



Request for Group Insurance from
 NEW YORK LIFE INSURANCE COMPANY
 51 Madison Avenue
 New York, NY 10010

**MAJOR MEDICAL INSURANCE PLAN
 FOR MEMBERS OF THE OKLAHOMA
 SOCIETY OF CERTIFIED PUBLIC
 ACCOUNTANTS** (Participating in
 the Oklahoma Professionals Insurance Trust)

01/06



PLEASE PRINT IN INK OR TYPE (BE SURE TO COMPLETE ENTIRE FORM)

1. Applicant Information:

SOCIAL [] [] [] - [] [] - [] [] [] []

LAST FIRST INITIAL

PLACE OF BIRTH:

EMPLOYER NAME

CITY STATE (OR PROVINCE)

EMPLOYER STREET ADDRESS

PHONE NUMBERS:

CITY

() HOME

STATE ZIP CODE

() WORK

APPLICANT'S HOME ADDRESS

() FAX

CITY

E-MAIL ADDRESS

STATE ZIP CODE

COUNTRY OF RESIDENCE

MARITAL STATUS Single Married Legally Separated Divorced Widowed

LIST PERSONS PROPOSED FOR INSURANCE

DATE OF BIRTH: HEIGHT: WEIGHT: SEX:

APPLICANT: (FULL NAME) / / ft. in. lbs. M F

SPOUSE: (FULL NAME) / / ft. in. lbs. M F

COUNTRY OF RESIDENCE:

CHILD(REN): (FULL NAME) / / ft. in. lbs. M F

(FULL NAME) / / ft. in. lbs. M F

If more than two children are proposed for insurance, attach a separate sheet, signed and dated

- I am now a member of the OSCPA YES NO

2. Insurance Requested: Refer to brochure for eligibility, options and coverage description. (To be completed by ALL applicants.) I hereby apply for the following coverage:

2a. BENEFIT OPTION SELECTION: Select Network PPO Oklahoma Preferred Community Choice

<input type="checkbox"/> PPO NETWORK 80% In-Network 50% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$7,500	<input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN OPTION I (Qualifies for use with an HSA) 100% In-Network; 80% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> <input type="checkbox"/> Plan I: \$2,600 Individual / \$5,200 Family Aggregate <input type="checkbox"/> Plan II: \$5,000 Individual / \$10,000 Family Aggregate	<input type="checkbox"/> HIGH DEDUCTIBLE HEALTH PLAN OPTION II (Qualifies for use with an HSA) 80% In-Network; 60% Out-of-Network <u>CALENDAR YEAR DEDUCTIBLE</u> <input type="checkbox"/> Plan I: \$1,500 Individual / \$3,000 Family Aggregate <input type="checkbox"/> Plan II: \$2,600 Individual / \$5,200 Family Aggregate
--	--	---

2b. BILLING OPTIONS: Monthly Draft (Requires Pre-Authorized Checking (PAC) Request) Quarterly Premium Notice

2c. COVERAGE DESIRED: Insured Only Insured & Spouse Insured & Children Family

2d. What hospital, surgical or medical insurance do you or your dependents now carry or have application pending for?

Company	Plan	Benefit

2e. What group hospital, surgical or medical insurance terminated for you or your dependents within the past 63 days?
(Please submit certificate of creditable coverage from the prior insurance carrier.)

Insured's Name	Company	Plan/Benefit	Termination Date

2f. Will the coverage you applied for replace any existing Individual Health Insurance Coverage?
 Group Health Insurance Coverage?

If coverage applied for replaces any existing individual or group health insurance, please provide the following:

The last date of coverage under that policy: _____ Name of Carrier: _____ Policy #: _____

3. Statement of Health:

Please provide answers to the following as they pertain to all individuals proposed for insurance. For questions that pertain to health conditions, check "yes" if any of the individuals have or have had any of the following conditions in the past. Please circle conditions that apply and complete the grid below if you have answered "yes" to any question (except #29.)

	YES	NO		YES	NO
1) Epilepsy, stroke, paralysis	<input type="checkbox"/>	<input type="checkbox"/>	17) Cancer, tumors, cysts	<input type="checkbox"/>	<input type="checkbox"/>
2) Head or spinal injuries, muscular dystrophy, Cerebral palsy, multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>	18) Genital herpes, syphilis, or other sexually transmitted diseases	<input type="checkbox"/>	<input type="checkbox"/>
3) Migraines	<input type="checkbox"/>	<input type="checkbox"/>	19) Currently pregnant (due date) _____	<input type="checkbox"/>	<input type="checkbox"/>
4) Blood disorders, sickle cell	<input type="checkbox"/>	<input type="checkbox"/>	20) Liver disorder (including Hepatitis Hepatitis A, B, C, D (circle one))	<input type="checkbox"/>	<input type="checkbox"/>
5) Bladder, kidney, prostate, renal failure, uterine, testicular, breast problems	<input type="checkbox"/>	<input type="checkbox"/>	21) Any hospitalizations in the last 5 years	<input type="checkbox"/>	<input type="checkbox"/>
6) Vascular disease	<input type="checkbox"/>	<input type="checkbox"/>	22) Any planned surgeries	<input type="checkbox"/>	<input type="checkbox"/>
7) Colitis, diverticulosis, ulcers, gall bladder, hernias	<input type="checkbox"/>	<input type="checkbox"/>	23) Any drug/alcohol problems If yes, when _____	<input type="checkbox"/>	<input type="checkbox"/>
8) Asthma, allergies, hay fever	<input type="checkbox"/>	<input type="checkbox"/>	24) Disorder of the eyes, ears, nose, or throat (not glasses)	<input type="checkbox"/>	<input type="checkbox"/>
9) Emphysema, tuberculosis, lung disorder	<input type="checkbox"/>	<input type="checkbox"/>	25) Any illness, disease not listed above	<input type="checkbox"/>	<input type="checkbox"/>
10) Diabetes (Hb A1C) _____	<input type="checkbox"/>	<input type="checkbox"/>	26) Had or are planning an organ transplant	<input type="checkbox"/>	<input type="checkbox"/>
11) Thyroid, hormones, glandular disorders	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
12) AIDS, HIV, Autoimmune Disease	<input type="checkbox"/>	<input type="checkbox"/>	27) Cigarette use - how many/day _____	<input type="checkbox"/>	<input type="checkbox"/>
13) High blood pressure, heart disease, heart murmur, circulatory disorder, chest pain, mitral valve prolapse Last blood pressure reading _____	<input type="checkbox"/>	<input type="checkbox"/>	28) Rehabilitation	<input type="checkbox"/>	<input type="checkbox"/>
14) Are you on any medication not already mentioned?	<input type="checkbox"/>	<input type="checkbox"/>	29) Valid drivers license	<input type="checkbox"/>	<input type="checkbox"/>
15) Mental or nervous problems; Psychotherapy or psychiatric care	<input type="checkbox"/>	<input type="checkbox"/>	30) Alcohol use - how much/week _____	<input type="checkbox"/>	<input type="checkbox"/>
16) Arthritis, lupus, gout, fibromyalgia, fractures, limb loss	<input type="checkbox"/>	<input type="checkbox"/>			

Question Number	Person to whom it applies	Date	Names and addresses of physicians and hospital (if any)	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results

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.

PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM

I request the group insurance shown on the reverse side. To the best of my knowledge and belief: (a) I am eligible for such insurance and (b) the statements I have made are true and complete. I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above and that any misstatements or failure to report information material to the risk may be used as the basis of rescission of my insurance subject to the incontestable period provision of the policy.

I understand that insurance will become effective on the first day of the month on or after the date received by New York Life, if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age on the date insurance is to be effective. I also understand that (a) any person who was not performing his or her normal activities on the day insurance would otherwise become effective, will not become insured until the date he or she is performing such activities provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance, (b) insurance may be subject to any impairment restrictions established by New York Life and that payment of the contribution establishes acceptance of the coverage with impairment restrictions, and (c) any dividend apportioned to the group policy will be paid to the Trustee of the Oklahoma Professionals Insurance Trust.

I also understand that with respect to medical coverage, benefits will not be payable for up to twelve months for conditions for which medical advice, diagnosis, care or treatment was recommended or received within the twelve month period ending on the enrollment date. The period of any Pre-existing Condition Exclusions will be reduced by the period of Creditable Coverage as of the enrollment date except that: a period of Creditable Coverage will not be counted if, after such period and before the enrollment date, there was a 63 day period exclusive of any waiting period during all of which the individual was not covered under such Creditable Coverage.

AUTHORIZATION

By my signature, I authorize disclosure of the types of information detailed in the AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

By my signature, I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance).

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and otherwise use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator, Gilsbar, Inc., in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent will receive a copy of this signed AUTHORIZATION.

Applicant's Signature X _____ Date _____
(Please sign and date in ink)

To the best of my knowledge and belief the statements made regarding my health are true and complete

Spouse's Signature X _____ Date _____

(Necessary only if spouse coverage is requested)

Dependent's Signature X _____ Date _____

(Necessary only if coverage is requested for dependent children 18 years of age and older.)

X _____ Date _____

To Request Major Medical Insurance complete this form In ink and mail to:



P.O. Box 60809, Oklahoma City, OK 73146-0809
1-800-530-4863 OKC Metro: (405)521-1600