AAOS
AMERICAN ASSOCIATION OF ORTHOPAEDIC SURGEONS
#51302

REQUEST FOR COVERAGE FORM
Please complete this form and return to:
AAOS Plan Administrator,
1200 E. Glen Ave. Peoria Heights, IL 61616-5348
QUESTIONS: Please call **866.679.0888**

AAOS GROUP TERM LIFE APPLICATION

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. MEMBER INFORMATION

Full Name: ______ Social Security No: ___-__-____

Street Address: ______ Home Phone: ______

City: ______ State (or Province): ______ Zip: ______ Work Phone: ______

Email: ______ Fax Number: ______
For internal use only. Email address will never be sold or shared.

2. SPOUSE INFORMATION–complete if you are requesting coverage for your spouse

Spouse Full Name: ______ Social Security No: ___-__-____

Street Address: ______ Home Phone: ______

City: ______ State (or Province): ______ Zip: ______ Work Phone: ______

3. ADDITIONAL INFORMATION

	Name *(if proposed for insurance)*	Date of Birth:	Height:	Weight:	Sex:
Member:		__/__/__	__ft. __in.	__lbs.	◯ M ◯ F
Spouse:		__/__/__	__ft. __in.	__lbs.	◯ M ◯ F
Child:		__/__/__	__ft. __in.	__lbs.	◯ M ◯ F
Child:		__/__/__	__ft. __in.	__lbs.	◯ M ◯ F

4. MEMBER AFFILIATION

Association Membership is required for participation in this plan: **AAOS Membership ID#:** ______

5. HEALTH QUESTIONS

Please answer these questions by checking "Yes" or "No."	**MEMBER**	**SPOUSE/ DOMESTIC PARTNER** (if applicable)
1. Within the last 12 months, have you smoked cigarettes?	◯ Yes ◯ No	◯ Yes ◯ No
2. Within the last five years, have you been evaluated for, medically treated for, diagnosed with, taken medications for, or experienced symptoms of any of the following conditions:	◯ Yes ◯ No	◯ Yes ◯ No
a. Disease or disorder of the heart, blood, or circulatory system	◯ Yes ◯ No	◯ Yes ◯ No
b. High blood pressure	◯ Yes ◯ No	◯ Yes ◯ No
c. Cancer or tumors	◯ Yes ◯ No	◯ Yes ◯ No
d. Lung, respiratory, or breathing disorders	◯ Yes ◯ No	◯ Yes ◯ No
e. Diabetes	◯ Yes ◯ No	◯ Yes ◯ No
f. Liver or kidney disorders	◯ Yes ◯ No	◯ Yes ◯ No
g. Gastrointestinal, stomach, or intestine disorders, including ulcers or gallstones	◯ Yes ◯ No	◯ Yes ◯ No
h. Mental or nervous illness or disorder, alcoholism, or drug addiction	◯ Yes ◯ No	◯ Yes ◯ No
i. Chronic pain or fatigue syndrome	◯ Yes ◯ No	◯ Yes ◯ No
j. Neurological disorders such as Multiple Sclerosis or Parkinson's Disease	◯ Yes ◯ No	◯ Yes ◯ No
k. Musculoskeletal disorders including arthritis, fractures, or carpal tunnel syndrome	◯ Yes ◯ No	◯ Yes ◯ No
3. Within the last five years, have you been diagnosed with or treated by a physician for Human Immunodeficiency Virus (HIV), AIDS-related Complex (ARC), or Acquired Immune Deficiency Syndrome (AIDS)?	◯ Yes ◯ No	◯ Yes ◯ No
4. Within the last five years, have you been in a hospital or other institution for observation, rest, diagnosis, or treatment?	◯ Yes ◯ No	◯ Yes ◯ No
5. Within the last five years, have you been attended to by a doctor or licensed practitioner for anything other than a routine physical?	◯ Yes ◯ No	◯ Yes ◯ No
6. Do you have any k toms or physical or mental impairments not mentioned in the previous questions?	◯ Yes ◯ No	◯ Yes ◯ No
7. Are you taking any medication or being treated for any condition, including pregnancy, not mentioned in the previous questions?	◯ Yes ◯ No	◯ Yes ◯ No

If you answered "Yes" to any of the questions 3–7, please include details. *(If more space is needed, please attach an additional sheet.)*

MEMBER	SPOUSE	Question Number	Date of Illness	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatment, and medications prescribed and taken	Names, complete addresses, and phone numbers of physicians
◯	◯					
◯	◯					

Primary Care Physician Information for Member *(if Spouse's Primary Care Physician is different, please provide information on a separate sheet and attach)*

Physician Name: ______ Date Last Seen (Member): ______

Address: ______ Phone: (____) ______

6. COVERAGE AMOUNTS

I hereby apply for the following Group Term Life Insurance coverage:

Member Coverage: Requested Coverage Amount: $__________________ *($50,000 increments up to $1,000,000)*

Optional Coverage(s) Requested: ◯ Spouse Coverage: Amount: $__________________ *($50,000 increments up to $500,000; cannot exceed Member amount)*

◯ Dependent Child Coverage: ◯ $10,000 ◯ $20,000

7. BENEFICIARY INFORMATION

Full Name: ______________________________ Relationship: ______________

Address: ______________________________ Date of Birth: ______________

Phone Number: ______________ Social Security No: ___-__-____ **SHARE:** ______ %

Full Name: ______________________________ Relationship: ______________

Address: ______________________________ Date of Birth: ______________

Phone Number: ______________ Social Security No: ___-__-____ **SHARE:** ______ %

(If more space is needed, please attach a separate sheet.) **TOTAL (MUST EQUAL 100%):** 100 %

8. CONTRIBUTION PAYMENT BASIS

I request the following payment basis *(please check one)*: ◯ Annual ◯ Semi-Annual ◯ Monthly Electronic Fund Transfer (EFT)*

**If electing EFT, you must complete the Electronic Fund Transfer Authorization section below*

Electronic Fund Transfer Authorization: (If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your savings account, you must confirm that your bank permits electronic fund withdrawals from savings accounts.) By my signature below, I authorize the AAOS Member Insurance Program, in accordance with the Agreement (included below), to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation or insurance is terminated.

Account Owner's Name: ______________________________ Bank Name: ______________________________

Bank's Transit Routing #*(checking account only)*: ______________ Your Account #: ______________ ◯ Checking ◯ Savings

Signature of Account Owner: **X** ______________________________

9. SIGN AND DATE

AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule. I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the MIB, Inc. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded,) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the MIB, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below. I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer coverage; and 4) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 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 sending a signed request for revocation to The Prudential Insurance Company of America. Group Medical Underwriting, P.O. Box 8796. Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I, or a person authorized to act on my behalf, have the right to request and receive a copy of this Authorization.

Statement of Understanding: I (We) represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and: the answers and statements in this application continue to be true and complete until the Effective Date. I (We) also understand that coverage will not take effect if the facts have changed. I (we) have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application in no way implies that I (we) will be accepted for insurance coverage.

Accelerated Death Benefits: Accelerated Death Benefit option is a feature that is made available to group life insurance participants. It is not a health, nursing home, or long-term care insurance benefit and is not designed to eliminate the need for those types of insurance coverage. The death benefit is reduced by the amount of the accelerated death benefit paid. There is no administrative fee to accelerate benefits. Receipt of accelerated death benefits may affect eligibility for public assistance and may be taxable. The federal income tax treatment of payments made under this rider depends upon whether the insured is the recipient of the benefits and is considered terminally ill. You may wish to seek professional tax advice before exercising this option.
Please consult Fraud warnings appearing on next page. I have read and understand the terms and requirements of these Fraud warnings.
I have received the Group Life and Disability Income Medical Underwriting Notice included with this form.

Member Signature: **X** ______________________________ Date: ______________

Spouse Signature *(If applying for Spouse Coverage)*: **X** ______________________________ Date: ______________

10. IMPORTANT NOTICES—retain a copy for your records

Virginia Residents: Any person who, with the intent to defraud or knowing that he/she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may have violated state law.

Beneficiary Designation: If more than one beneficiary is desired, please write their name(s) and relationship(s) on a separate sheet and submit to the Plan Administrator. If more than one primary beneficiary is designated, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) who are then still living, unless their shares are specified. If there is no named beneficiary, or no beneficiary survives the insured, settlement will be made in accordance with the terms of your Group Contract.

Electronic Fund Transfer Authorization: AAOS Member Insurance Program Automatic Insurance Payment Program Agreement provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will within six business days following the due date. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

This application is to be attached to and made part of the policy.
Please keep this notice for your records.