



EXCLUSIVE BENEFITS

# BUSINESS OVERHEAD EXPENSE ENROLLMENT FORM

For The Academy of General Dentistry Members



## GROUP CUSTOMER INFORMATION (To be Completed by the Recordkeeper)

Name of Policyholder: <b>THE ACADEMY OF GENERAL DENTISTRY</b>	Group Customer: # <b>204309</b>
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## MEMBER'S ENROLLMENT INFORMATION

Name (First, Middle, Last)	Social Security #	<input type="checkbox"/> Male <input type="checkbox"/> Female
Address (Street)	Date of Birth (MM/DD/YYYY)	
Address (City, State, Zip)	AGD Membership # (optional)	
Email Address		
Home Phone #	Cell Phone #	Work Phone #

I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible.  
 I understand that contributions are required for the benefits I select below.

## BUSINESS OVERHEAD EXPENSE INSURANCE

**Select your monthly benefit:**

Enter a multiple of \$100 \$ \_\_\_\_\_ (up to a maximum of \$15,000).

**Indicate your waiting period:**

45 days

60 days

**Select your benefit period:**

12 months

18 months

24 months

**MEMBER HEALTH INFORMATION (Section 1)**

Please complete all questions below. Incomplete information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.

Your name \_\_\_\_\_ Employee's Social Security/Identification # \_\_\_\_\_

1. Height \_\_\_\_\_ ft. \_\_\_\_\_ in. Weight \_\_\_\_\_ lbs.

	Member
2. Are you now on a diet prescribed by a physician or other health care provider? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Are you now pregnant? If "Yes," what is your due date? (MM/DD/YYYY) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Are you now, or have you in the past 5 years, used tobacco in any form?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 5 years, have you received medical treatment or counseling by a physician or other health care provider for, or been advised by, a physician or other health care provider to discontinue the use of alcohol or prescribed or non-prescribed drugs?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. In the past 5 years, have you been convicted of driving while intoxicated or under the influence of alcohol and/or any drug? If "Yes," specify date(s) of conviction(s). (MM/DD/YYYY) _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Have you had any application for life, accidental death and dismemberment or disability insurance declined, postponed, withdrawn, rated, modified, or issued other than as applied for?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Are you now receiving or applying for any disability benefits, including workers' compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. Have you been <b>Hospitalized</b> as defined below (not including well-baby delivery) in the past 90 days? <b>Hospitalized</b> means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.	<input type="checkbox"/> Yes <input type="checkbox"/> No
10. Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection?	<input type="checkbox"/> Yes <input type="checkbox"/> No
11. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for:	
a. cardiac or cardiovascular disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. stroke or circulatory disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
c. high blood pressure?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d. cancer, Hodgkins disease, lymphoma or tumors? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
e. anemia, leukemia or other blood disorder? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
f. diabetes? Your age at diagnosis: _____ <input type="checkbox"/> Check if insulin treated	<input type="checkbox"/> Yes <input type="checkbox"/> No

**MEMBER HEALTH INFORMATION (Section 1) Continued**

	Member
g. asthma, COPD, emphysema or other lung disease? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
h. ulcers, stomach, hepatitis or other liver disorder? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
i. colitis, Crohn's, diverticulitis or other intestinal disorder? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
j. memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No
k. epilepsy, paralysis, seizures, dizziness or other neurological disorder? Specify date of last seizure (MM/YY) _____ Indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
l. Epstein-Barr, chronic fatigue syndrome or fibromyalgia?	<input type="checkbox"/> Yes <input type="checkbox"/> No
m. multiple sclerosis, ALS or muscular dystrophy?	<input type="checkbox"/> Yes <input type="checkbox"/> No
n. lupus, scleroderma, auto immune disease or connective tissue disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
o. arthritis? <input type="checkbox"/> osteoarthritis <input type="checkbox"/> rheumatoid <input type="checkbox"/> other/type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
p. back, neck, knee, spinal, joint or other musculoskeletal disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
q. carpal tunnel syndrome?	<input type="checkbox"/> Yes <input type="checkbox"/> No
r. kidney, urinary tract or prostate disorder? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
s. thyroid or other gland disorder? If "Yes," indicate type _____	<input type="checkbox"/> Yes <input type="checkbox"/> No
t. mental, anxiety, depression, attempted suicide or nervous disorder?	<input type="checkbox"/> Yes <input type="checkbox"/> No
u. sleep apnea?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**For "Yes" answers, please provide full details on the next page in Section 2, then complete Section 3. If all questions are "No," you may proceed directly to Section 3 on the next page.**

**MEMBER HEALTH INFORMATION (Section 2)**

Please provide full details below for each "Yes" answer to the preceding questions 1 through 11. If you need more space to provide full details, attach a separate sheet with the information and sign and date it. Delays in processing your application may occur if incomplete details are provided. MetLife may contact you for additional or missing information.  Check here if you are attaching another sheet.

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (MM/YY)	Date of Last Treatment (MM/YY)	Type of Treatment

**Treating Health Professional**

Personal Physician's Name: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date of last visit (MM/DD/YYYY): \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Question Number	Condition/Diagnosis	Medication Prescribed
		<input type="checkbox"/> Yes _____ <input type="checkbox"/> No _____
Date of Diagnosis (MM/YY)	Date of Last Treatment (MM/YY)	Type of Treatment

**Treating Health Professional**

Personal Physician's Name: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_ Phone #: \_\_\_\_\_  
Date of last visit (MM/DD/YYYY): \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**PERSONAL PHYSICIAN INFORMATION (Section 3)**

Personal Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
Date of last visit (MM/DD/YYYY): \_\_\_\_\_ Reason for visit: \_\_\_\_\_

**PRESCRIPTION INFORMATION**

Are you currently taking any prescribed medications?  Yes  No      If "Yes," list the medications.  
Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_  
Prescribing Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
Medication: \_\_\_\_\_ Condition/Diagnosis: \_\_\_\_\_  
Prescribing Physician's Name: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Address (Street, City, State, Zip): \_\_\_\_\_  
 Check here if you are attaching another sheet for any additional medications.

## FRAUD WARNINGS

Before signing this Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

**Alabama, Arkansas, District of Columbia, Louisiana, Massachusetts, New Mexico, Ohio, Rhode Island and West Virginia:** 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.

**Colorado:** It is unlawful to knowingly provide false, incomplete or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

**Kansas and Oregon:** Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law.

**Kentucky:** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

**Maine, Tennessee and Washington:** 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.

**Maryland:** 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.

**New Jersey:** Any person who files an application containing any false or misleading information is subject to criminal and civil penalties.

**New York (only applies to Accident and Health Benefits):** 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 each such violation.

**Oklahoma:** 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.

**Puerto Rico:** Any person who knowingly and with the intention to defraud includes false information in an application for insurance or files, assists or abets in the filing of a fraudulent claim to obtain payment of a loss or other benefit, or files more than one claim for the same loss or damage, commits a felony and if found guilty shall be punished for each violation with a fine of no less than five thousand dollars (\$5,000), not to exceed ten thousand dollars (\$10,000); or imprisoned for a fixed term of three (3) years, or both. If aggravating circumstances exist, the fixed jail term may be increased to a maximum of five (5) years; and if mitigating circumstances are present, the jail term may be reduced to a minimum of two (2) years.

**Vermont:** Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

**Virginia:** 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 a false or deceptive statement may have violated the state law.

**Pennsylvania and all other states:** 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.

## DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any health information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability.
2. I declare that I am actively at work on the date I am enrolling and that I was actively at work. I understand that if I am not actively at work on the scheduled effective date of insurance, such insurance will not take effect until I return to active work.
3. If I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase.
4. I have read the applicable Fraud Warning(s) provided in this enrollment form.



Signature of Member

Print Name

Date Signed (MM/DD/YYYY)

**THE ACADEMY OF GENERAL DENTISTRY**  
**EF-SOH-NW (10/19)**

**GEF09-1**  
**DEC**

*(The form number above applies to residents of all states except as follows: Form number **GEF09-1** applies to residents of Montana;*

**GEF09-1**

*DEC applies to residents of North Dakota and Utah)*

## PAYMENT INFORMATION

I am selecting the following payment option (check one of the boxes below):

Select frequency of payment:  Annual  Semiannual  Quarterly  Monthly (an EFT Authorization Form will be sent to you)

Some services in connection with your coverage may be performed by our affiliates, MetLife Global Operations Support Center Private Limited and MetLife Services and Solutions, LLC., unless prohibited by state or local law or by mutual agreement with the group customer. These service arrangements in no way alter Metropolitan Life Insurance Company's obligation to you. Your coverage will continue to be administered in accordance with Metropolitan Life Insurance Company's policies and procedures.

## AUTHORIZATION

This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) (“employee,” spouse, and any other person(s) named below). Underwriting means classification of individuals for determination of insurability and/or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes:

- Any medical practitioner, facility or related entity; any insurer; MIB, Group Inc. (“MIB”); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company (“MetLife”) or any third party acting on MetLife’s behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information; medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment, including information and data records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

**Note to All Health Care Providers:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. “Genetic information” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Expiration, Revocation and Refusal to Sign:** This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured’s revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person’s enrollment for group insurance cannot be processed.

**By signing below, each proposed insured acknowledges his or her understanding that:**

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse protected by Federal Regulations 42 CFR part 2, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.
- I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.

X

Signature of Member

Date Signed (MM/DD/YYYY)

Print Name

State of Birth

Country of Birth



**After completion, make a copy for your records and return to:**  
**Hagan Insurance Group, P.O. Box 1889, Sioux Falls, SD 57101**  
Phone: 1-877-280-6487