GUARANTEED ACCEPTANCE ENROLLMENT FORM

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

HospitalIncome SELECT℠
Group Hospital Indemnity Insurance Plan

WEB**02NY

1 Choose the benefit amount & payment mode you prefer.

(See rates enclosed.)

DAILY BENEFIT AMOUNT I WANT:

☐ $500 ☐ $400 ☐ $300
☐ $200 ☐ $100

PLEASE BILL ME:

☐ Annually ☐ Semi-Annually

If benefit amount and payment mode are not selected, a daily benefit of $100 will be designated and billing will be annually.
Semi-annual mode has a 2% billing fee.
Monthly EFT payment option is available after enrollment.

PLEASE ENROLL THE FOLLOWING:

☐ Physician Only
☐ Physician & One Dependent
☐ Physician & More Than One Dependent*

*If coverage is selected for Physician & More Than One Dependent, all eligible dependents will be covered. If coverage is not selected, Physician Only coverage will be designated.

2 Answer all personal information, including names of dependents to be covered.

Please print in ink or type all answers.

Physician Name: _____

Address: _____

City: _____

State: ____ Zip: _____

Please indicate whether above address is: ☐ Home ☐ Office

If not indicated above, please provide your primary home address here:

Address: _____

City: _____

State: ____ Zip: _____

Date of Birth: _____ Sex: ☐ M ☐ F

Social Security #: _____

Phone: _____ Fax: _____

Dependent Name: _____

Date of Birth: _____

Relationship: _____ Sex: ☐ M ☐ F

Dependent Name: _____

Date of Birth: _____

Relationship: _____ Sex: ☐ M ☐ F

Attach separate sheet for additional dependents.

E-Mail: _____

May AMA Insurance Agency, Inc. e-mail you regarding our other products and services? ☐ Yes

3 Please read, sign and date.

(Send no money now)

I am a Physician under age 80 actively engaged full time in the practice of medicine or retired, not due to illness or injury and request the coverage indicated. I affirm that any dependents I have enrolled meet the eligibility requirements for coverage as described. To the best of my knowledge and belief I am eligible for such insurance and these statements I have made are true and complete. I understand that this plan will not cover pre-existing conditions (injury or sickness, diagnosed or undiagnosed for which medical care or treatment has been received by me or my dependent(s) within twelve months prior to the effective date of coverage until twelve months following the effective date of coverage.

Coverage will be effective on the date AMA Insurance Agency receives this request provided eligibility requirements are met and required premium is paid when due. If I or any covered dependent is confined to a home, in a hospital, or other medical facility on that date, coverage for that person will be deferred until the day after he/she is no longer so confined provided that the person is still eligible.

Signature x _____

Date _____

Mail your enrollment form in the enclosed postage-paid envelope to:

AMA Insurance Agency, Inc. | 515 North State Street | Chicago, Illinois 60654

Not available in all states at this time. Contact the Administrator for current information.