


Enrollment Form AVMA GHLIT Student Group Insurance Program

 <p>Request For Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010</p>	Group Policy G-14884	CERTIFICATE NO.		
	SOCIAL SECURITY NO.			
	DATE OF BIRTH / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
MEMBER'S FULL NAME	MARITAL STATUS	DATE OF MARRIAGE / /		
BILLING ADDRESS				
CITY	STATE	ZIP CODE		
MAILING ADDRESS				
CITY	STATE	ZIP CODE		
HOME PHONE	FAX NUMBER	E-MAIL ADDRESS		
IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS (i.e. lawful spouse/domestic partner and dependent children under age 26):				
SPOUSE'S/DOMESTIC PARTNER'S NAME	DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
CHILD (NAME)	DATE OF BIRTH	MALE/FEMALE	HEIGHT	WEIGHT
MEMBERSHIP AFFILIATION-STUDENT STATUS:				
Veterinary College _____		Membership Number _____ Year of Graduation _____		
BENEFICIARY DESIGNATION: (Complete this section only if applying for Life Insurance and Long Term Disability Insurance.) I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan.				
BENEFICIARY NAME				
BENEFICIARY'S RELATIONSHIP TO YOU		SOCIAL SECURITY NO.		
BENEFICIARY'S STREET ADDRESS				
CITY	STATE	ZIP CODE		

BEFORE YOU MAIL THIS ENROLLMENT FORM, it will greatly speed action on your application if you will review it carefully. Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strike-outs, these must be initialed by the student.

ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED:

	Yes	No		Yes	No
1. Are you now enrolled for and attending a full-schedule of classes?	<input type="checkbox"/>	<input type="checkbox"/>	h. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
2. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	i. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
			j. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
			k. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			l. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you or any other person to be insured now ill, receiving or contemplating medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	m. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
			n. Other health or physical impairment including: (i) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Condition (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	(ii) Any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
			(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
			(iv) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>	8. Have you or your spouse/domestic partner (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 months? Member <input type="checkbox"/> Spouse/Domestic Partner <input type="checkbox"/> If yes, when did you last use tobacco or nicotine products? Member _____ Spouse/Domestic Partner _____ Mo/Yr Mo/Yr	<input type="checkbox"/>	<input type="checkbox"/>
6. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>			
7. During the past 5 years, has any person to be insured had:					
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>			
b. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
c. Fainting spells, convulsions, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>			
d. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>			
e. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
f. Disorder of breasts or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>			
g. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>			

9. If you have answered Question 1 "No," or any of the other Questions "Yes," give complete details below. (Attach a separate sheet if necessary, sign and date.)

Name(s) of Proposed Insured:	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:

10. NOTE: THIS QUESTION MUST BE ANSWERED FOR HOSPITAL INDEMNITY COVERAGE TO BECOME EFFECTIVE. Do you understand that the Hospital Indemnity Plan will not pay benefits for a confinement resulting from any condition which required medical care or treatment during the 12 months preceding an insured individual's effective date unless the confinement begins after he or she has been continuously insured for at least 12 months? Yes

