AVMA | LIFE
Veterinarian Inspired Coverage

Limited time Offer – from August 1, 2021 to September 30, 2021

Family Group Life Insurance (FGL)
Guaranteed Acceptance Application

NEW YORK LIFE

Complete this form and return to:

AVMA LIFE Trust Plan Administrator ♦ 1200 E. Glen Ave. ♦ Peoria Heights, IL 61616-5384

PLEASE PRINT IN INK OR TYPE ALL ANSWERS AND INITIAL ANY CHANGES

Questions? Call 1-800-621-6360 (7am-7pm Central Time)

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010	GROUP POLICY G-14884-0	CERTIFICATE NO.
	SOCIAL SECURITY NO.	DATE OF BIRTH MM / DD / YYYY
MEMBER'S FULL NAME	MARITAL STATUS: ❒ Married ❒ Single ❒ Domestic Partner ❒ Divorced ❒ Widowed Maiden Name	
PRIMARY (RESIDENTIAL) ADDRESS		SEX ❒ MALE ❒ FEMALE
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) ❒ HOME ❒ BILLING
CITY / STATE / ZIP CODE		

Are you presently insured by any AVMA LIFE Trust Insurance plan? ❒ Yes ❒ No If yes, provide details.

MEMBERSHIP AFFILIATION – OCCUPATIONAL STATUS

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

DEPENDENT SPOUSE/DOMESTIC PARTNER (DP): (Complete only if applying for Spouse/DP coverage.)

SPOUSE/DP FULL NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH MM / DD / YYYY	SEX ❒ MALE ❒ FEMALE

INSURANCE REQUESTED: (Refer to the brochure for eligibility and coverage descriptions.)

☑ **YES!** I HEREBY APPLY FOR THE FOLLOWING FAMILY GROUP LIFE INSURANCE (FGL) COVERAGE FOR MYSELF AND/OR MY SPOUSE/DOMESTIC PARTNER **(if applying)** BASED ON THE PROPOSED INSUREDS INSURANCE IN-FORCE and AGE ON THE EFFECTIVE DATE OF COVERAGE:

- NON-INSURED under age 45: $100,000; age 45 but under age 60: $50,000
- FGL INSURED under age 50: $50,000; age 50 but under age 60: $30,000

This offer is only available to eligible AVMA members and/or their spouse/domestic partner provided the proposed insured is under age 60, a resident of the 50 United States, District of Columbia or Puerto Rico, for the amounts indicated above. To be ELIGIBLE the member and/or spouse/domestic partner (if applying) must be actively working FULL-TIME; never been declined for insurance through AVMA LIFE Trust (formerly known as AVMA GHLIT); and have not taken advantage of another Guaranteed Acceptance offer in the past 24 months.

FULL-TIME work means the active performance of the regular duties for pay or profit of one's normal occupation on a basis of at least 20 hours each week at a place where such duties are normally performed or other location to which travel is required.
Are you presently working full-time? **Member:** ❒ Yes ❒ No **Spouse/DP:** ❒ Yes ❒ No

NOTE: Total AVMA LIFE Trust Life coverage any person may be insured for under all AVMA LIFE Trust Life Insurance plans combined is $2,000,000. If acceptance of this offer exceeds the aggregate maximum or the FGL policy maximum ($2 million for Member, $1 million for spouse/domestic partner), the coverage amount will be reduced accordingly.

TOBACCO / NICOTINE USE: (Must be completed.)

Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?
If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: ❒ Yes ❒ No Month/Year_____ Product: _____

Spouse/DP: ❒ Yes ❒ No Month/Year_____ Product: _____

Please Bill Me:	❒ Quarterly	❒ Semi-Annually	❒ Monthly Electronic Funds Transfer (EFT)*	❒ Credit Card*

Application continued - see next page

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

INSURANCE QUESTION (Must Be Completed.)

Residents of ALL States (except New York): Is the 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 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 (Attach a separate signed and dated sheet to provide additional beneficiary information)

I hereby make the following beneficiary designation with respect to all the insurance on my life under the Family Group Term Life, and if I am already insured under the Plan, I hereby revoke any prior beneficiary designation.

The beneficiary for Spouse/DP coverage shall be the insured member as provided in the Group Policy

(If you wish to name a different beneficiary for spouse/DP coverage, 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.

BENEFICIARY NAME (for member coverage)	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

I request the group insurance shown on page 1. To the best of my knowledge and belief: (a) I, and my spouse/domestic partner (if applying) am/are eligible for such insurance as defined on page one (1) of this form; and (b) the statements I have made are true and complete.

I understand that insurance will become effective on the first day of the month following receipt of this application provided (a) the application is received by the Trust Office within the "limited time offer" period indicated on page one; (b) the initial contribution is paid; and (c) I and my spouse/domestic partner (if applying), must be actively working full-time (20 hours per week) on the day insurance would become effective.

By signing and dating this application, the member **requests** the insurance indicated; and I (we) **attest** to having read the Fraud Notices on page three (3) of this form, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature (required) _____ **Date**_____
(The member must sign even if not applying for coverage for him/herself)

Spouse/Domestic Partner's Signature _____ **Date**_____
(Necessary only if applying for coverage)

Application continued – see next page

Once completed, signed, and dated, this 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

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

AGENT'S NAME_____

FRAUD NOTICES – PLEASE READ BEFORE SIGNING THE APPLICATION

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 AR/LA/MD/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: 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 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 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.

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