AAFP INSURANCE
RISK MANAGEMENT · FINANCIAL PLANNING

Disability Income Insurance Application

NEW YORK LIFE

(Policy G7201)

Request for association-group insurance from: New York Life Insurance Company • 51 Madison Avenue • New York, NY 10010
PLEASE COMPLETE THIS FORM AND RETURN IT TO THE PLAN ADMINISTRATOR:
AAFP Insurance Services, Inc., Suite 430, 11400 Tomahawk Creek Parkway, Leawood, KS 66211

Questions? Call 913-386-4004 Web: www.aafpins.com Email: insurance@aafp.org

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AAFP MEMBER INFORMATION

Full Name: _____ Soc. Sec. #: ☐☐☐ ☐☐ ☐☐☐☐ Date of Birth: _____ (MM/DD/YYYY)

Address: _____ Sex: M ☐ F ☐ Height: _____ ft. _____ in. Weight: _____ lbs.

State _____ Zip Code _____ Email: _____

Are you now a member of the American Academy of Family Physicians? Yes ☐ No ☐ Membership #: _____

Do you intend to reside outside the U.S. in the next 12 months? Yes ☐ No ☐ Country: _____ For how long? _____

What is your occupation? _____ Main duties? (Please be specific) _____

"FULL-TIME WORK" means the active performance for pay or profit of the regular duties of your normal occupation on a basis of at least 20 hours a week at the place such duties are normally performed.

Are you now at FULL-TIME WORK? Yes ☐ No ☐ Gross Annual Income $_____

MEDICAL UNDERWRITING REQUIRED **Please indicate the best contact number for a Service Provider to contact you on behalf of New York Life Insurance Company.**
(Please provide a contact number that has the ability to accept voice messages for missed calls.)

Contact Number : _____ Residence ☐ Business ☐ Mobile ☐

INSURANCE REQUESTED

Choose amount of protection from $100 to $15,000 in increments of $100: $_____ (90-Day Waiting period)
Inflation Protection Option: Yes ☐ No ☐

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? Yes ☐ No ☐ If "yes," please list below. If more space is needed, attach separate sheet with your signature and date.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, if approved, replace any of the above: Yes ☐ No ☐
(if so, indicate which, and date it will be terminated) _____

PLEASE READ, SIGN AND DATE.

I understand that New York Life Insurance Company 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.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company, 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 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, I **request** the insurance indicated; **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 protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE enclosed and Fraud Notices on the reverse of this page, including how my 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.

AAFP Member's Signature X _____ Date _____
(Please sign and date in ink.)

PLEASE SEND NO MONEY NOW. You will be billed when your coverage is issued upon approval of your benefit request.

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 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.

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