ADA-SPONSORED STUDENT TERM LIFE
Application for Insurance

ADA® Members Insurance Plans

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

READY TO GO? SLWS18-045
P.O. Box 340
Denver, CO 80201
Fax 303.737.4843

MEMBER'S PERSONAL INFORMATION

Social Security Number_____

ADA/ASDA Identification No. _____

Name _____

Address _____

City _____

State _____ ZIP _____

Are you an ADA or ASDA member **under age 65?** ❑ Yes ❑ No

Home Phone _____

Office 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

PAYMENT INFORMATION

Please complete this section ONLY if you are applying for coverage BEYOND the $50,000 provided at no cost to students. Send no money now; accepted applicants will be billed upon approval.

I wish to pay premiums by (select one):
- ❑ Check - semi-annually
- ❑ Autopay bank withdrawal - semi-annually

Bank name _____
Account number _____
Account holder's name (if other than yourself) _____
Account type: ❑ Savings ❑ Checking

If selecting Autopay, please attach your voided check here.

Autopay Terms and Conditions: All withdrawals will be made, as elected, on the 1st 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.

COVERAGE INFORMATION

AMOUNT

The amount of insurance coverage desired

Check the TOTAL amount desired (INCLUDING any existing coverage under this Plan). Minimum increase is $50,000.

MEMBER COVERAGE

You may apply for coverage under this Plan at any time before age 65.

❑ $500,000 (maximum*)
❑ $50,000 (minimum)
❑ Other_____

****You can apply for up to $3,000,000 in member coverage in the calendar year of your graduation.***

SPOUSE COVERAGE

You may apply for coverage for your Legal Spouse or Domestic Partner* under age 65 as long as you are a current participant or applicant in this Plan.

Coverage is for: ❑ Spouse or ❑ Domestic Partner***
Full Name_____
Social Security Number_____
❑ $500,000 (maximum**)
❑ $50,000 (minimum)
❑ Other_____

Spouse/Domestic Partner coverage can-not exceed Member coverage amount.

****You can apply for up to $1,000,000 in Spouse or Domestic Partner coverage in the calendar year of your graduation.***

*****If 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.***

OPTIONS

Optional coverage

Any election made here will override any previous election 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. As a student participant, your free coverage automatically includes these two options. 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.

1 ❑ Yes ❑ No **Accidental Death Insurance:** Doubles the insured person's death benefit, up to a maximum of $1,000,000, if death is by accidental means

2 ❑ Yes ❑ No **Disability Waiver of Premium:** Allows all coverage to continue without premium payment if the insured Member is totally disabled prior to age 60

3 ❑ Yes ❑ No **Dependent Child Coverage:** $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 Have any of your eligible children been hospitalized or treated in a hospital outpatient facility due to any disease or disability within the last six months?

If "Yes" name child and give details: _____

BENEFICIARY

The person(s) who will receive insurance proceeds upon the insured person's death

Attach another sheet if space is not adequate.

❑ 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. Percentages must total 100%.

Full Name | Relationship | Percent of Benefit

_____ %
_____ %

The beneficiary on 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.

MISCELLANEOUS

Additional information is required to determine eligibility and proof of insurability

Complete Medical Questionnaire on back.

Member

Birthdate____/____/____ (month day year) ❑ Male ❑ Female Height_____ Weight_____lbs

Current Personal Physician _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

Spouse or Domestic Partner

Birthdate____/____/____ (month day year) ❑ Male ❑ Female Height_____ Weight_____lbs

Current Personal Physician _____
Address _____
City, State, Zip _____
Phone _____
Fax _____

MEDICAL QUESTIONNAIRE FOR ADA-SPONSORED STUDENT TERM LIFE PLAN

Please answer all questions and explain any "Yes" answers below (attach additional sheet if necessary).	*Member*		*Spouse or Domestic Partner*	
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	❑ Yes	❑ No
2. Have you ever had or been treated for high blood pressure, elevated cholesterol, heart problems, diabetes, cancer, kidney disorder, stomach complaints, arthritis, or other joint disease?	❑ Yes	❑ No	❑ Yes	❑ No
3. Have you ever been treated for anxiety, depression, or other emotional disturbances?	❑ Yes	❑ No	❑ Yes	❑ No
4. Have you ever applied for insurance which was declined, postponed, or modified in any way?	❑ Yes	❑ No	❑ Yes	❑ No
5. Have you had a checkup, consultation, illness, surgery, injury, or disease not mentioned in the questions above?	❑ Yes	❑ No	❑ Yes	❑ No
6. **Foreign Travel:** Do you plan to travel to or reside in a country other than the U.S.A. at any time in the next two years? If yes, identify all anticipated travel and lengths of stays.	❑ Yes	❑ No	❑ Yes	❑ No
7. **Aviation:** Have you ever flown a private aircraft or do you intend to fly as a pilot or crewmember?	❑ Yes	❑ No	❑ Yes	❑ No
8. **Avocations/Hobbies:** Do you now or do you intend to participate in sky diving, hang gliding, parachuting, racing motor vehicles, or any other hazardous or extreme sports?	❑ Yes	❑ No	❑ Yes	❑ No
9. **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
10. **Motor Vehicle Use:** In the last five years have you had any motor vehicle accidents or moving violations or had your drivers license revoked or suspended?	❑ Yes	❑ No	❑ Yes	❑ No
11. **Use of Nicotine:** Do you now or have you ever smoked cigarettes, cigars, or used nicotine products in any form? If yes, give details including the date you last consumed nicotine if you have quit.	❑ Yes	❑ No	❑ Yes	❑ No
12. **Alcohol or Drugs:** In the past ten years:				
a. Have you ever used narcotics, barbiturates, hallucinogens, heroin, cocaine, or other habit forming drugs except as prescribed by a physician?	❑ Yes	❑ No	❑ Yes	❑ No
b. Have you self prescribed any of these substances?	❑ Yes	❑ No	❑ Yes	❑ No
c. Have you ever received treatment or counseling for the use of alcohol or other habit forming substances?	❑ Yes	❑ No	❑ Yes	❑ No

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

NOTICE TO APPLICANTS

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.

The insurance will become effective on the date the application is approved by the Company. 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. 104TLP 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.

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.

SIGNATURES

Ensure that owner signs if owner and applicant are not the same.

Signature of **Member** **X** ..... **Date** / /

Signature of **Legal Spouse or Domestic Partner** (if applicable) **X** ..... **Date** / /

Signature of Owner (if applicable) **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. **Domestic Partner Disclosure:** Definitions, eligibility, and issues arising from any required documentation regarding Domestic Partner coverage are governed by the laws of the State of Illinois.

Benefits provided under respective Group Policy No. (104TLP Term Life) issued to the American Dental Association, underwritten by Great-West Life & Annuity Insurance Company, and filed in accordance with and governed by Illinois law. The ADA is entitled to receive royalties from the ADA Members Insurance Plans. Coverage is available to all eligible ADA members residing in any U.S. state or territory. Term Life premiums increase annually based on age. Each Plan participant will receive a Certificate of Insurance explaining the terms and conditions of the policy.

GREAT-WEST LIFE & ANNUITY INSURANCE COMPANY
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