



# CHANGE OF COVERAGE FORM

## For AVMA GHLIT Group Insurance Program

**Request For Group Insurance From  
New York Life Insurance Company**

**Group Policy G-14884**

**Certificate No.**

51 Madison Avenue □ New York, NY 10010

SOCIAL SECURITY NO.

MEMBER'S FULL NAME		DATE OF BIRTH / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
BILLING ADDRESS		MARITAL STATUS	DATE OF MARRIAGE / /	PLACE OF BIRTH	
CITY	STATE OR PROVIDENCE	ZIP CODE	OFFICE PHONE		
FAX NUMBER	E-MAIL ADDRESS		HOME PHONE		

**IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS** (i.e. lawful spouse/domestic partner and dependent children under age 26)

SPOUSE'S/DOMESTIC PARTNER'S NAME					DATE OF BIRTH / /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.						
Child (Name)	Date of Birth	Ht.	Wt.	M/F	Child (Name)	Date of Birth	Ht.	Wt.	M/F	Child (Name)	Date of Birth	Ht.	Wt.	M/F

**I HEREBY APPLY FOR A CHANGE IN MEDICAL COVERAGE TO THE PLAN CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION. (Refer to brochure or certificate for eligibility, options and coverage descriptions).**

**Please note that this change in coverage can be applicable to all current family members covered by the medical plan unless they are already enrolled in Plan E. Please make sure you indicate those individuals that this change in coverage is being requested for. If you do not indicate who the change in coverage is for, only the participant noted on this form will have their major medical plan changed.**

**Check new Plan and deductible being requested.**

**Who does this change in coverage apply to?**

Applicant only  Applicant and all insured dependents – except those covered by Plan E

**Traditional Major Medical Plan Please check deductible desired:**

Plan C  \$500    Plan D  \$750    Plan X  \$1,500\*    Plan V  \$3,000    Plan Y  \$5,000\*

**PPO Plans Please check deductible desired:**

Platinum Plan H  \$250    Gold Plan I  \$500    Bronze Plan J  \$1,000

**PPO Value Plans Please check deductible desired:**

Plan F  \$250    Plan K  \$500    Plan L  \$1,000    Plan R  \$2,500    Plan T  \$5,000

\*It should be noted that these medical plans are not considered creditable coverage for Medicare Part D. (This means the Rx benefits of these plans **DO NOT EQUAL** the standard Medicare Part D benefits.)

**I request a change to the group insurance plan indicated above. 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 this change in medical insurance will become effective on the latest of May 1 or November 1 immediately preceding my (or any person to be insured's) 65<sup>th</sup> birthday provided this application is received by the Trust Office by the special enrollment deadline date and applicable premium is paid in a timely manner.**

**Member's Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Please sign in Ink)

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

**Spouse's/Domestic Partner's Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Necessary only if spouse/domestic partner coverage is requested)

Form GPA-AC-1 as amended by GMA-5-NY Fraud  
G-14884-0/3 (NC)

**Residents of FL:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer, files a statement of claim of an application containing any false, incomplete or misleading information is guilty of a felony in the third degree.

**Residents of AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH, PA:** 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. **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 DC:** the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**(A)**