/> Please change my coverage NOTE: If you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the <u>TOTAL AMOUNT</u> of coverage you are requesting					
Critical Illness Insurance					
Member coverage available from \$10,000 up to \$100,000 in units of \$5,000 \$ _____ Spouse/Domestic Partner coverage available from \$10,000 up to \$100,000 in units of \$5,000 \$ _____ (Your spouse/domestic partner coverage may not exceed your own coverage at time of application)					
PAYMENT OPTIONS					
Please bill me: <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Monthly Electronic Funds Transfer (EFT)* <input type="checkbox"/> Credit Card*					

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* Upon receiving your approval letter, please login to www.AVMALife.org
or contact Customer Service at 1-800-621-6360, 8 AM – 8 PM, Monday – Friday,
to select your method of payment and submit your information.

FAMILY HISTORY

Have you or your Spouse/Domestic Partner (DP) 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

MEDICAL HISTORY Please indicate the best place, days and times for a Service Provider to contact you and/or your spouse on behalf of New York Life Insurance Company for Medical History. (choose one from each section)

	<u>Member</u> <input type="checkbox"/> Yes <input type="checkbox"/> No	<u>Spouse/DP</u> <input type="checkbox"/> Yes <input type="checkbox"/> No
1) Are you or your Spouse/DP now ill, or receiving or contemplating any medical attention or surgical treatment?		
2) Are you or your Spouse/DP taking any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3) Have you or your Spouse/DP used tobacco or nicotine in any form, including patch or gum, within the past 24 months?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
4) During the past five years, have you or your Spouse/DP 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="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) Organ Transplant?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c) Stroke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) Coma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e) Cancer, carcinoma in situ, tumor or cyst?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f) Dementia or problems with memory or ability to think or reason?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g) Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h) Thyroid, liver or respiratory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i) Alcoholism or drug habit?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j) Disorder of the blood, except for HIV?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l) Other health or physical impairment including:		
i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC); immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
iii) Any other impairment?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered "Yes" to any Question above, 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:

Have all questions been answered?
Please Initial and date any changes you make on this form

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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. 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, and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I **understand** that insurance will become effective on the day approved by New York Life if I am alive on that date; the initial contribution is paid within 31 days after the date I am billed; I and any approved dependent are actively performing the normal activities of a person in good health of like age on the effective (residents of NC "performing normal activities" is replaced by the requirement that health status remains the same as stated on the application

I also **understand** that (a) a Critical Illness that is classified as a Pre-existing condition will not be covered under this plan. "Preexisting Condition" means any condition that was diagnosed or treated by a physician within 12 months prior to the becoming insured under this plan or produced symptoms within 12 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or treatment); and (b) benefits will not be paid for a Critical Illness diagnosed during the first 30 days of coverage.

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.

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the plan administrator in writing at the address given on this form. My 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 this 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, I acknowledge that I, or my authorized agent or representative, may request a copy of this signed AUTHORIZATION.

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.

THIS INSURANCE 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.

Member's Signature _____ Date _____

Spouse's/Domestic Partner's Signature _____ Date _____
(Necessary only if Spouse/Domestic Partner coverage is requested)

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Once completed and dated, this should be submitted at once
to*: Vivian R. Wright
508 Ashcroft, Spring Creek, NV 89815, Phone: 877.224.0925

*Residents of Puerto Rico - please send your completed application to
Global Insurance Agency, Inc., P.O. Box 9023919, San Juan, PR 00902-3918

AGENT'S NAME Vivian R. Wright AGENT'S NUMBER XAV000260

Fraud Notices

Please read before signing the application form

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: 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: 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.

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IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for AVMA LIFE Trust Group Insurance Coverage

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 (TTY 866 346-3642). 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.

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.