

GROUP DISABILITY INCOME APPLICATION AMERICAN MARKETING ASSOCIATION INSURANCE PROGRAM



**Insurance Program
1-800-233-3938**

**TO APPLY COMPLETE THIS FORM
AND RETURN TO:**

NEBCO

P. O. Box 152501
Irving, TX 75015-2501

*Please Print in Ink or Type All Answers.
Initial and date any changes you make.*



The Company You Keep.®
**Request for Group Insurance from
New York Life Insurance Co.
51 Madison Avenue
New York, NY 10010**

Member's full name: Last			First		MI		AMA Membership Number:		
What is your occupation?					Email Address			<input type="checkbox"/> Male	
				<input type="checkbox"/> Female					
Billing Address		Street			City		State		Zip Code
Home Address		Street			City		State		Zip Code
In the next 12 months does any person proposed for insurance intend to reside outside the U.S.?									
Member:		<input type="checkbox"/> Yes <input type="checkbox"/> No		Country (ies): _____			For how long? _____		
Spouse:		<input type="checkbox"/> Yes <input type="checkbox"/> No		Country (ies): _____			For how long? _____		
Date of Birth			Height		Weight		Social Security Number		
Mo.	Day	Yr.	Ft.	Ins.	Lbs.				
Home Phone Number				Office Phone Number			Fax Number		
Area Code ()				Area Code ()			Area Code ()		
Marital Status:			Are you presently insured under this AMA Disability Insurance Plan?				BILLING INSTRUCTIONS:		
<input type="checkbox"/> Married <input type="checkbox"/> Divorced			<input type="checkbox"/> YES <input type="checkbox"/> NO				Please send premium statements		
<input type="checkbox"/> Widowed <input type="checkbox"/> Single							<input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually		
							<input type="checkbox"/> Annually		

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:

NOTE: If you are increasing or altering present AMA coverage in any way, do not mark the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you will have with AMA.

AVAILABLE IN \$100 INCREMENTS FROM \$200 TO \$5,000.

- Total Monthly Benefit Desired.....\$_____
- **BENEFIT PERIOD:** 5 Years To Age 65
- **WAITING PERIOD:** 60 Days 90 Days
- Do you carry Disability Coverage with any other company? Yes No
 - Name of Co.: _____
 - Elimination period: _____
 - Benefit period: _____
 - If yes, what is the monthly benefit? \$ _____
- Will the AMA disability coverage applied for replace any other company's coverage?
 - Yes No If yes, how much will be replaced? \$ _____
- What is your estimated MONTHLY gross earned income? \$ _____

Note: Your Group AMA Disability Insurance, together with all other disability benefits you already carry, may not exceed 70% of your Monthly Gross Earned Income.

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Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief please answer the following questions as they apply to you and your spouse if applying.				
California residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.	MEMBER YES NO		SPOUSE YES NO	
Maine residents: You are not required to disclose whether you have been tested for HIV if you have not developed symptoms of the disease, AIDS or AIDS Related Complex (ARC) in your answers to any of the following questions:				
1. Is any person to be insured now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. During the past five years, has any person to be insured ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for: a) Heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury? b) Other health or physical impairment including: i. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ii. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? iii. Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Worker's Compensation benefits or on waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past two years, has any person to be insured participated in, or does any person plan to participate in: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Driver's License: Member No: _____ State Issued: _____ Spouse No: _____ State Issued: _____				
8. During the past five years, has any person to be insured had his or her driver's license suspended, or revoked, or had any moving violations?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. During the past 24 months, has any person to be insured ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10. Are you currently incarcerated, or have an arrest pending, or during the past 15 years (7 in Maryland) served time in prison?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(Florida residents only – answer the following :) Have you ever been tested positive for exposure to the HIV infection, or been diagnosed as having ARC (AIDS-related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection, or other sickness or condition derived from such infection.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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Statement of Health continued: Please initial any changes you make on this form.

If you answered any of the above Questions 1-10 “Yes,” give complete details below. (If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as “etc.,” “various” or “miscellaneous”).

Question Letter/No.	Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and Address of Physicians or other Practitioners and Hospitals where confined or treated:

Declaration:

I request the group insurance shown above. *(VA Residents: I certify that I have read (or had read to me) this completed application and that)* 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, and that such insurance may be subject to any impairment restriction(s) established by New York Life. I ask New York Life to rely on all 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 premium has been paid and I am actively performing the normal activities of a person in good health of like age on the date of approval; (b) if I am unable to perform my normal duties as required, I will not become insured until the day I can perform such activities, 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 dividends apportioned to the group policy will be paid to the Group Policyholder of the Insurance Plan. 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.

Fraud Warning Statements

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 AR and LA: 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.

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 D.C.,** the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by 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 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 denial of insurance benefits.

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 TN and 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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AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering my request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for insurance will not be accepted unless this AUTHORIZATION is signed. ■ I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. 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, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). ■ New York Life may release information covered by this AUTHORIZATION to the Plan Administrator, MIB, or other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). **(VT Residents NOTE: This AUTHORIZATION EXCLUDES the release of any information about previously administered tests for HIV antibodies, T-Cell counts, AIDS or ARC. The proposed insured/applicant IS NOT authorizing the company to forward the results from any new test requested by the company to any outside, non-affiliated company or any entity not under specific contract to perform underwriting services.)** ■ This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Plan Administrator in writing at the address given on this form. 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

By signing and dating this application, I and my spouse (if proposed for insurance), request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest that to the best of my knowledge and belief, the statements made regarding my health are true and complete.

x		
	Member's Signature (Please sign and date in ink)	Date
x		
	Spouse's Signature (Necessary only if spouse coverage is requested)	Date



**Insurance Program
1-800-233-3938
www.nebenefit.com/ama**

Do Not Send Payment: Upon approval,
you will be notified of the premium due.



1-800-433-1672

www.nebenefit.com/ama

IMPORTANT NOTICE:

How New York Life Underwrites Your Request For Group Long Term Disability Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, 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 (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 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.

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.

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. 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 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 at P.O. Box 105, Essex Station, Boston, MA 02112, telephone (617) 426-3660. For Canadian residents, the address is 330 University Avenue, Suite 403, Toronto, Canada M5G 1R7, telephone (416) 597-0590 (TTY 866-346-3642).

For NM Residents: *PROTECTED PERSONS* have a right of access to certain CONFIDENTIAL ABUSE INFORMATION** 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 current address.*

** 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.*

*** 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 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 that there is any insurance in force before the effective date as determined by New York Life.

New York Life Insurance Company

9/05 ed.

RETAIN FOR YOUR RECORDS