

ADA MEDCASHSM PLAN

Application for Insurance

MEMBER'S PERSONAL INFORMATION

ADA Identification No. _____
Name _____
Address _____
City _____
State _____ ZIP _____

Home Phone _____ MCEM10-CH
Office Phone _____
Cell Phone _____
Fax Number _____
Email _____
 Yes! Please sign me up to receive promotional information and announcements from ADA Insurance Plans via email.
Best way to be contacted (if needed): Phone Email

ELIGIBILITY VERIFICATION You must be under age 60 to request new or additional Member, Spouse or Domestic Partner, and/or Child coverage. If you are age 60 or over and already insured in this Plan, you may enroll your Legal Spouse or Domestic Partner under age 60 and/or any eligible dependent child under age 21, or under age 27 if a full-time student.

1 Yes Are you an ADA member under age 60?
 No **Must be under age 60 to apply.**

2 Yes Are you actively engaged in the full-time duties of your profession? **Must work at least 20 hours per week.**
 No If "No," please give details. _____

PAYMENT INFORMATION Please complete this section ONLY if you are applying for coverage for the FIRST TIME.

I wish to pay premiums by (select one):

- Check - semi-annually
- Autopay bank withdrawal - semi-annually
- Autopay bank withdrawal - monthly, 1st of the month*
- Autopay bank withdrawal - monthly, 10th of the month*

If selecting Autopay, please ATTACH your voided check here.

For Autopay bank withdrawals, please provide the following information and ATTACH a VOIDED CHECK to your application.

Bank name _____
Account number _____
Account holder's name (if other than yourself) _____
Account type: Savings Checking

Autopay Terms and Conditions: All monthly withdrawals will be made, as elected, on the 1st or 10th of the month in which premium is due. Autopay will terminate (1) when you (or the bank depositor, if other than the Certificate owner) provide Great-West Life 30 days written notice; or (2) at Great-West Life's election, upon 30 days written notice to you and/or the bank depositor; or (3) at the discretion of Great-West Life, if your designated bank does not transfer funds. In this case, you will receive a lapse notice detailing how to reinstate your coverage. Should the Autopay program terminate, you will be notified to select another payment preference.

*A 2% service charge will apply to monthly Autopay premiums.

Send no money now; you will be billed later.

GUARANTEED ACCEPTANCE

Coverage in the core MedCASH Plan, which includes Hospital Coverage and Basic Critical Condition Coverage, is guaranteed for all eligible enrollees.

INDIVIDUALS TO ENROLL

1. **Member** Full name _____ Birthdate _____ Gender M F
2. **Spouse or Domestic Partner*** Full name _____ Birthdate _____ Gender M F
3. **Child(ren)** Full name _____ Birthdate _____ Relationship _____
Full name _____ Birthdate _____ Relationship _____

*When applying for coverage for a Domestic Partner, you and your partner must also complete an Affidavit of Domestic Partnership. Call 800-568-2001 or visit www.insurance.ada.org to obtain this form.

DAILY BENEFIT DESIRED

You may select any Daily Benefit amount desired. All family members insured under this Plan will have the same Daily Benefit. Critical Condition Coverage included automatically in the MedCASH Plan is 10 x the Daily Benefit.

\$500 \$300 \$100 Other* \$ _____

*Contact a Plan Specialist for details at 866-442-3890

With regard to Hospital Coverage, I understand that the Company will not pay for any condition for which I or any of my eligible dependents received medical treatment, care, medication, or advice within 12 months prior to the effective date of New Coverage or any Increased Coverage, until such Coverage has been in force for 12 consecutive months without medical treatment, care, medication, or advice being rendered or recommended for such condition or until such Coverage has been in force for 24 consecutive months, whichever occurs first.

SIGNATURE

Signature of Member **X** _____ Date / /

Your Coverage will become effective as of the date your completed Application is received at the Company's Executive Offices, subject to payment of your premium when billed. You will be sent a Certificate and a notice of the interim premium due from the date Coverage begins until the next renewal date. When you have paid this premium, you will receive your Certificate. If the Member or an eligible Dependent is confined in a Hospital on the effective date, then the Coverage will not start until the date the Member or Dependent is discharged from the Hospital.



CORE COVERAGE

Stop here if you want the core MedCASH Plan only. Core MedCASH Coverage is guaranteed upon enrollment.



OPTIONAL COVERAGE

If you are applying for MedCASH 100, you must complete the Medical Questionnaire on back.

MEDICAL QUESTIONNAIRE FOR MEDCASH 100 COVERAGE

Complete this side by answering ALL questions if applying for MedCASH 100. You may apply for (a) Member coverage only, (b) Member and Spouse or Domestic Partner coverage, or (c) Spouse or Domestic Partner coverage only (if you already have Optional Member coverage in force). You may not apply for Optional Spouse or Domestic Partner coverage without Optional Member coverage. Each applicant must be under age 60 to apply for new or increased Optional coverage.

OPTIONAL MEDCASH 100 COVERAGE DESIRED

Member Spouse or Domestic Partner

Please answer all questions for each applicant.

	Member	Spouse or Domestic Partner
1. Have you ever been diagnosed with or received treatment, care, advice, or medication for any of the following conditions, procedures, or diseases:		
a. Partial or total loss of hearing in one or both ears, middle ear tumor, or acoustic nerve tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Alcohol or drug abuse (treatment) within 5 years?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Partial or total loss of speech or motor neuron disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Alzheimer's Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. Angina?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. Cancer in any form, other than basal or squamous cell carcinoma?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
g. Heart attack, coronary heart disease, angioplasty, or heart valve defects?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. Cystic fibrosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. Diabetes or glucose intolerance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. Blindness, vision worse than 20/100 corrected, glaucoma, or a pituitary tumor?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. Hemophilia?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Hepatitis other than Type A?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. Huntington's Chorea?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. Kidney disease or kidney failure?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. Any organ or tissue transplant (or awaiting one subject to availability of a donor)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. Multiple sclerosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
q. Muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
r. Parkinson's Disease?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
s. Paralysis, peripheral vascular blood vessel disease, or congenital deformities of limbs?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
t. Pulmonary fibrosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
u. Stroke or transient ischemic attack (TIA)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
v. Systemic lupus erythematosus (SLE)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
w. AIDS, AIDS related disease, or a positive HIV test or its antibodies?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. What is your current height and weight?	Height _____ Weight _____ lbs	Height _____ Weight _____ lbs
3. Have you ever been diagnosed with or received treatment, care, advice, or medication for any serious illness not mentioned above?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you answered "Yes" to any of the above medical questions, please explain in detail below. If space is not adequate, attach another sheet.

Question	Applicant	Dates	Reason Consulted/Diagnosis	Physician's Name, Address, and Phone Number	Current Status

I REPRESENT that all information shown above is correct. I CERTIFY that I have read, or had read to me, the completed application, and that I realize that any false statement or misrepresentation therein may result in loss of coverage under the Group Policy. I UNDERSTAND that my responses to the above health questions will be considered during medical underwriting, and that Great-West Life will obtain a privacy authorization from me prior to processing my application. I REALIZE that Optional Critical Condition Coverage will not be effective until approved by Great-West Life & Annuity Insurance Company.

SIGNATURES *Ensure that owner signs if owner and applicant are not the same.*

Signature of Member (required) **X** Date / /

Signature of Legal Spouse or Domestic Partner (if applicable) **X** Date / /

QUESTIONS?

866-442-3890
www.insurance.ada.org
ada@gwl.com

READY TO GO?

P.O. Box 340
Denver, CO 80201
Fax 303-737-4843

V13A

California Disclosure: For your protection California law requires the following to appear on this form: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison. **Pennsylvania Disclosure:** 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. **New York Disclosure:** 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for such violation. **Domestic Partner Disclosure:** Definitions, eligibility, and issues arising from any required documentation regarding Domestic Partner coverage are governed by the laws of the state of Illinois.

IMPORTANT: Please complete, SIGN, and DATE application on BOTH sides if applying for MEDCASH 100 coverage.