GROUP OFFICE OVERHEAD EXPENSE INSURANCE PLAN APPLICATION

FOR MEMBERS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

TO APPLY:
Send no money now.
Complete this form and return to:
ADMINISTRATOR
ACADEMY GROUP INSURANCE PROGRAM
P.O. Box 14533 • Des Moines, IA 50306

For Puerto Rico Residents, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023919 • San Juan, PR 00902-3919

QUESTIONS?
Call: 1-888-424-2308
customerservice.service@getamba.com

AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

NEW YORK LIFE

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address:_____
AMBA will not share your email information

Member's Date of Birth: _____ Sex: ❑ M ❑ F
MO. DAY YR.

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. Weight _____lbs.

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widowed
❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Do you intend to reside outside the U. S. in the next 12 months?
❑ YES, Countries: _____ For how long? _____ ❑ No

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the American Academy of Ophthalmology? ❑ Yes ❑ No Membership # _____
B. What is your occupation?_____
Main Duties: _____
C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at "FULL-TIME WORK"? ❑ Yes ❑ No
D. What was the average monthly amount of Eligible Overhead Expenses you incurred in the preceding 12 months? (Complete the Financial Worksheet to determine Eligible Overhead Expenses): $_____
E. What is the type of business? ❑ Sole Proprietor ❑ Corporation ❑ Partnership
F. If corporation or partnership, for what percent of the monthly Eligible Overhead Expenses are you responsible? _____ %

3. Insurance Requested:

Refer to the Plan Information/Plan Details for eligibility, options, and coverage description.

I request the following coverage: ❑ new ❑ additional
If you are increasing or altering your present a mount of coverage, indicate the new TOTAL AMOUNT in item A. below.
I hereby apply for the coverage indicated below, based upon all my statements made in this application:
A. **Monthly Benefit** (from $1,500 to $12,500 in $100 increments): $_____ B. **Waiting Period:** ❑ 30 days ❑ 90 days
C. Payment Option Selected:
❑ **Option 1:** Electronic Funds Withdrawal (EFT): I request and authorize the AAO Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check and such bank to process the withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Insurance Plan. (Enclose a voided check.)

_____
SIGNATURE (S) AS REQUIRED ON ALL CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT

❑ **Option 2:** Periodic Billing: ❑ Quarterly ❑ Annual ❑ Semiannual

3. Insurance Requested: *(continued)*

D. 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

4. Statement of Health:

Please initial and date any changes you make on this form.

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

	YES	NO
1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?	❑	❑
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:		
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 trou ble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	❑	❑
b. Other or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)or AIDS-Related Complex (ARC)?	❑	❑
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	❑	❑
(iii) Any other impairment?	❑	❑
3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	❑	❑
4. Are you now pregnant?	❑	❑
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?	❑	❑
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?	❑	❑
7. Driver's License No.: _____ State in which issued: _____		
8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?	❑	❑
9. Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?	❑	❑

If "Yes," please state when you last used tobacco or nicotine products and specify the product used:

_____ _____
Mo/Yr Product

10. **Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	❑	❑
For residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	❑	❑

4. Statement of Health: *(continued)* Please initial and date any changes you make on this form.

11. If you have answered any of the above Questions 1-10 "YES," give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

FRAUD NOTICE – *For residents of all states <u>except</u> 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. **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.

RESIDENTS OF AL/AR/LA/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 CA: For your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state 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 an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF NJ: WARNING: 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 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 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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss will incur a felony, and upon conviction will be penalized for each violation, with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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 the 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.

I understand that New York Life Insurance Company 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.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, LLC ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. 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 your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE including making a brief report of my protected health information to MIB, LLC; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature X_____ **Date**_____
(PLEASE SIGN AND DATE IN INK)

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

8/18 ed.

OO113E-24465

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Office Overhead Expense Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, LLC ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your 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 your 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 your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other application for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, LLC 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site at www.mib.com.

For NM Residents: PROTECTED PERSONS[1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION[2]*** *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1]PROTECTED PERSON *means a victim of domestic abuse; who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured person.*

[2]CONFIDENTIAL ABUSE INFORMATION *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company **7/15 ed.**

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Group Office Overhead Expense

AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

Underwritten by New York Life Insurance Company

FOR MEMBERS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

HELPS YOU MAINTAIN YOUR PRACTICE WHILE YOU ARE DISABLED

Office expenses need to be met, even if you aren't around to pay them. The Academy Group Office Overhead Expense Insurance can help you keep your practice running by providing financial coverage for your normal operating expenses while you are recovering from a disability. You will be able to take the time needed to recuperate while finding comfort in knowing that your office and staff will be ready and waiting for your return.

WHO IS ELIGIBLE?

If you are a member of the Academy of Ophthalmology ("Academy") under age 60 and at FULL-TIME WORK, you may apply for the Group Office Overhead Expense Insurance.

"FULL-TIME WORK" means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed or other location to which travel is required.

This offer is available only to residents of the U.S. (except TX, VT, WA and territories) and Puerto Rico. Coverage may not be available in all states at this time; contact the Administrator for current information.

HOW IT WORKS

This coverage is designed to pay Monthly Benefits when you are Totally Disabled. Totally Disabled is defined in the group policy as being prevented by illness or injury from performing the material and substantial duties of your regular occupation as a specialist in ophthalmology, provided (a) that was your primary occupation at the time of disability; and (b) you are not otherwise working for pay or profit.

Choice of Monthly Benefit

You may apply for a Monthly Benefit of $1,500 to $12,500 per month (in $100 units). The actual monthly benefit payable will not exceed the lesser of: a) the Monthly Benefit in force; b) the Eligible Expenses incurred for that month and; c) the average of monthly Eligible Expenses incurred during the six month period immediately preceding your Total Disability. To find the amount that's appropriate, check your records for your actual expenses and calculate your average monthly expenses for the past twelve months. (See enclosed worksheet.)

For some benefit amounts requested, a financial questionnaire may be required as evidence of insurability.

Choice of Waiting Periods

A waiting period is the number of consecutive days you must be Totally Disabled before benefits can begin. You have a choice of 30 or 90 days.

Benefit Period

Benefits begin following the end of the applicable waiting period and are payable up to 24 months during Total Disability.

Eligible Overhead Expenses

This insurance provides coverage for the normal operating expenses of your current practice which are incurred while you are Totally Disabled. Eligible Overhead Expenses include, but are not limited to:

- Office rent
- Interest payments on outstanding business debts
- Utilities (heat, water, telephone, electricity, etc.)
- Employees' salaries and payroll taxes
- Postage and stationery
- Equipment maintenance
- Rental, lease or depreciation of office equipment
- Monthly average of taxes on the premises
- Insurance premiums
- Accounting fees, to the extent that such expenses are normal and customary in the conduct and operations of the business
- Such other fixed expenses as are normal and customary in the conduct and operation of your office.

If you're incorporated, a partner or joint tenant, Eligible Overhead Expenses include only your share of overhead expenses.

Eligible Overhead Expenses do not include: the salary, fees, drawing accounts, profits, or any compensation for you, your partner or any member of your profession employed by or working for you; any individual hired after the date your disability begins (except your temporary replacement); income taxes; personal expenses; charitable contributions; the cost of the purchase of office equipment, goods or merchandise; or the payment of principal on any indebtedness.

YOUR COST

Cost is based on the Waiting Period, Monthly Benefit selected, your age and usage of tobacco/nicotine products when coverage becomes effective and increases on the premium due date on or immediately after you reach a higher age bracket.

CURRENT **2025** QUARTERLY PREMIUM CONTRIBUTIONS FOR NON-SMOKERS

$1,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$13.90	$8.50
40-49	24.80	14.30
50-59†	41.50	24.70

$5,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$69.50	$42.50
40-49	124.00	71.50
50-59†	207.50	123.50

$10,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$139.00	$85.00
40-49	248.00	143.00
50-59†	415.00	247.00

CURRENT **2025** QUARTERLY PREMIUM CONTRIBUTIONS FOR SMOKERS

$1,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$16.40	$10.00
40-49	29.20	16.80
50-59†	48.80	29.00

$5,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$82.00	$50.00
40-49	146.00	84.00
50-59†	244.00	145.00

$10,000 Monthly Benefit

Member's Age	30-Day Waiting Period	90-Day Waiting Period
Under 40	$164.00	$100.00
40-49	292.00	168.00
50-59†	488.00	290.00

If you do not qualify, please contact the Administrator for applicable rates.

†Contact the Administrator for renewal rates at ages 60 and over. Coverage terminates at age 70.

The premium contributions shown reflect the current rate and benefit structure. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Ophthalmologists Insurance Trusts. Premium contributions may be changed by New York Life Insurance Company on any premium due date and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insureds. For example, a class of insureds is a group of people with the same issue age.

How To Determine Your Cost for Other Monthly Benefits

If you wish to request a Monthly Benefit (in $100 units) for an amount not shown, please contact the Administrator for assistance.

Note: If you prefer to pay annually, the cost is four times the quarterly cost; if you prefer to pay semiannually, the cost is twice the quarterly cost. Please indicate your choice on the application.

WHEN COVERAGE ENDS

Insurance can remain in force until you reach age 70, provided: you do not cease FULL-TIME WORK (other than for reason of disability); Academy membership is maintained; premium contributions are paid when due; active duty in the armed forces (except for training purposes of two months or less) is not begun; and the group policy is not terminated or modified by the policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong.

YOUR EFFECTIVE DATE

Insurance will take effect on the date specified by New York Life Insurance Company, provided the initial contribution has been paid and you are at FULL-TIME WORK on that date. If you are not at FULL-TIME WORK as required, coverage will not become effective until the day you are at FULL-TIME WORK, provided such date is within three months of the date insurance would have become effective and you are still eligible for coverage.

Payment of a premium contribution for insurance does not mean that there is any coverage in force before the effective date as specified by New York Life Insurance Company.

There are instances where New York Life Insurance Company may be able to offer insurance (at the same premium contribution) by eliminating coverage for specific impairments or diseases.

FEATURES

Waiver of Premium Contributions

If you have been Totally Disabled for six consecutive months, premium contributions due thereafter will be waived for as long as benefits are payable for that Total Disability, provided the disability began before age 60.

Benefits for Recurring Disability

Successive periods of disability which are due to the same or related causes and are not separated by return to FULL-TIME WORK for at least six consecutive months will be considered as one period of disability, as will unrelated disabilities that are not separated by return to FULL-TIME WORK. Disabilities which meet these separation requirements will be treated as a new disability, subject to a new benefit and waiting period.

Tax-Deductible Premium Contributions

The IRS currently recognizes “Office Overhead Expense Insurance” as a legitimate business expense and allows deductions of its premium contributions as a business expense under Rev. Rul. 55-264, 1955-IC.B11. This aspect should be discussed with your financial advisor.

EXCLUSIONS AND LIMITATIONS

The coverage does not provide benefits for any disability that is due or related to: Chemical Dependency or ingestion of a narcotic (unless prescribed or administered by a doctor other than you or your close relative); declared or undeclared war or any act thereof; military service; pregnancy or childbirth (except complications thereof); any impairment or disease specifically excluded from your coverage; pre-existing limitations (see below); intentionally self-inflicted injury while sane or insane *[**Missouri Residents:** This exclusion is not applicable to injury caused by an intentionally self-inflicted injury while insane]*; operating, riding in or descending from any aircraft except when traveling solely as a passenger on a licensed non-military aircraft; or your incarceration or participation (except as a victim) in an illegal occupation/activity or the commission of a crime.

No benefits will be paid if you are outside the U.S., Puerto Rico, or the U.S. Virgin Islands when these benefits are payable.

In addition, no benefits will be paid unless the disability occurs while you are insured under this policy and you are under the care of a licensed physician other than yourself (or immediate family/household member) during the period of disability.

Pre-Existing Condition Limitation

PRE-EXISTING CONDITION is an injury or sickness for which you consulted a doctor, received any medical services or supplies, or took any medication during the 12 months immediately before becoming insured under this policy.

Benefits are not payable for a disability which is classified as a PRE-EXISTING CONDITION until the end of the earlier of: 12 consecutive months during which you have not consulted a doctor, received any medical services or supplies, or taken any medication for the condition; and 24 consecutive months during which you have been insured.

HOW TO APPLY
IT'S AS EASY AS 1, 2, 3.

1. Be sure to read the information in this brochure carefully. Choose the Monthly Benefit you wish to request.
2. Complete, sign and date the Application. It is extremely important that you answer fully the questions about medical history on this form. New York Life will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage.

If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form or go to www.aaoinsure.mybenefitsolutions.com to download the form.

If you choose the Electronic Funds Transfer (EFT) Option, be sure to include a voided check.

3. Mail the Application to:
   Academy Group Insurance Program
   P.O. Box 14533
   Des Moines, IA 50306

Residents Of Puerto Rico:
Please send your completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023919
San Juan, PR 00902-3919

MEDICAL REQUIREMENTS

New York Life Insurance Company reserves the right to request medical information needed to determine an applicant's eligibility for coverage. Based upon the age of the person proposed for insurance and the amount of coverage requested, a physical exam, EKG, blood test or other medical information may be required.

Not all applicants will have to supply additional information. However, if required, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be free of charge.

Requests for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

Send no money now. You will be billed upon approval.

HOW TO FILE A CLAIM

To file a claim, call or write the Administrator for claim forms.

30-DAY FREE LOOK

If you are not completely satisfied with the terms of your Certificate, you may return it, without claim, within 30 days. Your coverage will be invalidated and your premium refunded no questions asked!

This Group Office Overhead Expense is Administered by:

Association Member Benefits Advisors, LLC (AMBA)
AAO Group Insurance Program
PO Box 14533
Des Moines, IA 50306

Any questions?
Phone:1-888-424-2308
Web: www.aaoinsure.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

This Group Office Overhead Expense is Underwritten by:

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-14308-1
on Policy Form GMR-AC-1/G-14308-1

The Academy Insurance Trust incurs costs in connection with this sponsored Program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The Academy also receives a fee for the license of its name and logo for use in connection with this coverage.

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustees of the Ophthalmologists Insurance Trust.

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#1700505

FINANCIAL WORKSHEET

Use the average monthly office operating expenses incurred for the preceding 12 months to calculate the average monthly amount of Eligible Overhead Expenses. Benefits are payable to help cover these operating expenses.

HOW TO DETERMINE YOUR MONTHLY BENEFIT AMOUNT

Use this chart to calculate the monthly benefit amount you may need to maintain the operation of your office if you become Totally Disabled. Keep in mind that benefits are based on your actual average monthly expenses during the six months before your covered Totally Disability begins, up to the amount for which you are insured. Therefore, you should apply only for the coverage amount you expect you will need.

Office Rent:		$_____
Interest payments on outstanding business debts:		$_____
Utilities (heat, water, telephone, electricity, etc.):		$_____
Employees' salaries and payroll taxes:		$_____
Postage and stationery:		$_____
Equipment maintenance:		$_____
Rental, lease or depreciation of office equipment:		$_____
Monthly average of taxes on the premises:		$_____
Insurance Premiums for:		
Workers' Compensation:	$_____	
Employee Medical Plans:	$_____	
Employee Taxes:	$_____	
General Liability:	$_____	
Professional Liability/Malpractice:	$_____	
TOTAL:		$_____
Accounting fees, to the extent that such expenses are normal and customary in the conduct and operation of the business:		$_____
Professional membership and/or subscription dues:		$_____
Such other fixed expenses as are normal and customary in the conduct and operation of the insured's office:		$_____
Total Eligible Overhead Expenses:		$_____

Important Notes: This policy does not cover: the salary, fees, drawing accounts, profits, or any compensation for you or any member of your profession employed by or working for you: any individual hired after the date your disability begins (except your temporary replacement); income taxes; personal expenses; charitable contributions; the cost of the purchase of office equipment; goods or merchandise; or the payment of principal on any indebtedness. Benefits are based on your actual average monthly expenses during the six months before a covered Total Disability, up to the Monthly Benefit for which you are insured.