AVMA LIFE®
Veterinarian Inspired Coverage

The following notice applies to Hospital Indemnity Insurance only

IMPORTANT: This is a fixed indemnity policy,
NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

AVMA LIFE
Veterinarian Inspired Coverage

NEW YORK LIFE

AVMA LIFE Trust Group Insurance Application • Enrollment Form

for eligible members of the American Veterinary Medical Association

Complete this form and return to:
AVMA LIFE Trust Program Administrator ♦ 1200 E. Glen Ave. ♦ Peoria Heights, IL 61616-5384

Please print in ink or type all answers – initial and date any changes you make to this form **Questions? Call 1-800-621-6360**

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	**Group Policies** G-14884/14885/14886	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	MARITAL STATUS: ❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Domestic Partner Maiden Name_____ Date of Marriage_____		

CITY	STATE	ZIP CODE	HOME PHONE
FAX NUMBER	E-MAIL ADDRESS		BUSINESS PHONE

BILLING ADDRESS			**SEND CORRESPONDENCT TO** (includes certificates, bills, and all other correspondence)
CITY	STATE	ZIP CODE	❒ HOME ❒ BILLING

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

Member: ❒ Yes ❒ No If yes, Country _____ How Long?_____

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

MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS

VETERINARY COLLEGE	YEAR OF GRADUATION	AVMA MEMBERSHIP #
OCCUPATION (Please specify type of practice or other occupation if not practicing)	ANNUAL EARNED INCOME	
MAIN DUTIES		

FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ❒ Yes ❒ No

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

lawful Spouse/Domestic Partner (DP) and unmarried, dependent children less than age 23 (age 26 for Hospital Indemnity Insurance) *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.	MM / DD / YYYY	❒ MALE ❒ FEMALE	4.	MM / DD / YYYY	❒ MALE ❒ FEMALE
2.	MM / DD / YYYY	❒ MALE ❒ FEMALE	5.	MM / DD / YYYY	❒ MALE ❒ FEMALE
3.	MM / DD / YYYY	❒ MALE ❒ FEMALE	6.	MM / DD / YYYY	❒ MALE ❒ FEMALE

BILLING OPTIONS

❒ Quarterly ❒ Semi-Annually ❒ Monthly Electronic Funds Transfer (EFT)* ❒ Credit Card*

GMA-AC-IR

Application continued – see following page

*** Send no money now – you will be billed when coverage is approved.**
Upon receiving your approval letter and invoice, 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.

INSURANCE REQUESTED: (Refer to brochure or certificate for eligibility, options and coverage descriptions)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):

If you are increasing or altering present coverage in any way, ONLY indicate the additional amount of coverage or options you are applying for.

NOTE 1: Except for Disability Insurance, a member may apply for Dependent coverage without being insured under the requested plan. A child may only be insured if the member or spouse is insured. A spouse/domestic partner who is a member must apply for member or dependent coverage, but not both. Children may only be covered by one parent. For Spouse Disability, the member must be insured for a minimum of $1,000 monthly benefit.

NOTE 2: AGGREGATE LIFE INSURANCE LIMITS: The maximum coverage available for member and spouse under all Life plans combined is $2,000,000 (this aggregate does not include the Basic Protection Package or 45+ Term Life Advanced). Child(ren) may only be covered under one life insurance plan.

☐ 10-Year/20-Year Level Term Life Insurance

Select Term: ❒ 10-Year Level Term ❒ 20-Year Level Term

Member coverage available from $100,000 up to $2,000,000 in units of $10,000 …… $ _____

Spouse/Domestic Partner coverage available from $100,000 up to $1,000,000 in units of $10,000…… $ _____

Child(ren) Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 …. $ _____

☐ Family Group Term (FGL) Life Insurance

Member coverage available from $100,000 up to $2,000,000 in units of $10,000 …… $ _____
Chronic Care Option*…… ❒ Yes ❒ No

Spouse/Domestic Partner coverage available from $100,000 up to $1,000,000 in units of $10,000 …… $ _____
Chronic Care Option*…… ❒ Yes ❒ No

Child(ren) Unmarried dependent children from 14 days old to age 23 may be covered for $5,000 or $10,000 …….. $ _____

* If you answer "Yes" to Chronic Care Option (Chronic Illness Option in California), this option will apply to the total FGL life insurance amount not to exceed $1,000,000 (maximum acceleration is 50% of this amount up to $500,000) subject to terms of the Certificate of Insurance. Premiums are charged based on FGL insurance amount subject to this option. If you answer "No" and already insured for this option, it will be removed in its entirety.

☐ 45+ Term Life Advanced

Member coverage available from $25,000 up to $100,000 in units of $1,000 …… $ _____

Spouse/Domestic Partner coverage available from $25,000 up to $100,000 in units of $1,000 …… $ _____

☐ Long-Term Disability Income(LTDI) Insurance (check coverage/options to apply and complete all necessary information)

Member LTDI Age-70 Maximum Benefit Period – See Brochure for Details.

- **Waiting Period:** (select one) **Plan 2:** 30-day, **Plan 3:** 90-day, **Plan 4:** 180-day, **Plan 5:** 60-day…… **Plan** _____
- **LTD Monthly Benefit** (from $1,000 to $12,500 in $100 units – see brochure for age limitations)…… $_____
- **Optional LTD Benefits** - By checking the boxes below, I hereby apply for the following Optional Benefits
  - ❒ Future Purchase Option (FPO) – ($500 to $7,000 in $100 units) ……$_____
  - ❒ Cost of Living Adjustment (COLA) Option
  - ❒ "Own Occupation Plus" Definition Option

Spouse LTDI - $500 Monthly Benefit; 30-day Waiting Period; 2-Year Maximum Benefit Period) …… ❒ Yes ❒ No
Only available if member is applying for LTDI, or already insured.

THIS QUESTION MUST BE ANSWERED FOR SPOUSE DISABILITY TO BECOME EFFECTIVE:
Do you understand that the Spouse Long-Term Disability plan will not pay benefits for a disability resulting from any condition which required medical care or treatment during the 12 months preceding an insured individual's effective date unless the disability begins after he or she has been continuously insured for at least 12 months?..... ❒ Yes ❒ No

☐ Short-Term Disability Income Insurance (STDI)

Plans 1 & 2 include a 30-day maximum benefit period for pregnancy-related disabilities (routine pregnancy, delivery, or related medical condition) incurred after insurance has been in force for 12 continuous months, provided the disability is certified by an attending physician as medically necessary.

Member Only Plan: ❒ **Plan 1:** 1st-day Accident/8th-day Sickness Waiting Period / 6-Month Maximum Benefit Period
❒ **Plan 2:** 30-day Waiting Period / 6-month Maximum Benefit Period

Monthly Benefit (from $200 to $5,000 in $100 units – see brochure for age limitations)……$_____

INSURANCE REQUESTED (CONTINUED): (Refer to brochure or certificate for eligibility, options and coverage descriptions)

☐ Basic Protection Package (Only available with Long-Term Disability* whether already insured or applying now.)

The Basic Protection Package includes: **Decreasing Term Life ♦ Accidental Death & Dismemberment ♦ Rabies Prophylaxis Benefits ♦ Monthly Long-Term Disability Income***

*If you are already insured for LTD, you can apply for Basic Protection Package without selecting LTD on this form. If you are not presently insured for LTD benefits, please complete the Long Term Disability Income section on Page 2 (Waiting Period and Monthly Income Benefit are required fields)

☐ Professional Overhead Expense (POE) Insurance

- **POE Waiting Period/Maximum Benefit Period** (**Plan 1:** 15 day/12-month, **Plan 2:** 30 Day/24-month) Plan _____
- **POE Monthly Benefit** ($300 to $45,000 in $100 Units) …….. $_____

1. What was your average monthly amount of eligible overhead expenses in the past 6 months? _____
2. If practicing as a partnership or corporation, for what percentage* of these were you responsible? _____%
3. What was your average number of employees in the past 6 months? _____

*If you are incorporated, a partner or a joint tenant, include only your personal share of covered overhead. "Personal share" is defined as (a) your percentage of ownership of the business, or (b) your share of the office space if a joint tenant.

☐ Student Loan Disability (Supplemental Disability (Supp DI) for Educational Expense Obligations)

Monthly Supplemental Disability Benefit Amount ($200 to $2,000 in $100 units) …….. $_____
(Total Monthly Benefit amount may not exceed required Monthly Payment rounded up to the next higher $100)

Maximum Benefit Period: …….. ❒ 5-Years ❒ 10-Years

Complete the Supplemental Disability Loan Information Form on Page 7 which MUST be submitted with this application

☐ Large Scale Accidental Death & Dismemberment Insurance

Member coverage up to $200,000 principal sum in $10,000 units…… $ _____

Spouse/Domestic Partner coverage up to $100,000 Principal Sum in $10,000 units……..$ _____

CRITICAL ILLNESS INSURANCE AND HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE.

☐ 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 …… $ _____

☐ Hospital Indemnity Insurance

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 …….. $ _____

Child(ren) Daily Benefit amount available from $100 to $200 in $50 units not to exceed member or spouse amt..$ _____

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

DISABILITY INSURANCE QUESTIONS Must Be Completed if applying for DISABILITY (LTD, STDI, POE, Supp DI)

Do you now have or are you applying for any other insurance which provides benefits if you are unable to work because of disability? …… ❒ Yes ❒ No

If yes, indicate company (including coverage through AVMA LIFE), type and amounts below.

Company	Plan Type (LTD, STDI, POE) and Waiting Period	Monthly Benefit	Maximum Benefit Period	Replace?

Do you intend to replace any of the above listed coverage with the insurance applied for today? ❒ Yes ❒ No

If "yes", indicate which plan(s) you will be replacing. NOTE: If you are increasing present coverage, it is not a replacement.

LIFE INSURANCE QUESTIONS Must Be Completed if applying for Life Insurance (including Basic Protection Package)

Do you have other life insurance in force? **Member:** ❒ Yes ❒ No **Spouse/Domestic Partner (DP):** ❒ Yes ❒ No

If "Yes," total amount in all companies: Member: $_____ Spouse/DP: $_____

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

Member: ❒ Yes ❒ No Amount $_____ Company_____

Spouse/Domestic Partner: ❒ Yes ❒ No Amount $_____ Company_____

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance (including Basic Protection Package)

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.

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

Residents of New York: I have read the Important Replacement Information on page 5. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

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

I (the member) hereby make the following beneficiary designation with respect to a) all the insurance on my life under the Family Group Term Life, Basic Protection and/or Large Scale AD&D Insurance Plan(s) being applied for under this application, and if I am already covered under the Plan(s), I hereby revoke any prior beneficiary designation; b) ONLY the insurance issued as a result of this application for Group 10-Year Level Term Life Insurance/20-Year Level Term Life Insurance. **The beneficiary for dependent spouse and child coverage shall be the insured member as provided in the Group Policy** *(If you wish to name a different beneficiary for spouse coverage or change the beneficiary for insurance under any other 10- or 20-Year Term Life Insurance Certificate, contact the Trust Office at the number provided below). 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.*

☐ Primary ☐ Secondary/Contingent Share: _____% (must total 100% when combined)

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /

CITY	STATE	ZIP CODE	PHONE NUMBER (include area code)

☐ Primary ☐ Secondary/Contingent Share: _____%

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /

CITY	STATE	ZIP CODE	PHONE NUMBER (include area code)

MEDICAL HISTORY **Please indicate the best contact number for a Service Provider to contact you and/or your spouse/domestic partner on behalf of New York Life Insurance Company for Medical History.**

(Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

Member	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile	**Spouse /Domestic Partner**	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile

Have all questions been answered? Please Initial and date any changes you make on this form and sign page 5

Questions? Call 1-800-621-6360, 8 AM – 8 PM, Monday – Friday

READ AND SIGN: I **request** the group insurance shown on page(s) 2 and/or 3 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, and on any supplemental forms, and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of this 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 (a) the proposed insured is alive on that date; (b) the initial contribution is paid within 31 days after the date billed; (c) I and/or any approved dependents 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); and (d) for Disability Income (LTD, STD and Supplemental) and Overhead Expense Insurance, I am actively working 20 or more hours per week.

I understand that (a) for Short-Term Disability (Plans 1 and 2) and Hospital Indemnity Insurance, a disability or hospitalization that is due to a pregnancy, childbirth or a related medical condition, except for complications of pregnancy, will not be covered until the prospective insured person has been continuously insured for 12 months under the respective plan; (b) for Short-Term Disability (Plans 1 and 2) and Professional Overhead Expense Insurance, a disability that is due to a pregnancy, childbirth or a related medical condition, except for complications of pregnancy, is subject to a limited maximum benefit period of up to 30-days for STDI and up to 3-months for Professional Overhead Expense Insurance; (c) for Hospital Indemnity Insurance, benefits will not be paid for a confinement resulting from any condition which required medical care or treatment during the 12 months preceding the prospective insureds effective date, unless the confinement begins after such person has been continuously insured under the policy for 12 months; (d) for Professional Overhead Expense Insurance, benefits will not be paid for pre-existing pregnancy, childbirth or a related medical condition which the proposed insured has consulted a physician, received medical services or supplies or taken any medication for that condition within the six months prior to the initial effective date of coverage, until the end of nine consecutive months during which the member has been continuously insured; and (e) for Long Term Disability (30-day and 60-day Waiting Period plans) a disability that is due to a pregnancy, childbirth or a related medical condition, except for complications of pregnancy, are excluded.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, 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 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. This AUTHORIZATION may be used for a period of 24 months from the date signed below 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 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.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL.

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 (required)_____ Date_____

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

Agent Name (Print) _____ **(Sign)**_____ Date_____
(If you are working with an agent, please print your agents name above. Agent signature is required in the states of MI, CA, MN, MS, VA, WA,IL, LA, NH,WV)

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: 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 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.

Once completed, signed and dated, this application should be submitted at once to*:

AVMA LIFE Trust Program Administrator

1200 E. Glen Ave. ♦ Peoria Heights, IL 61616-5384 • Phone: 1-800-621-6360

Customer Service: 1-800-621-6360, 8 AM – 8 PM, Monday – Friday

*Residents of Puerto Rico - please send your completed application to
Global Insurance Agency, Inc., P.O. Box 9023918, San Juan, PR 00902-3918

STUDENT LOAN INFORMATION FORM

Supplement to Application

AVMA LIFE Trust

Group Supplemental Disability Insurance

AVMA LIFE
Veterinarian Inspired Coverage

Underwritten by: NEW YORK LIFE

Must be completed if applying for Supplemental Disability Insurance (for educational expense obligations) and attach a financial statement for each loan. If you have any questions please call 1-800-621-6360 or consult with your agent.

PRINT APPLICANT'S FULL NAME:____

GROUP POLICY NUMBER: G-14884-7 **Number of Pages** (including this sheet)____________________

Must Attach Copy of Financial Statement for each Loan showing proof of monthly payment

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Name of Financial Institution: ____

Date Loan Initiated:__________________ Length of Loan Repayment: ____________*months*

Required Monthly Payment: $_______________ ☐ please check to acknowledge financial statement attached

Member Signature:____________________________________ **Date:**_________________________

Please retain a copy for your records

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. 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.*

New York Life Insurance Company 7.15ed