Texas Dental Association Group Major Medical Insurance Program

APPLICATION FORM

1.800.648.1258

COMPLETE THIS FORM AND RETURN TO:
NEBCO
P. O. Box 153004
Irving, TX 75015-3004
Please Print or Type All Answers

**Request for Group Insurance from New York Life Insurance Co.
51 Madison Avenue
New York, NY 10010**

❑ New Applicant ❑ Change in Existing Coverage ❑ Add Dependent to Existing Coverage

Applicant's full name: Last	First	Middle Initial	TDA/ADA Membership Number
What is your occupation?		❑ Male ❑ Female	Are you presently insured by any TDA Major Medical plan? ❑ YES ❑ NO
Home Address Street	City	State	Zip Code
Date of Birth Mo. Day Yr.	Height Ft. In. / Weight Lbs.	Place of Birth City State	Date of Employment
Social Security No.	Home Phone Number Area Code ( )	Office Phone Number Area Code ( )	Fax Number Area Code ( )

Coverage Class: *(Please indicate member status)* ❑ Member / Dentist ❑ Team Member / Associate ❑ Full-time Dental Student

Payment Option (Choose One): ❑ Check-Matic Monthly* ❑ Check-Matic Quarterly* ❑ Direct Bill Monthly ❑ Direct Bill Quarterly
*(*Please be sure to complete the CHECK-MATIC REQUEST FORM below)*

Billing Address Street City State Zip Code

CHECK-MATIC REQUEST FORM

Complete this form only if paying premiums via Automatic Check Withdrawal
Check Mode and Draft Date Desired

Mode: ❑ Monthly ❑ Quarterly
Draft Date: ❑ 1st ❑ 5th (if none selected the draft date will be the 5th)

Applicant Name:______________________________ SS#______________________
Name of Depositor/Payer____
Address of Payer______________________________ Phone #___________________

I (we) hereby authorize NEBCO Administrators, Inc. to initiate debit entries to my (our) checking account and the bank named below to debit same to such account. NEBCO will not be held responsible for a policy lapse or cancellation due to nonpayment if the withdrawal is presented and not honored for any reason and the amount due is not paid.

Bank Name____
Street Address_________________________City_____________State________Zip__________

This authorization is to remain in full force and effect until NEBCO and the bank have received written notification from me (either of us) of its termination in such time and in such manner as to afford NEBCO and the bank a reasonable opportunity to act on it.

Name(s)____

Date____________________ Signature______________________________________

(Please attach a voided check)

I Hereby Apply For The Following Coverage: (Refer to the Plan Brochure for eligibility and coverage description.

MAJOR MEDICAL

Check Plan and Deductible Choice

Standard Major Medical

Deductible Options

(Available to Member (Dentist)/Student Member only)

☐ $1,000* ☐ $2,500 ☐ $5,000 ☐ $10,000

(Available to Team Member / Associate only)

☐ $500 ☐ $1,000

Coverage For:

☐ Applicant Only ☐ Applicant and Spouse
☐ Applicant and Children ☐ Applicant, Spouse and Child(ren)

*(*Available Student Member Only)*

High Deductible Health Plan (HDHP)

Qualifies for Health Savings Account – HSA

Plan Options - Check Plan & Deductible desired

(Available to Member (Dentist)/Student Member only)

☐ HDHP 1A - ☐ $1,500 Individual Deductible ☐ $3,000 Family Deductible
☐ HDHP 1 - ☐ $3,000 Individual Deductible ☐ $6,000 Family Deductible
☐ HDHP 2 - ☐ $5,000 Individual Deductible ☐ $10,000 Family Deductible

(Available to Team Member / Associate only)

☐ HDHP 3 - ☐ $1,500 Individual Deductible ☐ $3,000 Family Deductible
☐ HDHP 4 - ☐ $3,000 Individual Deductible ☐ $6,000 Family Deductible

Coverage for: ☐ Individual Only ☐ Family

REMEMBER TO SIGN APPLICATION ON PAGE 4

■ ***Please list*** any hospital, surgical or medical insurance you or your dependents now carry or have an application pending for. Also indicate if you intend to terminate this coverage if your application for coverage under this plan is approved.

Company	Type of Plan	Coverage to be Terminated?
		❑ Yes ❑ No
		❑ Yes ❑ No
		❑ Yes ❑ No

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS
(i.e. lawful spouse and unmarried, dependent children under age 25):

Spouse's full name (last, first, middle initial):	Date of Birth (mm/dd/yy)	Place of Birth	Height (Ft., In.)	Weight (lbs.)	❑ Male ❑ Female
Child (full name):					❑ Male ❑ Female
Child (full name):					❑ Male ❑ Female
Child (full name):					❑ Male ❑ Female

If more than three children proposed, attach a separate sheet with details for each child.

STATEMENT OF HEALTH
COMPLETE HEALTH QUESTIONS BELOW: ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED

YES NO

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 20 or more hours per week at your usual place of business? ❑ ❑
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? ❑ ❑
3. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ❑ ❑
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? ❑ ❑
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? ❑ ❑
6. Is any person to be insured now pregnant? ❑ ❑
7. During the past 5 years, has any person to be insured ever had:
   a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ❑ ❑
   b. Arthritis, back trouble, bone or joint disorder? ❑ ❑
   c. Fainting spells, convulsions, or epilepsy? ❑ ❑
   d. Sugar, blood, albumin or pus in urine? ❑ ❑
   e. Diabetes, kidney trouble, ulcers or digestive disorder? ❑ ❑

YES NO

   f. Disorder of breast or reproductive organs or functions? ❑ ❑
   g. Nervous or mental disorder, emotional condition or psychiatric care? ❑ ❑
   h. Cancer, tumor or cyst? ❑ ❑
   i. Varicose veins, hemorrhoids or hernia? ❑ ❑
   j. Disorder of eyes, ears, nose or sinuses? ❑ ❑
   k. Thyroid, liver or respiratory disorder? ❑ ❑
   l. Alcoholism or drug habit? ❑ ❑
   m. Disorder of the blood? ❑ ❑
   n. Other health or physical impairment including:
      (i) Testing positive for exposure to HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) caused by the HIV infection, or other sickness or condition derived from such infection? ❑ ❑
      (ii) Any other disorder of the immune system? ❑ ❑
      (iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years? ❑ ❑
      (iv) Any other impairment? ❑ ❑
8. If you have answered Question 1 "No," or any other Questions "Yes," give complete details below. (Attach a separate sheet if necessary, sign and date.)

Question # and 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:

I request the group insurance shown on the reverse side. 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 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 misstatements or failure 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 am actively performing any and all duties of my occupation and any approved dependents are actively performing the normal activities of a person in good health of like age on the date of approval; (b) any person who is not performing such duties/activities as required will not become insured until the day he/she is performing such duties/activities, 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 Group Policyholder. I also understand that benefits may not be payable for up to two years after the effective date of coverage for losses due to a disease or condition which I or any person to be covered, now have/has or have had in the past, and which is not disclosed on this form.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, 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 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, past convictions, 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, or other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

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 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. The information New York Life obtains through this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage, my authorized agent or I will receive a copy of this signed AUTHORIZATION, and that in all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION.

DETACH AND RETAIN FOR YOUR RECORDS

IMPORTANT NOTICE: How New York Life Underwrites Your Request for Coverage

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 non medical information may be given to the Bureau, which may then be furnished to member companies.

(continued on reverse)

Member's Signature x____ ____________________________

(PLEASE SIGN IN INK) DATE

To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Spouse's Signature x ____ ____________________________

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) DATE

Form GPA-AC-1
G-29074-0

rev. 01/09

COMPLETE THIS FORM AND RETURN TO:
NEBCO
P. O. Box 153004
Irving, TX 75015-3004

DO NOT SEND YOUR CHECK WITH THIS APPLICATION FORM.
YOU WILL BE BILLED FOR THE APPROPRIATE AMOUNT.

DETACH AND RETAIN FOR YOUR RECORDS

If we cannot provide the coverage you requested, 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: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590.

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 rev. 01/09