Statement of health: Note: To evaluate your insurability, New York Life Insurance Co. may ask you to supply further medical information, which could include an examination and/or laboratory studies.
ANSWER THESE QUESTIONS AS THEY APPLY TO YOU.
Please initial any changes you make on this form.

	Yes	No
A. Are you now receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance?	☐	☐
B. Are you now ill, receiving or contemplating any medical attention or surgical treatment?	☐	☐
C. During the past five years have you consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury?	☐	☐
D. Are you under any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐
E. Are you now pregnant?	☐	☐

F. Have you ever had:

	Yes	No
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐
2. Arthritis, back trouble, bone or joint disorder?	☐	☐
3. Fainting spells, convulsions or epilepsy?	☐	☐
4. Sugar, blood, albumin or pus in urine?	☐	☐
5. Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐
6. Disorder of breasts or reproductive organs or functions?	☐	☐
7. Nervous or mental disorder, emotional condition or psychiatric care?	☐	☐
8. Cancer, tumor or cyst?	☐	☐
9. Varicose veins, hemorrhoids or hernia?	☐	☐
10. Disorder of eyes, ears, nose or sinuses?	☐	☐
11. Thyroid, liver or respiratory disorder?	☐	☐
12. Alcoholism or drug habit?	☐	☐
13. Disorder of the blood?	☐	☐
14. Other health or physical impairment including:		
(a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Condition (ARC)?	☐	☐
(b) Any other disorder of the immune system?	☐	☐
(c) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past five years?	☐	☐
(d) Any other impairment?	☐	☐

G. **If you have answered any of the above questions "Yes", give complete details below.**
(Attach a separate sheet with your signature and date if you need additional space.)

question number and/or letter	illness or condition, date of onset, duration, treatment, operations, degree of recovery and date	name and address of physicians or other practitioners and hospitals where confined or treated

I request the group insurance shown on the reverse side. 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 that any 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: (a) insurance will become effective on the date approved by New York Life provided the initial contribution is paid within 31 days after the date I am billed and I am at FULL-TIME WORK (as defined on reverse side) on the date of approval or, if later, the date the contribution is paid; (b) if I am not at FULL-TIME WORK as required, I will not become insured until the day I return to FULL-TIME WORK, provided such date is within three months of the date insurance would have been effective and I am still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the AAFP. I understand that benefits will not be payable for up to two years for losses due to a disease or condition which I now have or have had in the past and which is not disclosed fully on this form. **I authorize** disclosure of the types of information detailed in the AUTHORIZATION in this pamphlet, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE in this pamphlet which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau).

(Note: The following Fraud Warning is included in the AAFP Group Practice Overhead Expense Policy Application in compliance with New York State statutes.) ***Fraud Warning Statement:*** *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 contain-ing 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.*

Member's signature X ______________________________ Date ____________

Form GPA-AC-1, As Amd. by GMA-5-NYFR, G-29072 7/00 ed.

G-29072-USA4 -2 8/00

Residents of AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH, OR and PA: *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 is a crime and subjects such person to criminal and civil penalties.* **For 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.* **For residents of DC, the following also applies:** *An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.*

AAFP Group Practice Overhead Expense Plan
SCHEDULE OF SEMI-ANNUAL PREMIUMS
(Per $100 of Monthly Benefits)

Member's Age	PLAN I 30-Day Waiting Period	PLAN II 90-Day Waiting Period
Under 35	$ 1.50	$ 0.90
35-44	2.60	1.80
45-54	5.30	4.00
55-59	8.90	7.20
60-64	12.10	8.40
65-69*	16.70	12.50

*Renewal only

The initial cost is based upon your age when insurance becomes effective and increases as you grow older and enter a higher age bracket.

Select one of the waiting periods across the top, then find the row corresponding to your age group to determine your premium. Then multiply this amount by the number of $100 units selected.

Example: A 37 year-old who selected a 90-day waiting period and a $12,000 monthly benefit amount would have a semi-annual premium contribution of $216. [Calculation: 120 x $1.80]

Practice Overhead Insurance

is a cost effective way to help keep your office up & running should you become Totally Disabled.

Apply today.

All premium contributions shown are the current rates based upon the current benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date and on any date on which benefits are changed. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the American Academy of Family Physicians.

G29072-2-2 8/00

AAFP GROUP PRACTICE OVERHEAD EXPENSE INSURANCE APPLICATION

For members of the American Academy of Family Physicians

HOW TO APPLY

1. Please read this application and give complete answers to all questions. Failure to provide complete and truthful information may invalidate coverage.
2. Detach the application at the perforation. Save this section for your records. Use the enclosed postage-free envelope to mail your signed application to: **AAFP Insurance Services, Inc.**
3. **Enclose no money at this time.** Upon approval of your application, we will bill you.

QUESTIONS?

Contact your Plan Administrator: AAFP Insurance Services, Inc.

Call toll-free: 800-325-8166
Fax toll-free: 800-223-7463
E-mail: insurance@aafp.org

AAFP Headquarters, Suite 430
11400 Tomahawk Creek Parkway
Leawood, KS 66211

Underwritten by:

New York Life Insurance Company (on Policy Form GMR)
51 Madison Avenue
New York, NY 10010

Medical Requirements

The AAFP Group Practice Overhead Expense Policy is medically underwritten based on the information you provide on the application and possible additional medical information as indicated below. It is important that you complete the application truthfully and completely. • Your application is subject to New York Life Insurance Company approval. Occasionally, an application must be declined due to past health history. Do not cancel any existing insurance until you receive your Certificate Of Insurance and you have had a chance to review it. • New York Life may request further medical information. Based on the age of the person proposed for insurance and the amount of coverage requested, a physical examination, EKG, blood test or other information may be required. • Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to perform a simple exam with blood tests at your convenience and at our expense. If you prefer to use your own physician, you may do so at your own expense with prenotification to New York Life of your intention. If that exam provides the information needed to underwrite your application for insurance, you will be reimbursed for the charge normally incurred by New York Life for an exam conducted by a professional paramedic.

Important Notice – "How New York Life Underwrites Your Request For Practice Overhead Expense Insurance"

Information regarding insurability will be treated as confidential. In considering whether you qualify for coverage, we will rely on the medical information you provide and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may make a brief report to MIB; however, we will not disclose our underwriting decision. Information in our files may be seen by New York Life and the Plan Administrator (AAFPInsurance Services, Inc.) 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. • MIB is a nonprofit organization of life insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or nonmedical information may be given to the Bureau, which may then be furnished to member companies. • Upon written request to New York Life or MIB, you will be provided with nonmedical information; medical information, however, will only be given to a physician you designate. (Note: In certain jurisdictions, you may choose to receive medical information directly.) If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. • ***For NM residents****: In addition, 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.

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

New York Life Insurance Company 7/99 ed.

Authorization

I authorize any physician, medical practitioner, hospital, medical or medically-related facility, insurance company or MIB to release information to New York Life Insurance Company, its subsidiaries or the Plan Administrator about my physical and mental health, including significant history, findings, diagnosis and treatment. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with nonmedical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). New York Life and its subsidiaries may release to the Plan Administrator, MIB, other insurance companies and to others whom I authorize in writing, information covered by this AUTHORIZATION. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 30 months from the date the application was signed. A photocopy of this request form shall be as valid as the original. I know that I may request a copy of this AUTHORIZATION.

Detach at perforation and save.

AAFP GROUP PRACTICE OVERHEAD EXPENSE INSURANCE APPLICATION

For members of the American Academy of Family Physicians
Request for Group Practice Overhead Expense Insurance from New York Life Insurance Co., 51 Madison Avenue, NY, NY 10010
Administered by AAFP Insurance Services, Inc., AAFP Headquarters, Suite 430, 11400 Tomahawk Creek Parkway, Leawood, KS 66211
Attention FL, MN, NC, VA and VT residents: Do not use this form. Call AAFP Insurance Services for a special form.
Questions? Call: 800-325-8166 Fax: 800-223-7463

Full answers to all questions are required. Please print in ink or type all answers. Thank you.

AAFP member information:

Full name: last, first, middle ______________________ Social Security # ______________

Date of birth ____________ Place of birth (City, State) ______________________

Sex ☐ male ☐ female Height_____ft._____in. Weight _______lbs. E-mail______________

Home address (street, city, state, zip) ______________________

Business name ______________________ Business type: ☐ Corp. ☐ Partnership ☐ Proprietorship

Business address (street, city, state, zip) ______________________

Home phone ______________ Business phone and fax ______________

Your confidentiality is important to us. Please indicate the address where you want to receive:
Medical underwriting information: ☐ Home ☐ Business Policy information and premium notices: ☐ Home ☐ Business

Membership affiliation–occupational status:

Are you now a member of the American Academy of Family Physicians? ☐ Yes ☐ No AAFP membership # ________ (if available)

What is your occupation? ______________ Main duties? ______________

____

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours each week at the place such duties are normally performed.
Do you presently meet this definition of FULL-TIME WORK? ☐ Yes ☐ No

Practice Overhead Expense calculator:

Refer to the brochure and/or your Certificate Of Insurance for eligibility, options and coverage description.
I hereby apply for the coverage indicated below based upon all my statements made in this application.

A. **Enter** your monthly "Eligible Practice Overhead Expenses".
(To determine this amount, please complete the worksheet inside the brochure.) — **A.** $ ____________

x ____________%

B. **Multiply** Line A by the percent of the monthly "Eligible Practice Overhead Expenses" for which you are responsible if the business is a corporation or partnership.
(If a proprietorship, simply enter the amount from Line A here.) — **=B.** $ ____________

– $ ____________

C. **Subtract** the monthly amount of any other business/office overhead insurance you now have or for which you are now applying. *(Please specify insurance company, plan and benefit period on the line below.)* — **=C.** $ ____________

____

Enter the Monthly Benefit Options you wish to apply for, not to exceed line C. $ ____________

Select your waiting period: ☐ 30-days ☐ 90-days

Payment option: ☐ Annually (January) ☐ Semi-annually (January & July)

Form GPA-AC-1 G29072

Be sure to complete and sign reverse side ➩