ADA INCOME PROTECTION

Application to Exercise Student Disability Conversion Privilege

Since 1934 ADA INSURANCE PLANS from Great-West Life

QUESTIONS? 888-463-4545
www.insurance.ada.org
ada@gwl.com

READY TO GO? P.O. Box 340
Denver, CO 80201
Fax 303-737-4843

ICW08

PERSONAL INFORMATION

Please provide personal information here. Additional financial data may be requested by the underwriter.

ADA Identification No._____

Member Name_____

Address_____

City_____

State_____ Zip_____

Date of Birth_____ Gender ❑ M ❑ F

Home Phone_____

Office Phone_____

Cell Phone_____

Fax Number_____

E-mail_____

Best way to be contacted (if needed): ❑ Phone ❑ Fax ❑ E-mail

Best time to be contacted: M T W Th F at ____:____ ❑ am ❑ pm

BENEFICIARY INFORMATION

The beneficiary you designate is the person who will receive your benefits if you should die while disabled.

Beneficiary (Print name in full)_____

Relationship to Insured_____

GUARANTEE ISSUE

ELIGIBILITY

Subject to all other terms and conditions of the Group Policy, Great-West Life & Annuity Insurance Company will not ask a member to provide Proof of Good Health and will guarantee to issue insurance under the following circumstances:

1. The Member was insured under the ADA Group Student Disability Insurance Plan as a student.
2. The Member graduated from an accredited dental school.
3. The Member is an Active ADA Member.
4. The Member is actively working full-time (at least 20 hours per week) as a dentist.

ELECTION

Please check below to exercise your conversion privilege.

❑ **I hereby apply for the guaranteed issue Long Term Benefit Plan provided under Group Disability Income Protection Policy 1105GDH-IPP issued by Great-West Life & Annuity Insurance Company to the American Dental Association.**
I wish to exercise the conversion privilege under Group Policy 1108GDH-SDP and convert the same monthly coverage amount and the same 90-day waiting period to Group Policy 1105GDH-IPP. I understand I have the option, at any time, to reduce my monthly coverage amount and/or switch to a longer waiting period for this coverage. Such adjustment would result in reduced premiums but also reduced benefits.

Your insurance will become effective as of the date your application is received by Great-West Life. You will be sent a notice of the interim premium due from the date coverage begins until the next regular renewal date. When you have paid this premium, you will receive your Certificate of Insurance.

SIGNATURE

Signature of Member **X** _____ Date / /

❑ I'm interested in more ADA Income Protection insurance to further safeguard my income and lifestyle. Please send me rates and an application.

❑ I'm interested in the Residual Plus Option, which can entitle me to benefits even if I'm not totally disabled. Please send me more information.

❑ I'm interested in the Future Increase Option, which can provide up to $2,500 in extra coverage without a medical exam. Please send me more information.

❑ I'm interested in the COLA Option, which could increase my benefit payments (if I'm disabled) to keep up with inflation. Please send me more information.

❑ I'm interested in ADA Office Overhead Expense insurance, which can provide separate disability protection for my practice. Please send me more information.

Great-West
LIFE & ANNUITY INSURANCE COMPANY

©2008 Great-West Life & Annuity Insurance Company. Benefits for the Income Protection Plan are provided under Group Policy No. 1105GDH-IPP issued to the American Dental Association and underwritten and administered by Great-West Life & Annuity Insurance Company. Benefits are provided through a group policy filed in the state of Illinois, and all eligible ADA members residing in any U.S. state or territory may apply for coverage. This policy is subject to, governed by, and shall be construed in accordance with Illinois law. Each approved Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the policy.