ADA Annually Renewable Term Life Plan

Application for Insurance TLWS18

GREAT-WEST FINANCIAL™

 Read all forms  Complete sections 1 thru 10  Mail or Fax ALL completed forms 

Questions? 866.607.5334 | insurance.ada.org | planspecialist@greatwest.com | **Submit to:** P.O. Box 340 | Denver, CO 80201 | Fax: 303.737.4843

1 Member Information

Are you an ADA member **under age 65?** ☐ **Yes** ☐ **No**

Please print legibly

ADA Number

Social Security Number

Full Legal Name

Address

City State ZIP

____/____/____
Date of Birth

☐ Male ☐ Female

Office Phone

Home Phone

Fax Number

Cell Phone

Email

Best way to be contacted (if needed): ☐ Phone ☐ Email

☐ Sign me up to receive relevant notices and special offers from ADA Members Insurance Plans via email.

2 Coverage Amount

Check the TOTAL amount desired (INCLUDING any existing coverage under this Plan). Minimum increase is $50,000. You may apply for coverage for yourself if under age 65 and for your legal spouse or domestic partner if he/she is under age 65 at any time, as long as you are a current participant or applicant.

Member Coverage	Spouse/Domestic Partner Coverage
You may elect any increment of $25,000, minimum amount $50,000. ☐ $3,000,000 (maximum) ☐ $50,000 (minimum) ☐ Other _____ ☐ No coverage change at this time	You may elect any increment of $25,000, not to exceed Member amount. Coverage is for: ☐ Spouse ☐ Domestic Partner* Full Name ☐ $1,000,000 (maximum) ☐ $50,000 (minimum) ☐ Other _____ ☐ No coverage change at this time

*When applying for coverage for a Domestic Partner, you and your partner must also complete an Affidavit of Domestic Partnership. Call 800.568.2001 or visit insurance.ada.org to obtain this form.

3 Optional Coverage

Any elections made here will override any previous elections for optional coverage. Any dependent coverage will also have the chosen option(s).

For Options 1 and 2: A "YES" response will be assumed if neither box is checked. A "NO" response will constitute an official request for immediate termination of any existing Member and Dependent optional coverage. NOTE: This optional coverage will be subject to underwriting approval if you wish to apply for it again in the future.

If you are applying ONLY for Dependent coverage, you do not need to make any election at this time for Options 1 or 2. The same option(s) previously elected for the Member will automatically apply to any Dependent coverage.

Option	Check One for Each Option
Accidental Death Insurance Doubles the insured person's death benefit, up to a maximum of $1,000,000, if death is accidental as defined by the policy	☐ Yes ☐ No
Disability Waiver of Premium Allows all coverage to continue without premium payment if the insured Member is totally disabled as defined by the policy prior to age 60	☐ Yes ☐ No

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3 Optional Coverage (continued)

1. $15,000 for each eligible unmarried dependent child from 6 months to 21 years of age (or to age 23 if a full-time student)

☐ Yes ☐ No

2. If "yes," name eligible dependent children:

Name: _____ Birthdate: _____ Full-time student? ☐ Yes ☐ No

Name: _____ Birthdate: _____ Full-time student? ☐ Yes ☐ No

4 Beneficiary

The person(s) who will receive insurance proceeds upon the insured person's death. Attach another sheet if space is not adequate.

Member Coverage	Spouse/Domestic Partner Coverage
☐ I hereby revoke any previous beneficiary designation I may have made and appoint the person(s) named below as the beneficiary of any monies payable upon my death. ☐ No beneficiary change at this time **Please print and be sure to check the appropriate box above. Percentages must total 100%** Full Name / Relationship / Percentage of Benefit Full Name / Relationship / Percentage of Benefit	**The beneficiary of any Dependent coverage will be the ADA Member unless otherwise named in an Appointment of New Beneficiary form. Call 800.568.2001 or visit insurance.ada.org to obtain this form.**

5 Miscellaneous

Additional information is required to determine eligibility and proof of insurability. Complete the Questionnaire below.

Member Coverage	Spouse/Domestic Partner Coverage
Primary Care Physician Address City / State / ZIP Phone Number / Fax Number	___/___/___ Date of Birth ☐ Male ☐ Female Social Security Number Primary Care Physician Address City / State / ZIP Phone Number / Fax Number

6 Questionnaire

Please answer all questions and explain any "Yes" answers in the Remarks Section (attach additional sheet if necessary).

		Member	Spouse/ Domestic Partner
1.	Have you ever been diagnosed with or treated for Diabetes?	☐ Yes ☐ No	☐ Yes ☐ No
2.	Have you ever been diagnosed with or treated for Multiple Sclerosis, Systemic Lupus, Parkinson's or Rheumatoid Arthritis?	☐ Yes ☐ No	☐ Yes ☐ No
3.	Have you ever been diagnosed with or treated for Non-Hodgkin's Lymphoma or other cancer?	☐ Yes ☐ No	☐ Yes ☐ No
4.	Have you ever been diagnosed with or treated for a heart attack (including stents or bypass surgery)?	☐ Yes ☐ No	☐ Yes ☐ No
5.	**Foreign Travel:** Do you plan to travel to or reside in a country other than the U.S. at any time in the next two years? If "yes," identify all anticipated travel and lengths of stays.	☐ Yes ☐ No	☐ Yes ☐ No
6.	**Aviation:** Have you ever flown a private aircraft, or do you intend to fly as a pilot or crew member?	☐ Yes ☐ No	☐ Yes ☐ No
7.	**Avocations/Hobbies:** Do you now or do you intend to participate in skydiving, hang gliding, parachuting, racing motor vehicles, or any other hazardous or extreme sports?	☐ Yes ☐ No	☐ Yes ☐ No

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6 Questionnaire (continued)

		Member	Spouse/ Domestic Partner
8.	**Family Health History:** Did either of your parents or any of your siblings die prior to age 60 due to coronary heart disease, diabetes, cancer, or stroke?	☐ Yes ☐ No	☐ Yes ☐ No
9.	**Motor Vehicle Use:** In the last five years, have you had any motor vehicle accidents or moving violations or had your driver's license revoked or suspended?	☐ Yes ☐ No	☐ Yes ☐ No

Member: _____ Driver's License # _____ State Issued

Spouse/Domestic Partner: _____ Driver's License # _____ State Issued

Remarks Section

Explain in full all "yes" answers to questions 1 through 9 below. Specify the number of the question and then describe in detail diagnosis, symptoms, tests performed, dates, types and amounts of medications, names and addresses of all physicians, medical or mental health professionals, counselors, holistic practitioners or hospitals.

QUESTION #	Dates	Reason Consulted/Diagnosis	Physician's Name	Current Status

7 Payment Information

If applying for coverage for the FIRST TIME, please select your premium payment preference. I wish to pay premiums by **(select one)**:

- ☐ Check (annual)*
- ☐ Check (semi-annual)
- ☐ Autopay (annual)*
- ☐ Autopay (semi-annual)
- ☐ Autopay (monthly, 1st of the month)**
- ☐ Autopay (monthly, 10th of the month)**

*A 3% discount will apply to premiums paid annually

**A 2% service charge will be added to monthly Autopay withdrawals

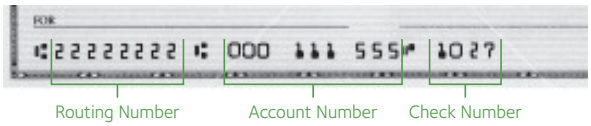
If you selected Autopay, please fill out the information below.

Bank Name _____

Routing No. _____

Account No. _____

Check one: ☐ Checking ☐ Savings



To ensure accurate account information, please ATTACH a voided check or deposit slip to your application.

Autopay Terms and Conditions: All monthly withdrawals will be made, as elected, on the 1st or 10th of the month in which premium is due. Autopay will terminate (1) when you (or the bank depositor, if other than the Certificate owner) provide Great-West Life & Annuity Insurance Company 30 days' written notice; or (2) at Great-West Life & Annuity Insurance Company's election, upon 30 days' written notice to you and/or the bank depositor; or (3) at the discretion of Great-West Life & Annuity Insurance Company, if your designated bank does not transfer funds. In this case, you will receive a lapse notice detailing how to reinstate your coverage. Should the Autopay program terminate, you will be notified to select another payment preference.

8 Fraud Warnings

Arkansas, District of Columbia, Louisiana and Rhode Island: 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. **California:** For your protection, California law requires the following to appear on this form: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Colorado:** It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies. **Florida:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree. **Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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. **Maine, Tennessee and Virginia:** 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. **Maryland:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. **Massachusetts, Oregon and Pennsylvania:** Any person who knowingly and with the 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. **Oklahoma:** 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. **New Jersey:** Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. **Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. **Washington:** 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. **All Other States:** 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 is a crime and subjects such person to criminal and civil penalties.

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9 Notice To Applicants

Please read the following information carefully before you sign this.

This standard disclosure is required of all insurance providers. Be assured that Great-West Life & Annuity Insurance Company's (the Company) business practices meet the highest industry standards.

Information Practices and Notice Regarding MIB, Inc.
Information regarding your insurability will be treated as confidential. Great-West Life & Annuity Insurance Company, or its reinsurers, may however make a brief report thereon to MIB, Inc., a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If you apply to another MIB, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of information in MIB, Inc.'s file, you may contact them directly and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB, Inc.'s information office is 50 Braintree Hill Park, Suite 400 Braintree, MA 02184-8734. Information for consumers about MIB, Inc. may be obtained on its website at www.mib.com or by calling (866) 692-6901.

Great-West Life & Annuity Insurance Company, or its reinsurers, may also release information in its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted and to any other persons as allowed by law. A medical examination by an examiner, approved by the Company, may be requested for any applicant. The fee for the examination will be paid by the Company. Applications accepted for insurance will receive insurance certificates stating the terms and provisions of the group policy.

Acceptance of your application is subject to the underwriting requirements of Great-West Life & Annuity Insurance Company. Depending on your medical history, coverage may be declined or a rider(s) issued excluding coverage for certain condition(s).

The effective date of coverage will be the date your application is approved by the Company. Premiums will be due from that effective date to the next renewal date, either January 1 or July 1. If your application for insurance is not accepted, you will be informed promptly.

Benefits provided under Group Policy No. 104TLP issued to the American Dental Association; insured by Great-West Life & Annuity Insurance Company. Benefits are provided through a group policy filed in the State of Illinois, and coverage is available to all eligible ADA members residing in any U.S. state or territory. This policy is filed in accordance with and governed by Illinois law. Premium Credit discount not guaranteed but reevaluated annually. Each Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the policy.

By my signature below, I hereby declare that my answers and statements to the questions contained herein are full, complete, true and a condition of obtaining this insurance. I understand and agree that providing false, incomplete, or misleading information as a part of this application, or in filing a claim may constitute fraud or misrepresentation which may result in the denial of claims, the rescission of coverage and potential criminal penalties. I have the right to access my personal medical and financial information in my files and to request that any inaccurate information be corrected. I hereby apply for insurance under Group Policy No. 104TLP issued by Great-West Life & Annuity Insurance Company to the American Dental Association subject to all terms, conditions, and provisions of said policy.

I authorize Great-West Life & Annuity Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. and/or obtain an investigative consumer report on me.

ADA No.

Print Name of Member — Date of Birth

Signature of Member — Date of Signature

Print Name of Legal Spouse or Domestic Partner — Date of Birth

Signature of Legal Spouse or Domestic Partner — Date of Signature

Print Name of Owner (if applicable) — Date of Birth

Signature of Owner (if applicable) — Date of Signature

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10 HIPAA Authorization for Release of Medical Information

Please fill out and mail this HIPAA Compliant Authorization form along with your application. We cannot begin to process your application until we receive the signed HIPAA form.

ADA No.

Print Name of Insured/Patient

Date of Birth / /

I authorize any health plan, physician, healthcare professional, hospital, clinic, laboratory, holders of prescription information on me, including but not limited to: pharmacies, pharmacy benefits managers, and insurers, medical facilities, or other healthcare professionals that have provided payment, treatment or services to me or on my behalf ("My Providers") to disclose my entire medical record, prescription history, medications prescribed, eligibility, prescribing physician, pharmacy information, insurance coverage information and any other protected health information concerning me to Great-West Life & Annuity Insurance Company (the Company). This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs and tobacco.

By my signature below, I acknowledge that any agreements I have made to restrict my protected health information do not apply to this authorization and I instruct any physician, healthcare professional, hospital, clinic, medical facility, or other healthcare provider to release and disclose my entire medical record without restriction.

This protected health information is to be disclosed under this Authorization so that Great-West Life & Annuity Insurance Company may 1) evaluate my application for insurance coverage or claims benefits, determine eligibility and risk rating; 2) obtain reinsurance; 3) administer coverage and claims; 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Great-West Life & Annuity Insurance Company.

This authorization shall remain in force for 30 months following the date of my signature below and a copy of this authorization is as valid as the original. I understand that I have the right to revoke this authorization in writing, at any time, by providing written notification to the entity identified above. I understand that a revocation is not effective to the extent that any of "My Providers" have already relied on this Authorization to disclose information about me or to the extent that Great-West Life & Annuity Insurance Company has a legal right to contest a claim under an insurance policy or to contest the policy itself. I understand that any information that is disclosed pursuant to this authorization is no longer covered by federal rules governing privacy and confidentiality of health information, but will not be re-disclosed by Great-West Life & Annuity Insurance Company except as authorized by me or as required by law.

I understand that my providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical record, Great-West Life & Annuity Insurance Company may not be able to process my application, or if coverage has been issued, may not be able to make any benefit payments.

Signature of Insured/Patient

Date of Signature / /

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Signature of Insured/Patient or Personal Representative

Date of Signature / /