AVMA | LIFE
Veterinarian Inspired Coverage

NEW YORK LIFE

Application • AVMA LIFE Trust Student Group Insurance Program

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 POLICY G-14884	GROUP INSURANCE CERTIFICATE #
	SOCIAL SECURITY NO.	
MEMBER'S FULL NAME	DATE OF BIRTH / /	❒ MALE ❒ FEMALE
BILLING ADDRESS	MARITAL STATUS: ❒ Married ❒ Single ❒ Domestic Partner (DP) ❒ Divorced ❒ Widowed Maiden Name_____ Date of Marriage_____	
CITY	STATE	ZIP CODE
MAILING ADDRESS		CELL PHONE
CITY	STATE	ZIP CODE

HOME PHONE	FAX NUMBER	EMAIL ADDRESS

Do you intend to reside outside the U.S. or Canada in the next 12 months?

Member: ❒ Yes ❒ No **Spouse/Domestic Partner:** ❒ Yes ❒ No If yes, Country _____ How Long?_____

MEMBERSHIP AFFILIATION – STUDENT STATUS

VETERINARY COLLEGE	YEAR OF GRADUATION	SAVMA MEMBERSHIP # (if pending checking pending box) ❒ Pending

ARE YOU ENROLLED FOR AND ATTENDING A FULL SCHEDULE OF CLASSES? ❒ Yes ❒ No

IF NO, PLEASE EXPLAIN_____

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

Applies to Hospital Indemnity Insurance Only - Lawful Spouse/Domestic Partner (DP) and unmarried, dependent children under age 26

Attach a separate signed and dated sheet to provide additional dependent information

FULL NAME:	DATE OF BIRTH	SEX
Spouse/DP		❒ Male ❒ Female
Child 1		❒ Male ❒ Female
Child 2		❒ Male ❒ Female
Child 3		❒ Male ❒ Female
Child 4		❒ Male ❒ Female

BENEFICIARY DESIGNATION

(*Complete this section only if applying for the Life Insurance/Long Term Disability Income plan – if necessary attach a separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan. 1) 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. 2) If naming a trust, please indicate the full name and date of the trust.

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

PLEASE BILL ME: ❒ Quarterly ❒ Semi-Annually ❒ Monthly Electronic Funds Transfer (EFT)* ❒ 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.**

I HEREBY APPLY FOR THE COVERAGE CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION: (Refer to brochure for eligibility, options and coverage descriptions)

☐ **HOSPITAL INDEMNITY INSURANCE** (from $100 Daily Benefit to $400 Daily Benefit in **$**50 units)

Member Daily Benefit amount available from $100 to $400 in $50 units $ _____

Spouse/Domestic Partner Daily Benefit amount available from $100 to $400 in $50 units $ _____
(Your spouse/domestic partner coverage may not exceed your own coverage.)

Child(ren) Daily Benefit amount available from $100 to $200 in $50 units $ _____

THIS QUESTION MUST BE ANSWERED FOR HOSPITAL INDEMNITY COVERAGE TO BECOME EFFECTIVE:
Do you understand that the Hospital Indemnity Plan will not pay benefits for a confinement resulting from any condition which required medical care or treatment during the 12 months preceding an insured individual's effective date unless the confinement begins after he or she has been continuously insured for at least 12 months? ❒ Yes ❒ No

☐ **STUDENT MEMBER BASIC PROTECTION PACKAGE: $100,000 GROUP TERM LIFE INSURANCE; 500/month LONG TERM DISABILITY INCOME INSURANCE and Rabies Prophylaxis Benefit**
(Disability Maximum Benefit Period 5 Years ♦ 30 Day Waiting Period)

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

Residents of New York: I have read the Important Replacement Information on the bottom of page 3. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Member:** ❒ Yes ❒ No

STUDENT MEMBER DECLARATION: I **request** the group insurance shown above. I **declare** that I am (a) a student member of the American Veterinary Medical Association, (b) attending veterinary school as a full-time student, and (c) under age 65 and not currently insured for Life or Disability Income Insurance under the AVMA LIFE Trust Group Insurance Program.

I understand that insurance will become effective the date my request for group insurance is received by the AVMA LIFE Trust Office, provided, (a) I am performing the normal activities of a person in good health of like age on the date such insurance would take effect, and (b) the initial contribution is paid within 31 days of the date I am billed.

I understand that for Disability Income coverage, benefits will not be paid during the first six months of coverage following the effective date for a disability resulting from a disease, injury or condition for which I consulted a doctor, received medical services or supplies or took medication during the six month period immediately preceding the effective date of this coverage.

HOSPITAL INDEMNITY 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.

By signing and dating this application, the member and any person proposed for insurance **request** the insurance indicated; **understand** the effective date criteria; and **attest** to having read the Fraud Notices indicated on page 3; and that to the best of my/our knowledge and belief, the answers to the questions are true and complete.

IF I AM APPLYING FOR HOSPITAL INDEMNITY INSURANCE I HEREBY ATTEST THAT I AM PURCHASING THIS COVERAGE AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

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

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 insurance 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.

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.