

# GROUP DISABILITY INCOME APPLICATION

## For Members of the Massachusetts Bar Association



Request for Group Insurance  
 from New York Life Insurance Company  
 51 Madison Avenue  
 New York, NY 10010

**TO APPLY:**  
 Please complete this application,  
 sign, date and return it with your  
 first modal premium check made  
 payable to Selman & Company:

**MBA Members' Insurance Program**  
 6110 Parkland Boulevard  
 Cleveland, OH 44124

PLEASE PRINT IN INK OR TYPE ALL ANSWERS, AND INITIAL ANY CHANGES YOU MAKE ON THIS FORM.

### 1. Member Information

Last Name	First	M.I.	Date of Birth / /	
Social Security No.			<input type="checkbox"/> Male	<input type="checkbox"/> Female
Address	City		State	Zip
Home Phone		Work Phone		
Do you intend to reside outside the U.S. or Canada in 12 months? <input type="checkbox"/> Yes <input type="checkbox"/> No				
If Yes, country(ies): _____ For How long? _____				

### 2. Membership Affiliation/Occupational Status:

A. Are you now a member of the Massachusetts Bar Association? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, MBA ID no. _____	
B. What is your Occupation?	Main Duties?
C. Full-Time Work means the active employment of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you at Full-Time Work? <input type="checkbox"/> Yes <input type="checkbox"/> No	
D. What was your annual earned income (net after business expenses) as reported for federal tax purposes last year? \$ _____	

### 3. Insurance Requested (Refer to brochure for eligibility and coverage description.)

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 60% of your Average Monthly Income, as defined in the brochure.

**I hereby apply for the coverage indicated below, based upon all my statements made in this application:**

**Monthly Benefit Period:** To Age 65 Plan

**Monthly Benefit Option:** \$ \_\_\_\_\_ **Waiting Period:**  90 Days  180 Days

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability?  Yes  No

If Yes, Please List:

Company	Plan	Monthly Benefit	Benefit Period

#### Payment Information

<input type="checkbox"/> Please send me a bill.	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual	<input type="checkbox"/> Annual
<input type="checkbox"/> Please withdraw premiums from my checking or savings account. (Be sure to complete and return the enclosed Automatic Payment Option Form.)	<input type="checkbox"/> Monthly	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Semiannual <input type="checkbox"/> Annual

G-29222-0

MBA 65 DI - 0310WS

**4. Statement of Health:**

**To the best of your knowledge and belief, please answer the following questions as they apply to you.**

**For CA Residents:** California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.

	Yes	No
1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:	<input type="checkbox"/>	<input type="checkbox"/>
a) heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	<input type="checkbox"/>	<input type="checkbox"/>
b) Other Health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
6. During the past two years, have you participated in, or does any person plan to participate in : aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	<input type="checkbox"/>	<input type="checkbox"/>
7. Driver's License No.: _____ State in which issued: _____		
8. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?	<input type="checkbox"/>	<input type="checkbox"/>
9. Are you currently incarcerated, or have an arrest pending, or during the past 15 years, served time in prison?	<input type="checkbox"/>	<input type="checkbox"/>

**If Any Answer to Items 1-9 is Yes, Give Names, Dates And Full Details Here.**

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.", "various" or "miscellaneous".)

Items	Date	Names and addresses of physicians and hospitals (if any)	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results

## 5. Member Declarations

I request the group insurance shown on the first page. 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 reserves the right to require additional information and, if necessary, an examination by a physician, and that such insurance may be subject to any impairment restriction(s) established. I ask New York Life to rely on all 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 for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that (a) insurance will become effective on the date approved by New York Life provided the initial premium contribution has been paid, and I am at Full-Time Work (as defined on reverse side); (b) if I am not at Full-Time Work as required, I will not become insured until the day I return to Full-Time Work, provided such date is within three months of the date insurance would have been effective and I am still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan. I understand that benefits will not be payable for up to two years for losses due to a disease or condition which I now have or have had in the past and which is not disclosed fully on this form, and that coverage may be invalidated if New York Life finds that I am not eligible or have not answered any of the above questions truthfully and completely.

**AUTHORIZATION:** I authorize disclosure of the types of information detailed in the AUTHORIZATION below, 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 Medical Information Bureau (MIB). My request for coverage will not be accepted unless this AUTHORIZATION is signed. ▪ I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratories, or insurance company to release prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources of 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 application for insurance). I understand that the information provided may include information that may predate the time frame state on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. ▪ New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and 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 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

**By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information by the providers noted, and attest that I have read the Fraud Notices indicated on the next page, and that to the best of my knowledge and belief, the answers to the questions are true and complete.**

**Members Signature (in ink) X \_\_\_\_\_ Date \_\_\_\_\_**

**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. **For 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.

**For 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 is 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 any insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

**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 NJ:** 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 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 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 include imprisonment, fines, and denial of insurance benefits.

**Residents of VA:** Any person who, with 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.



Automatic Payment Option (APO)  
**Savings or Checking Account Deduction Authorization Form**

**1. Applicant's Information** *(proposed insured)*

Applicant's Name \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:**

Policy Number: \_\_\_\_\_ Type of Insurance: \_\_\_\_\_

**2. Financial Institution Information**

Depositor Name (Payor) \_\_\_\_\_

*(As it appears on Financial Institution Records)*

Financial Institution Name \_\_\_\_\_ Account Number \_\_\_\_\_

*(Include Branch Name)*

Financial Institution City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**3. Account Selection:** I authorize an automatic deduction from my *(please choose one)*:

**Checking Account.** Attach a sample VOIDED check.

**Savings Account.** Account Number: \_\_\_\_\_ Routing Number: \_\_\_\_\_

Premium deduction should be made:

**Monthly**     **Quarterly**     **Semi-Annually**     **Annually**

*Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.*

**4. Signature/Authorization**

*In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.*

Signature of **Depositor** \_\_\_\_\_

Print Name of **Depositor** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature of **Applicant/Insured** *(If different from Depositor)* \_\_\_\_\_

Print Name of **Insured/Applicant** \_\_\_\_\_ **Date** \_\_\_\_/\_\_\_\_/\_\_\_\_

**5. Agreements & Conditions**

*Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:*

1. Premium payments will be debited from your account on or about the premium due date.
2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
4. A service fee of \$15.00 may be assessed for each dishonored payment.
5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
7. The Company will not send premium notices while APO is in effect.
8. A request for change or adjustment to the APO must be sent directly to the Company's Customer Service Department.
9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

<b>OFFICE USE ONLY</b> Insured ID: _____    APO Effective Date: _____
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