ADA-SPONSORED STUDENT DISABILITY
Application for Insurance

ADA® Members Insurance Plans

QUESTIONS? 888.463.4545
insurance.ada.org
planspecialist@greatwest.com

READY TO GO? P.O. Box 340
Denver, CO 80201
STWS18-045 Fax 303.737.4843

MEMBER'S PERSONAL INFORMATION

Additional financial data may be requested by the underwriter.

Name_____

Address_____

City_____

State_____ Zip_____

Are you an ADA or ASDA member **under age 60?** ❑ Yes ❑ No

Social Security Number_____

Home Phone_____

Cell Phone_____

Fax Number_____

Email_____

❑ **Yes!** Please sign me up to receive promotional information and announcements from ADA-sponsored insurance plans via email.

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

ELIGIBILITY VERIFICATION

1 Birthdate_____/_____/_____ (month / day / year) ***Must be under age 60 to apply.***

2 ❑ Yes Are you an ASDA member? ❑ No ❑ Membership applied for ***Must be a member of the American Student Dental Association or a student member of the American Dental Association.***

3 ADA/ASDA No. (if known)_____

4 ❑ Yes Are you actively engaged as a full-time pre-doctoral dental student? ❑ No ***Must be a full-time pre-doctoral dental student at an accredited U.S. dental school and apply before May 1 of your graduation year.***

5 Graduation year: _____

6 Full name of dental school _____

_____

COVERAGE INFORMATION

Coverage is subject to proof of good health and will be effective from the date your completed application is approved by Great-West Life.

1 I request the following coverage: ❑ $2,000 per month, plus up to $150,000 in student loan repayment benefits

All coverage includes a 90-day waiting period.

2 I currently have other disability insurance. ❑ Yes $_____ (Monthly coverage amount and name of Company) ❑ No ❑ Don't know

When disability coverage from all sources exceeds $3,000 per month, benefits from this Plan may be reduced.

HEALTH INFORMATION *Please also complete medical questionnaire below.*

❑ Male Height _____
❑ Female Weight _____ lbs

❑ 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:

_____

Current Personal Physician _____

Address _____

City, State, Zip _____

Phone _____

Fax _____

MEDICAL QUESTIONNAIRE *Please answer all questions and explain any "Yes" answers below (attach additional sheet if necessary).*

1. Has your weight changed in the past year by plus or minus 10 pounds or more? If yes, please indicate gain or loss and number of pounds. ❑ Yes ❑ No

2. In the past 10 years, have you had:

a. dizziness, fainting, convulsions, chronic headache, nervous breakdown, epilepsy, stroke, disorder of the brain or nervous system, or other mental or nervous disorders including anxiety, depression, or other emotional disturbances? ❑ Yes ❑ No

b. asthma, bronchitis, allergies, tuberculosis, pleurisy, emphysema, blood spitting, persistent cough, or disorder of the lungs or respiratory system? ❑ Yes ❑ No

c. high blood pressure, chest pain, palpitations, heart murmur, heart attack, or disorder of the heart or blood vessels? ❑ Yes ❑ No

d. ulcer, recurrent indigestion, intestinal bleeding, colitis, jaundice, hemorrhoids, hernia, or disorder of the stomach, intestines, rectum, gallbladder, liver, or pancreas? ❑ Yes ❑ No

e. sugar, albumin, pus, or blood in the urine; nephritis, kidney stone, or disorder of the kidneys or bladder? ❑ Yes ❑ No

f. diabetes, cancer, tumor, gout, venereal disease, or disorder of the prostate or reproductive organs? ❑ Yes ❑ No

g. backache, rheumatic fever, rheumatism, arthritis, paralysis, or disorder of the muscles or bones, including joints and spine? ❑ Yes ❑ No

Continue questionnaire on back

MEDICAL QUESTIONNAIRE FOR ADA-SPONSORED STUDENT DISABILITY

h.	recurrent infections, thyroid disorder, enlarged lymph glands, anemia, excess fatigue, or disorder of the glands or blood?	❑ Yes	❑ No
i.	disorder of the eyes, ears, throat, or skin (including skin lesions)?	❑ Yes	❑ No
j.	treatment or joined an organization because of alcohol or drug abuse or been medically advised to do so?	❑ Yes	❑ No
3.	Have your parents, brothers, or sisters ever had diabetes, high blood pressure, heart or kidney disease?	❑ Yes	❑ No
4.	In the last five years have you:		
a.	missed more than 15 consecutive days from work due to sickness or injury, or been disabled in any way?	❑ Yes	❑ No
b.	been a patient in a hospital, clinic, or other medical facility?	❑ Yes	❑ No
c.	had an EKG, X-ray, blood test, or other diagnostic test?	❑ Yes	❑ No
d.	had a checkup, consultation, illness, surgery, injury, or disease not mentioned in questions 2 or 3?	❑ Yes	❑ No
5.	Are you currently using any kind of medically prescribed medication?	❑ Yes	❑ No

If "Yes," indicate name of medication and medical condition _____

If you answered "Yes" to any of the above medical questions, please explain in detail below. If space is not adequate, attach another sheet.

Question	*Dates*	*Reason Consulted/Diagnosis*	*Physician's Name, Address, and Phone Number*	*Current Status*

NOTICE TO APPLICANTS *Please read the following information carefully before you sign this application.*

Information regarding your insurability will be treated as confidential. Great-West Life & Annuity Insurance Company may, however, make a brief report thereon to MIB, Inc., a not-for-profit membership organization of life 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 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 your file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB'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 life 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. Applicants accepted for insurance will receive insurance certificates stating the terms and provisions of the group policy. Applicants not accepted for insurance will be informed promptly.

I hereby apply for insurance under Group Policy No. 1108GDH-SDP issued by Great-West Life & Annuity Insurance Company to the American Dental Association subject to all terms, conditions, and provisions of said Policy.

By my signature below, I hereby declare that my answers and statements to the questions contained herein are full, complete, and true and a condition of obtaining this insurance. I understand and agree that knowingly providing false, incomplete, or misleading information as a part of this application, or in filing a claim, may constitute fraud 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.

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 MAY 1 OR NOVEMBER 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.

AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION

A. Great-West Life & Annuity Insurance Company, its reinsurers, and insurance support organizations may obtain medical and other information in order to evaluate my application for insurance.

B. Any physician, practitioner, hospital, clinic, other medical or medically related facility, the Veterans Administration, MIB, Inc., my employer, and consumer reporting agency or insurance company who possesses information of care, treatment, or advice of me or my spouse may furnish such information to Great-West Life & Annuity Insurance Company upon presenting this authorization or a photocopy.

C. This authorization includes information about drugs, alcoholism, and mental illness.

D. This authorization will be valid from the date signed for a period of two and one-half years.

E. Great-West Life & Annuity Insurance Company, or its reinsurers, may make a brief report regarding me to other companies to whom I have applied or may apply.

F. I authorize Great-West Life & Annuity Insurance Company, or its reinsurers, to obtain an investigative consumer report on me.

G. I authorize Great-West Life & Annuity Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc.

H. I have read the Notice to Applicants and the Authorization to Obtain and Disclose Information. I may obtain a copy of the Description of Information Practices on request.

SIGNATURE

Signature of Member **X** .....

Date / /

California Disclosure: For your protection, California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Pennsylvania Disclosure:** 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. **New York Disclosure:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation.

Benefits provided under Group Policy No. 1108GDH-SDP issued to the American Dental Association, insured by Great-West Life & Annuity Insurance Company, and filed in accordance with and governed by Illinois law. Coverage is available to all eligible ASDA/ADA members residing in any U.S. state or territory. Each Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the policy. Information about coverage provisions and limitations, terms for keeping coverage in force, and future insurance costs is available at insurance.ada.org or 800-568-2001.