ADA Office Overhead Expense Plan

Application for Insurance OEWS17

ADA American Dental Association®

Read all forms Complete sections 1 thru 8 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

Please print legibly

ADA Number ______

Full Legal Name ______

Address ______

City ______ State ______ ZIP ______

___/___/___ Date of Birth ☐ Male ☐ Female

Home Phone ______

Office 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.

Driver's License Number ______ State Issued ______

Have you been charged with and/or convicted of any motor vehicle moving violations or had your driver's license suspended or revoked in the last five years? ☐ No ☐ Yes (If yes, provide date and description of violation) ______

2 Eligibility Verification

☐ Yes ☐ No I am a member of the ADA

☐ Yes ☐ No I am under age 60

☐ Yes ☐ No I am full-time, active military

☐ Yes ☐ No I work at least 20 hours per week, performing the substantial and material duties of my occupation

Dental License Number ______ State Issued ______

3 Coverage Information

1. My office is organized as follows:
☐ Sole Proprietor ☐ S-corp. ☐ P-corp. ☐ C-corp. ☐ Partnership ☐ Other (define): ______

2. My share of total overhead expenses for which I am liable and legally responsible (**excluding** my own salary and the salaries of any dentists I employ, lab expenses, and dental supplies) is: $______ per month

3. ☐ Yes ☐ No I understand that the total monthly amount I request, together with any other overhead expense insurance I have in force or have applied for, cannot exceed my actual monthly overhead expenses.

4. I am requesting this total of monthly ADA Office Overhead Expense insurance coverage: $______ per month
Please write the TOTAL amount of coverage desired, INCLUDING any existing coverage you may have under this Plan. Coverage must be in increments of $500 and cannot exceed $25,000 per month.

5. I select the following Benefit Plan:

☐ 24x Insured Amount

☐ 12x Insured Amount

A separate certificate will be issued with any increase in coverage. Existing coverage will not be changed from this selection.

Continue to next page

3 Coverage Information (continued)

6. ☐ Yes ☐ No Do you have other overhead expense insurance in force or applied for?
If "Yes," provide the name of the carrier(s) and monthly benefit amounts.

Name Amount

Name Amount

7. ☐ Yes ☐ No Is this coverage intended to replace any overhead expense insurance you have in force?
If "Yes," provide the name of the carrier(s) and monthly benefit amounts this new coverage is intended to replace.

Name Amount

Name Amount

8. In the event of your death while receiving benefits, who do you wish to receive any survivor benefits that may be payable?

/ /

Print Full Legal Name Relationship Date of Birth

Address

City State ZIP

4 Health Information

Primary Care Physician Date last seen Reason seen

Address Phone Number

Please provide the names, addresses and phone numbers of any health care provider you have seen in the last 5 years (if more space is needed, please attach separate sheet)

Name Address Phone Number

Name Address Phone Number

☐ Yes ☐ No Have you ever had an application for life, health, or disability income insurance declined, postponed, or modified in any way? If "Yes," give names of companies and reason:

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

1.	Have you ever been diagnosed with or treated for Diabetes?	☐ Yes ☐ No
2.	Have you ever been diagnosed with or treated for Multiple Sclerosis, Systemic Lupus, Parkinson's or Rheumatoid Arthritis?	☐ Yes ☐ No
3.	Have you ever been diagnosed with or treated for Non-Hodgkin's Lymphoma or other cancer?	☐ Yes ☐ No
4.	Have you ever been diagnosed with or treated for a heart attack (including stents or bypass surgery)?	☐ Yes ☐ No
5.	**Use of Nicotine:** Do you now or have you ever smoked cigarettes or cigars or used nicotine in any other form? If yes, please give details, including the date you last consumed nicotine if you have quit.	☐ Yes ☐ No

Continue to next page

4 Health Information (continued)

Remarks Section

Explain in full all "yes" answers to questions 1 through 5 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

5 Payment Information

Please select your premium payment preference for coverage issued under this application. I wish to pay premiums by **(select one)**:

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

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

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.

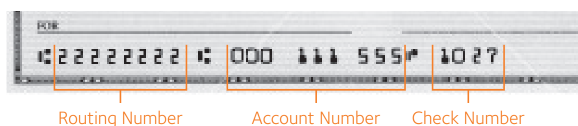
If you selected Autopay, please fill out the information below.

Bank Name

Routing No.

Account No.

Check one: ☐ Checking ☐ Savings



Routing Number Account Number Check Number

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

6 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.

Continue to next page

7 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 Medical Information Bureau
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 February 1 or August 1. If your application for insurance is not accepted, you will be informed promptly.

If you are not actively working full-time at least 20 hours per week doing all the duties of your profession or occupation on the date your application is approved by the Company, the coverage applied for will not begin until the date you are actively working full-time.

Benefits provided under Group Policy No. 1106GDH-OEP 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. 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. 1106GDH-OEP 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 Applicant — Date of Birth

______________________________ ___/___/___
Signature of Applicant — Date of Signature

Continue to next page

8 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 MIB, Inc., 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 facility, or other healthcare professional that has provided payment, treatment or services to me or on my behalf within the past 10 years ("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 administer claims and determine or fulfill responsibility for coverage and provision of benefits; administer coverage; and 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 12 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 healthcare services if I refuse to sign this authorization, or otherwise condition my enrollment or eligibility for health benefits on my signing 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 make any benefit payments. I understand that any authorized representative or I will receive a copy of this authorization upon request.

Signature of Insured/Patient or Personal Representative Date of Signature / /

Description of Personal Representative's Authority or Relationship to Patient