





**4 Coverage Amounts**

Choose the type of coverage and amounts for which you are applying.

**Member Term Life Insurance:**

*Member (please check one):*

- \$200,000       \$1,200,000
- \$400,000       \$1,400,000
- \$600,000       \$1,600,000
- \$800,000       \$1,800,000
- \$1,000,000     \$2,000,000\*
- Other (in \$10,000 increments to 2,000,000)  
\$ \_\_\_\_\_

*Spouse\*\* (please check one):*

- \$10,000
- \$50,000
- \$100,000
- \$150,000
- \$250,000
- Other (in \$10,000 increments to 1,000,000)  
\$ \_\_\_\_\_

*Children\*\* (please check one):*

- \$5,000
- \$10,000

\*\*Dependent coverage cannot exceed 50% of the Member amount. No Spouse can be covered for more than \$1,000,000 of TMAIT Life Insurance.

**Personal Accident Insurance:**

**Member:** \$ \_\_\_\_\_ (in increments of \$50,000, up to a maximum of \$1,000,000)

**Spouse:** \$ \_\_\_\_\_ (in increments of \$50,000, up to a maximum of \$500,000.  
Spouse's amount may not exceed member's amount)

**Children:** \$ \_\_\_\_\_ (in increments of \$5,000, to lesser of \$30,000 or 50% of the Member's amount)

**Long Term Disability Insurance**

**Please complete the following to determine the total amount of benefits you are eligible to apply for:**

- Total monthly benefit desired: (a) \$ \_\_\_\_\_
- Total monthly (net) income from the practice of medicine: (b) \$ \_\_\_\_\_
- Calculate 66% of monthly income (to nearest \$1,000): (b) x .66 = (c) \$ \_\_\_\_\_
- Indicate amount of any other monthly disability benefit currently in force: (d) \$ \_\_\_\_\_
- Calculate amount of additional coverage needed to equal 66%: (c) - (d) = (e) \$ \_\_\_\_\_
- Will TMAIT coverage replace any other company's coverage?  Yes  No If yes, enter amount: (f) \$ \_\_\_\_\_
- Add (e) and (f) to determine total coverage available: = (g) \$ \_\_\_\_\_

You are eligible to apply for up to the amount of coverage shown in (g). The amount of coverage requested from TMAIT cannot exceed \$15,000 per month (the minimum amount is \$1,000).

**Your total monthly benefit may be allocated among the waiting periods in minimum units of \$1,000.**

Plan	Waiting Period	Monthly Benefit	Include Cost of Living Adjustment (COLA) Provision? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> <b>Option 1</b> Five-year own specialty option.
<input type="checkbox"/> A	30 Days*	\$ _____		<input type="checkbox"/> <b>Option 2</b> Catastrophic option.
<input type="checkbox"/> B	90 Days	\$ _____		
<input type="checkbox"/> C	180 Days	\$ _____		
<input type="checkbox"/> D	365 Days	\$ _____		

\*Maximum monthly benefit is \$15,000, but only \$7,000 may be under Plans A and B.

**Office Overhead Expense Insurance:**

**Average monthly overhead expense for the last six months:** \$ \_\_\_\_\_

**Monthly Benefit Desired** \$ \_\_\_\_\_

(Member may apply for increments of \$100 up to \$20,000. Payments will be made on actual expenses only.)

**5 Beneficiary Information**

Full Name of Beneficiary	Relationship	Share
<input type="text"/>	<input type="text"/>	<input type="text"/> %
Address		
<input type="text"/>		
(If more space is needed, please attach a separate sheet.)		<b>Total (Must equal 100%)</b> <input type="text"/> <b>100%</b>

**6 Contribution Payment Basis** I request the following payment basis (*please check one*):

Quarterly     Monthly Electronic Fund Transfer (EFT)\*

\*\* If electing EFT, you must complete the Electronic Fund Transfer Authorization section below

**7 Electronic Fund Transfer Authorization**

If you wish to use your checking account, enclose a blank voided check for that account. If you wish to use your savings account, you must confirm that your bank permits electronic fund withdrawals from savings accounts. By my signature below I authorize the TMAIT in accordance with the Agreement (included on page 5 of this Form) to charge my bank account for the amount of my insurance contribution payment until such time as I provide written notice of cancellation, or insurance is terminated.

Type of Account:

Checking     Savings

Account Owner's Name

Bank Name

Bank's Transit Routing Number (*if savings account only*)

Your Savings Account Number

**X**

Signature of Account Owner

**AUTHORIZATION For the Release of Information. This authorization is intended to comply with the HIPAA Privacy Rule.** I authorize any health plan, physician, health care professional, hospital, clinic, laboratory, medical facility, or other health care provider that has provided payment, treatment, or services to me or on my behalf within the past 5 years ("My Providers") to disclose the entire medical record and any other health information concerning me and/or any dependent proposed for coverage in the application to The Prudential Insurance Company of America ("Prudential") and through it, to its reinsurers, authorized agents, and the Medical Information Bureau, Inc.. This includes information on the diagnosis or treatment of Human Immunodeficiency Virus (HIV) infection (In Vermont, this information is excluded.) and sexually transmitted diseases. This also includes information on the diagnosis and treatment of mental illness and the use of alcohol and/or drugs, but excludes psychotherapy notes. I also authorize the Medical Information Bureau, Inc. to release any data it may have about me and/or any dependent proposed for coverage to Prudential. By my signature below, I acknowledge that any agreements I or my dependents have made to restrict my health information do not apply to this Authorization and I instruct My Providers to release and disclose the entire medical record for me and/or my dependent without restriction. This health information is to be disclosed under this Authorization so that Prudential may: 1) underwrite an application for coverage and make risk determinations; 2) obtain reinsurance; 3) administer claims and determine or fulfill responsibility for coverage and provision of benefits; 4) administer coverage; and 5) conduct other legally permissible activities that relate to any coverage I have or have applied for with Prudential. This Authorization shall remain in force for 24 months following the date of my signature below, and a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a signed request for revocation to The Prudential Insurance Company of America, Group Medical Underwriting, P. O. Box 8796, Philadelphia, PA 19176, Attention: Senior Medical Underwriting Consultant. I understand that a revocation is not effective to the extent that Prudential has relied on this Authorization

or to the extent that Prudential has a legal right to contest a claim under insurance coverage or to contest the coverage itself. I understand that any information that is disclosed pursuant to this Authorization may be redisclosed and no longer covered by federal rules governing privacy and confidentiality of health information. (In Montana only: I may request a record of any subsequent disclosures of protected health information.) I understand that if I refuse to sign this Authorization to release the entire medical record for me and/or my dependent, Prudential may not be able to process an application for coverage, or if coverage has been issued, may not be able to make any benefit payments. I understand that I have the right to request and receive a copy of this Authorization.

**Statement of Understanding:** I (We) represent that all statements and answers made within or attached to this Request Form are true and complete to the best of my (our) knowledge and belief. I (We) understand that coverage shall be in effect only after all of these conditions have been met: this application has been approved by Prudential; the Contract has been issued while all persons to be insured thereunder are alive, and; the answers and statements in this application continue to be true and complete until the Effective Date. I (We) also understand that coverage will not take effect if the facts have changed. I (we) have also read and understand and agree to the additional terms, conditions and requirements as stated in the Authorization for the Release of Information and Important Notice sections. I (We) understand that completion of this application in no way implies that I (we) will be accepted for insurance coverage.

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one—or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy. Make sure you understand the facts. You should ask the company or agent that sold you your existing policy to give you information about it. Hear both sides before you decide. This way you can be sure you are making a decision that is in your best interest.

**X**

Member Signature

Date (mm/dd/yyyy)

**X**

Spouse Signature (if applying for Spouse Coverage)

Date (mm/dd/yyyy)

**Important Notice for residents of Texas: Warning:** Any person who knowingly and with intent to injure, defraud, or deceive any insurance company or other person, or knowing that he is facilitating commission of a fraud, submits incomplete, false, fraudulent, deceptive, or misleading facts or information when filing an insurance application or a statement of claim for payment of a loss or benefit commits a fraudulent insurance act, is or may be guilty of a crime and may be prosecuted and punished under state law. Penalties may include fines, civil damages and criminal penalties, including confinement in prison. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant or if the applicant conceals, for the purpose of misleading, information concerning any fact material thereto.

**Accelerated Death Benefits:** Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. There is no administrative fee to accelerate death benefits. The accelerated amount is not discounted.

**Beneficiary Designation:** If you name more than one beneficiary, settlement will be made in equal shares to the designated beneficiaries (or beneficiary) that survive you, unless otherwise provided in the designation. If no named beneficiary survives you, settlement will be made to your estate. The beneficiary named herein will be the beneficiary for your total amount of insurance coverage issued.

**Electronic Fund Transfer Authorization: Texas Medical Association Automatic Insurance Payment Program Agreement** provides for Electronic Fund Transfer for the purpose of making your insurance payment without the use of a check. Your signed authorization is required. The electronic debit will occur on the first of each month that the payment is due. If the transfer falls on a weekend or bank holiday, your checking/savings account will be charged the next business day. The amount of the automatic debit may vary due to changes in the amounts of insurance or a premium contribution change. You will be notified in advance of changes to the amount of your debit due to premium contribution changes.

**Please keep this notice for your records.**