



Group Accidental Death & Dismemberment (AD&D) Insurance APPLICATION FORM



Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave
New York, NY 10010

Plan Administrator:
Affinity Insurance Services, Inc.
159 East County Line Road
Hatboro, PA 19040-1218
(800) 98-AIChE (982-4243)

Complete this form and return to the Plan Administrator

Group Policy No. G-29343-0 Certificate No. _____

1. MEMBER INFORMATION

Name _____ Home Phone # _____
Address _____ Work Phone # _____
City _____ State _____ Zip _____ Fax # _____ Sex M F
Home E-mail address _____ Soc. Sec. # _____ Date of Birth _____

Marital Status Married Divorced Single Widowed Civil Union* Maiden Name _____
 Domestic Partner*(Submit a completed Declaration of Domestic Partnership Form – Not Applicable in Oregon) *Eligibility is determined by State Law

I am a Member of AIChE: Membership # _____ Expiration date _____
(Membership is required to participate in this plan)

Date you Became a Member _____

Are you presently insured by any AIChE plan? Yes No *If yes, provide details* _____

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member Yes No Spouse Yes No *If yes, how long?* _____ Country _____

2. BILLING OPTION SELECTION

OPTION 1: Electronic Funds Transfer Monthly Quarterly Semi-Annual Annual

Authorization for Electronic Funds Transfer

I request and authorize Affinity Insurance Services, Inc. (LifeHealth) to make withdrawals based on my selected payment method above against the account specified on the attached voided check or savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. **In order to process your electronic payment, both the Account # and Bank Routing # must both appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage at the end of the 31 day grace period, effective as of the due date if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

X _____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

OPTION 2: Direct Bill Quarterly Semi-Annual Annual (Make check payable to: Affinity Insurance Services, Inc.)

3. DEPENDENT INFORMATION

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under 19, or 26 if full time student). *Attach separate sheet to provide additional dependent information.*

Dependent Full Name (ie. Mary J. Doe)	Social Security #	Date of Birth (mo/day/yr)	Male or Female
Spouse's Full Name			
Child			
Child			
Child			

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4. INSURANCE REQUESTED

(Refer to the website www.aicheinsurance.com or your certificate for eligibility, principal sums, and coverage description)

I HEREBY APPLY FOR THE FOLLOWING AD&D COVERAGE(S): New Change

NOTE: If you are increasing or altering present AD&D coverage in any way, do not indicate just the additional amount of coverage, instead, indicate the TOTAL AMOUNT of coverage you are requesting.

MEMBER ONLY PLAN :Total Principal Sum Amount Desired: (from \$50,000 to \$500,000 in units of \$50,000) \$ _____

FAMILY PLAN: Total Principal Sum Desired: (from \$50,000 to \$500,000 in units of \$50,000) \$ _____

Dependent coverage is a percentage of member coverage

5. BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to all the insurance on my life under this Group AD&D Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage and Dismemberment Benefits shall be the insured member as provided in the Group Policy.

Primary Secondary

Beneficiary:	Last	First	Middle Initial	Relationship	Social Security #
Beneficiary Address:	Street	City	State	Zip Code	% of Benefits

Primary Secondary

Beneficiary:	Last	First	Middle Initial	Relationship	Social Security #
Beneficiary Address:	Street	City	State	Zip Code	% of Benefits

If necessary, attached separate signed and dated sheet to provide additional beneficiary information

I understand that insurance will not be effective until the first day of the month on or following acceptance of my enrollment form and receipt of the initial premium. If a person is hospitalized on the date insurance is to take effect, such insurance will take effect after the date of discharge.

By signing and dating this enrollment form, the member requests the insurance indicated; the member and any person proposed for insurance attest to having read the Fraud Notices indicated on the reverse side; and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member Signature X _____ Date _____
(PLEASE SIGN AND DATE IN INK)

Spouse Signature X _____ Date _____
(Necessary only if Spouse Coverage is requested)

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IMPORTANT FRAUD NOTICE

Please read before signing the application

FRAUD NOTICE: for residents of All States except those listed below: 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 may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO:** the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AR/LA/MD/RI: 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.

FOR RESIDENTS OF DC: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

RESIDENTS OF FL: 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.

RESIDENTS OF KS: 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 may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF ME: 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 denial of insurance benefits.

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF OK: 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.

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: 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 denial of insurance benefits.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

Please complete the enrollment form and return with payment to:*

AIChE Insurance Program Administrator
159 East County Line Road
Hatboro, PA 19040-9635

Don't let an unanswered question delay your enrollment.

Call toll free: 1-800-98-AIChE (982-4243)
www.aicheinsurance.com

*Residents of Puerto Rico: please send your completed application to Global Insurance Agency, Inc., P.O. Box 9023919, San Juan, PR 00902-3918

COMPENSATION and OTHER DISCLOSURE INFORMATION

Life & Health, a division of Affinity Insurance Services, Inc., exclusively offers the Group AD&D Insurance as an agent of The New York Life Insurance Company and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 42% of your paid premium. In addition, Affinity may charge a fee for administrative services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise. Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at http://www.aon.com/market_relationships for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit http://www.aon.com/market_relationships for more detail on these agreements.

The AIChE Insurance Program is brokered and administered by Aon Affinity, a division of Affinity Insurance Services, Inc.; in CA, MN & OK, a division of AIS Affinity Insurance Agency, Inc.; and in NY a division of AIS Affinity Insurance Agency. CA License #0795465. AR License #244489.