AVMA LIFE® Veterinarian Inspired Coverage

Family Group Life Insurance Application for Eligible SAVMA Members

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

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	**Group Policy** G-14884-0	CERTIFICATE # (office use only)
	SOCIAL SECURITY NO.	
MEMBER'S FULL NAME	DATE OF BIRTH	❒ MALE ❒ FEMALE
HOME ADDRESS	MARITAL STATUS: ❒ Married ❒ Single ❒ Domestic Partner ❒ Divorced ❒ Widowed Maiden Name____________ Date of marriage:__________	
CITY	STATE	ZIP CODE	HOME PHONE
BILLING ADDRESS		
CITY	STATE	ZIP CODE	MOBILE PHONE
FAX NUMBER	PERMANENT EMAIL ADDRESS (PLEASE DO NOT USE A SCHOOL EMAIL ADDRESS)	BUSINESS PHONE

SEND CORRESPONDENCE TO: (bills, certificates and other correspondence) ❒ Home ❒ Billing

Do you intend to reside outside the U.S. or Canada in the next 12 months? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No
If yes, Country ______________________________ How Long?____________________

MEMBERSHIP AFFILIATION – STUDENT STATUS – Student AVMA (SAVMA) membership required

ANNUAL EARNED INCOME	OCCUPATION (if practicing, specify type of practice)	
VETERINARY COLLEGE	GRADUATION DATE	SAVMA MEMBERSHIP #

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS lawful Spouse/Domestic Partner (DP) and unmarried, dependent children less than age 23. *Attach a separate signed and dated sheet to provide additional dependents*

Spouse/Domestic Partner (DP) Full Name	Date of Birth	❒ MALE ❒ FEMALE

Child (Name)	Date of Birth		Child (Name)	Date of Birth	
1.		❒ MALE ❒ FEMALE	2.		❒ MALE ❒ FEMALE

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:

Family Group Life Insurance (Member from $100,000 to $250,000 in $10,000 increments/. Spouse from)

Member: ❒ $100,000 ❒ $150,000 ❒ $200,000 ❒ $250,000 ❒ Other $ ______________________

Spouse/DP:* ❒ $50,000 ❒ $100,000 ❒ $150,000 ❒ $200,000 ❒ $250,000 ❒ Other $ ______________

Child(ren): ❒ $5,000 ❒ $10,000 *Spouse/DP cannot exceed insured Student Member

TOBACCO / NICOTINE USE: Must be completed

Have you or your spouse/DP (if applying for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum) within the past 12 months **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

Member: If "Yes," please state when you last used: mo/yr____________ and Product used: ________________

Spouse/DP: If "Yes," please state when you last used: mo/yr__________ and Product used: ________________

Please Bill Me: ❒ Quarterly (Feb, May, Aug, Nov) ❒ Semiannually (May, Nov) ❒ Annually (May) ❒ Monthly EFT*

GMA-EZ2

Application continued – see following page

G-14884-0
SAVMA FGL-SI 02/25

*** Upon receiving your approval letter, please login to www.AVMALife.org or contact Customer Service at 1-800-621-6360, 7 AM – 6 PM Central Time, Monday – Friday, to select your method of payment and submit your information.**

REPLACEMENT INFORMATION

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 below. 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

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.

BENEFICIARY DESIGNATION

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

I make the following beneficiary designation with respect to the insurance on my life under the Family Group Term Life Insurance and if I am already insured, (includes $25,000 Complimentary Life Insurance), I hereby revoke any prior beneficiary designation. The automatic beneficiary for dependent coverage is the insured member.

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)

STATEMENT OF HEALTH – To the best of your knowledge, answer the following questions as they apply to you.

a. Are you now taking any prescribed medication or receiving or contemplating medical attention or surgical treatment?
Member: ❒ Yes ❒ No **Spouse/DP**: ❒ Yes ❒ No

b. During the past five years, have you ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?
Member: ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

c. During the past five years, have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?
Member: ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

d. If you have answered "Yes" to any of the Questions above, give complete details below.
Attach another sheet if more space is needed.

Who	Illness or Condition	Date of Onset/Duration/Treatment/Medication /Operations/ Degree of Recovery and Date	Name and Address of Physicians or other Medical Care Practitioners and Hospitals where Confined or Treated

GMA-EZ2

Application continued – see following page

G-14884-0
SAVMA FGL-SI 01/25

Please complete all questions to the best of your knowledge and belief.
Please print in ink or type all answers – initial and date any changes you make.
Sign and date page 3 and return to the AVMA LIFE Trust Program Administrator.

READ & SIGN

I request the group insurance shown on Page 1. To the best of my knowledge and belief: (a) I, and any person proposed for insurance, am/are eligible for such insurance; and (b) the statements I have made are true and complete. 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 understand that the coverage afforded will be in consideration of the answers and statements set forth above.

FRAUD NOTICE – ***For Residents of all states except New York and those listed on Page 4:*** 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.

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 above and on page 4, including how my/our information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature (required)____________________________ Date__________

Spouse/Dependent Partner ____________________________ Date__________
(Necessary only if Spouse/DP 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)

Application continued – see following page

Once completed and dated, please return this form to:*

AVMA LIFE Trust Program Administrator
Pearl Insurance
1200 E. Glen Ave.
Peoria Heights, IL 61616-5384

1-800-621-6360 (7am-6pm Central Time)

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

Fraud Notices: Read before signing the application form

FRAUD NOTICE – ***For Residents of all states <u>except</u> New York and 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 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, 7am-6pm Central Time, 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

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, LLC., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866- 692-6901. 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.*