AIA Trust

Insurance & Financial Programs for AIA Members & Components

Group Disability Income & Group Business Overhead Disability Insurance Plans APPLICATION

For Members of the American Institute of Architects

Official Member No.: ____________________

Name: ____________________

Address: ____________________

City, State, Zip: ____________________

To Apply, Please Complete and Return to:
The AIA Trust Insurance Program
P.O. Box 22859
Santa Barbara, CA 93121

NEW YORK LIFE

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Ave., New York, NY 10010

Phone: 1.866.768.1075

1 Member Information:

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Member Name: ____________________
(FULL NAME: FIRST - M.I. - LAST)

Address: ____________________

City, State, Zip: ____________________

Home Phone: ( ) – Office Phone: ( ) – Fax: ( ) –

Social Security #: – – Height: ft. in. Weight: lbs. Sex: ◯ Male ◯ Female

Date of Birth: – – (MONTH DAY YEAR) Email Address: ____________________ (For internal use only. Email addresses will never be sold or shared.)

MEMBERSHIP AFFILIATION—OCCUPATIONAL STATUS:

a. Association Membership is required for participation in this plan. AIA Membership #: ____________________

b. Are you now a member or candidate of the American Society of Landscape Architects?. ◯ Yes ◯ No

Member #: ____________________

c. What is your occupation? ____________________ Main Duties? ____________________

d. "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 per week at the place such duties normally are performed, or other location to which travel is required. Are you at FULL-TIME WORK? . . . . ◯ Yes ◯ No

e. Gross Annual Income from Salary: $, Bonus: $, Commission: $,

f. Self-Employment: $, Self-Employment Start Date: – – (MONTH DAY YEAR) Total: $,

G-29059-2, 29059-4

Be Sure to Complete All Pages and Sign Last Page

Send no money with this application.

2 Insurance Requested:

I hereby apply for the coverages checked below, based upon all my statements made in this application:

○ **Disability Income** (from $1,000 to $5,000 per month in $100 units) . . . . Monthly Benefit: $ ☐, ☐☐☐

Check Plan Desired Below:

- ○ 60-day waiting period with maximum benefit of 24 months.
- ○ 60-day waiting period with benefits payable to age 65.
- ○ 90-day waiting period with maximum benefit of 24 months.
- ○ 90-day waiting period with benefits payable to age 65.
- ○ 180-day waiting period with maximum benefit of 24 months.
- ○ 180-day waiting period with benefits payable to age 65.

○ **Business Overhead Disability Plan** (from $500 to $10,000 in $100 increments.) . . . . Monthly Benefit: $ ☐☐, ☐☐☐

1. Maximum Benefit Period (Select One) ○ Up to 12 Months ○ Up to 24 Months
2. Average monthly amount of "Eligible Overhead Expenses" in preceding 6 months . . . . $ ☐☐☐, ☐☐☐
3. Practicing as: ○ Corporation ○ Partnership ○ Individual
4. Average number of Employees: ☐☐☐
5. If corporation or partnership, for what percent of the monthly "Eligible Expenses" are you responsible? . . . . ☐☐☐ %

3 Please Check Box (next line):

○ I understand that I will be billed Quarterly for my coverage.

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

To the best of your knowledge and belief, answer the following questions as they apply to you.
Notice to 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. **Notice to 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 Comples (ARC) in your answer to any of the following questions.

	YES	NO
A. Are you now ill or taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment?	○	○
B. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:	○	○
1. 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 neervous 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 wight loss or accidental injury?	○	○
2. other health or physical impairment including (in the past five years):		
a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	○	○
b. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue?	○	○
c. Any other impairment?	○	○
C. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	○	○
D. Are you now pregnant?	○	○

Continued on page 3 ➡

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Send no money with this application.

4 Statement of Health: Please initial any changes you make on this form. *(Continued)*

E. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance? . . . . . ○ ○

F. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or any type of organized motorcycle racing? . . . . . ○ ○

G. Your Driver's License No: ____________ State Issued: ____

H. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?. ○ ○

I. During the past 24 months, have you ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum? . . . . . ○ ○

J. Are you currently incarcerated, or have an arrest pending, or during the past 15 years (7 in Maryland) served time in prison? . . . . . ○ ○

If you have answered "Yes" to any Questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

QUESTION LETTER/#	NAME(S) OF PROPOSED INSURED	ILLNESS OR CONDITION	DATE OF ONSET	DURATION	TREATMENT/ OPERATIONS	DEGREE OF RECOVERY	DATE	NAME AND ADDRESS OF PHYSICIANS OR OTHER MEDICAL CARE PRACTITIONERS OR HOSPITALS WHERE CONFINED OR TREATED

5 Declaration: Please read, sign and date in ink.

I request the group insurance shown above. To the best of my knowledge and belief 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 material 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 first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age *[**for MD and NC residents:** I and any approved spouse's health status continues to be the same as stated on this application]* on the approval date; (b) any person who is not performing such normal activities *[**for MD and NC residents:** whose health status is not the same as stated on this application]* as required will not become insured until the day he/she is performing such normal activities *[**for MD and NC residents:** I and any approved spouse's health status continues to be the same as stated on this application]*, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the AIA Trust Group Disability Income and Business Overhead Disability Insurance Plan. I also understand that AD&D benefits will not be payable for losses due to an injury which occurred prior to the effective date of coverage.

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/LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss of 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 the 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 KS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in

Continued on page 4

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5 Declaration: Please read, sign and date in ink. *(Continued)*

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 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 be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.
Residents of VA, Any person who, with 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 a violated state law.

AUTHORIZATION

I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB 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 subsidiaries or the Plan Administrator regarding the physical and mental health of any persons proposed for insurance, including *significant history, findings, diagnosis and treatment, but excluding psychotherapy notes. *[**For Maine residents:** I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers to New York Life Insurance Company, its subsidiaries or the plan administrator regarding the physical and mental health of any persons proposed for insurance, including *significant history, findings, diagnosis and treatment, but excluding psychotherapy notes.] [**For Oklahoma residents:** The information authorized for release may include records which may indicate the presence of a communicable, or venereal disease which may include, but are not limited to, diseases such as hepatitis, syphilis, gonorrhea and the human immunodeficiency virus, also known as Acquired Immune Deficiency Syndrome (AIDS), or non-communicable disease.] [**For Virginia residents:** For the sole purpose of underwriting this application for insurance coverage, I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB 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 subsidiaries or the plan administrator regarding the physical and mental health of any persons proposed for insurance, including *significant history, findings, diagnosis and 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). I understand that the information provided might include information that may predate the time frame stated on the medical questions section, if any, of this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, 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).

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 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 my authorized agent or I may request a copy of this signed AUTHORIZATION. *[**For Maine residents:** Failure to sign or revoke the authorization may impair the ability to process your application and may be a basis for denying an application.]**
**This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of such tests. Such test results shall not be disclosed or published. Nothing in this caveat will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.*

By signing and dating this application, I request the Insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest to having read the Fraud Notices indicated above and that to the best of my knowledge and belief, the statements made regarding my health are true and complete.

Date: ☐☐ – ☐☐ – ☐☐☐☐
MONTH DAY YEAR

Member's Signature (PLEASE SIGN AND DATE IN INK)

Once completed and dated, this should be submitted at once to the AIA Group Insurance Office at the address below.

AIA Group Insurance Office • P.O. Box 22859 • Santa Barbara, CA 93121 • Phone: 1-866-768-1075

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20992 ©2008 AGIA 58112(DI) 59239(BOD)
4-LTD2/LTD2A-6012/6025/9012/9025/18012/18025-Q
8-BOE30/BOEA30-12/24-Q