

# AIA Trust



Insurance & Financial Programs for  
AIA Members & Components

## GROUP MASTER APPLICATION GROUP FIRM TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

Official Member No.: \_\_\_\_\_  
 Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City, State, Zip: \_\_\_\_\_

**To Apply, Please  
Complete and Return to:**

AIA Trust Insurance Program  
P.O. Box 22859  
Santa Barbara, CA 93121-9912

**Requested Effective Date:**

-   -      
 MONTH DAY YEAR



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

New Plan \_\_\_\_\_ Amendment \_\_\_\_\_

### 1 Policyholder Information:

Name of Employer:

Mailing Address:

City, State, Zip:

Name and Title of Correspondent:

Phone Number: (   )  -   Fax Number: (   )  -

Email Address:

Are you now a member of the AIA?  Yes  No Member Number:

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

Nature of Business:  SIC Code:

Length of Time in Business:  Tax ID Number:

ERISA Plan Number:  ERISA Plan Year:  to

Type of Business:  LLC  C-Corporation  Partnership  S-Corporation  
 Non-Profit  Other

Affiliates/Subsidiaries/Branches (If none, write NONE below.):

NAME AND ADDRESS	# OF EMPLOYEES EMPLOYED	# OF EMPLOYEES INSURED	% OWNED BY PARENT COMPANY

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**1 Policyholder Information: (Continued from Page 1)**

Eligible Class Description:  All active full-time employees working a minimum of 20 hours per week  
 Other: \_\_\_\_\_

Number of Eligible Full-Time Employees: \_\_\_\_\_ Number of Eligible Part-Time Employees: \_\_\_\_\_ Number Applying: \_\_\_\_\_

Name of Present Group Carrier for Basic Life/AD&D if applicable: \_\_\_\_\_

Cancellation Date: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  No Current Coverage  
MONTH DAY YEAR

**2 Insurance Requested:**

Coverage being applied for:

1. Employee Basic Life Insurance  Firm Paid (Note: must be 100% participation if paid by Firm)  
 Employee Contribution: \_\_\_\_\_ % amount Number of Employees Participating: \_\_\_\_\_

Amount of Coverage \$ \_\_\_\_\_, \_\_\_\_\_ cannot exceed \$100,000.

Waiting Period  
 For Present Employees: NONE  
 For Future Employees: Upon Completion of 90 days

Effective Date after Waiting Period: First of the Month Following

List the employees not actively at work on the proposed Effective date. Give a detailed reason for the absence. (Attach additional sheet if necessary.)

EMPLOYEE NAME	DATE OF BIRTH	INSURANCE AMOUNT	PERIOD OF ABSENCE	REASON FOR ABSENCE

NOTE: Coverage for your company will not be effective until it is approved in writing by New York Life Insurance Company.

**3 Declarations: Please read, sign and date in ink.**

Group insurance at New York Life's rates and under the terms of the policy(ies) applied for will take effect on the Requested Effective Date if all requested information is received on a timely basis and if the Application is accepted in writing by New York Life Insurance Company. If certain persons eligible are to contribute to the cost of the Group Insurance, such Group Insurance will take effect on the later of the date the required number have enrolled, or on the Effective Date Requested.

It is understood that no individual shall become insured while not actively at work.

It is further understood that no insurance will be effective until the plan is accepted in writing by New York Life. No contract of Insurance is to be implied in any way on the basis of the completion and submission of the specifications shown on this form.

**Fraud Warning Statements**

Any person who knowingly and with intent to defraud any insurance company or other person who 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.

**Continued on page 3**

### 3 Declarations: Please read, sign and date in ink. (Continued from Page 2)

#### Fraud Warning Statements (continued)

**For AR and LA residents:** 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 CO residents, 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 DC residents, the following also applies:** 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 an application for insurance may be guilty of insurance fraud as determined by a court of law. An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant. **For ME residents:** 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. **For NJ residents:** 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. **For TN residents:** 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. **For VA residents:** 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 violated state law.

**THE EMPLOYER DECLARES:** That he/she has read the above statement and to the best of his/her knowledge, the answers to the above questions are complete and true. The Employer agrees: (1) that this Application is offered as an inducement for the Group Insurance applied for; (2) that this Application will form a part of any policy issued; (3) that the information on the Application will not bind New York Life; and (4) that no waiver or change will bind New York Life unless signed by the President or Secretary of New York Life. Group Insurance will only be provided for persons eligible under the policy(ies) issued.

**By signing and dating this application, I request the insurance indicated for my Firm, understand the effective date criteria, and attest that to the best of my knowledge and belief, the statements made above are true and complete.**

Signed at (city, state):  **Date:**  -  -   
MONTH DAY YEAR

Name of Employer:

By:  Title:

**RETURN COMPLETED FORM TODAY TO:**  
**AIA TRUST INSURANCE PROGRAM**  
**P.O. BOX 22859, SANTA BARBARA, CA 93102-9912**  
 UNDER GROUP POLICY NO. G-11108-0, on policy form GMR-EMP