NJCPA MEMBER BENEFIT PROVIDER

Group Disability Income Insurance Plan

FOR EMPLOYEES OF NEW JERSEY SOCIETY OF CPAs MEMBERS

Why not join the millions of insureds who have chosen to help protect their families with

NEW YORK LIFE

New York Life Insurance Company?

USI AFFINITY

G-29461-0

You have medical insurance to help cover medical expense and car or homeowners insurance to help cover damage to your property. But none is designed to help protect your ability to earn a living.

As an employee of a member of the New Jersey Society of CPAs, you have an opportunity others don't. The NJCPA Insurance Program has put together features on Disability Income Insurance that are among the best in the market to help protect your income, your family, and your obligations if you are unable to work.

Affordability

The NJCPA Insurance Program gives you access to group buying power. Unlike plans you might find in the general market, you get the benefit of your group association. Plus, as part of a group plan, you can never be singled out for a rate increase.

Advocacy

For decades, the NJCPA has been sponsoring customized plans to meet the needs of New Jersey's accounting professionals. Our plan administrator, USI Affinity, employs a team to answer questions and help you understand your options. We're your advocate, and we work hard to understand and anticipate your needs as an accounting professional.

Stability

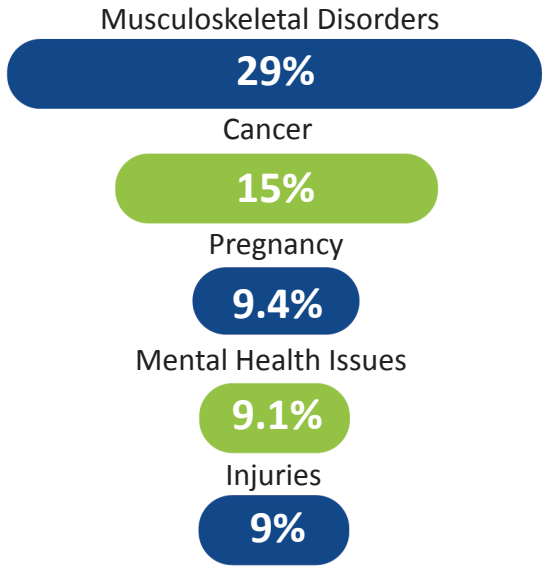
NJCPA and USI Affinity have gone through the paces of due diligence to ensure that you're getting coverage from a respected insurance carrier. This plan is underwritten by New York Life, a leading insurance provider who is rated A++ (Superior) by A.M. Best for financial strength and is a recognized leader in service and claims experience[1].

Eligibility

Employees of members of the New Jersey Society of CPAs who are under age 55, residents of the U.S., and actively engaged in FULL-TIME WORK[2] may apply for coverage.

Most Common Disability Claims

The most common reasons for long-term disability are*:



*Health and Productivity Benchmarking, Integrated Benefits Institute, 11/2017

How the Plan Works

This coverage is designed to pay monthly benefits if you suffer a Total Disability while insured under the policy due to a covered illness or accident which completely and continuously prevents you from peforming the substantial and material duties of your regular occupation. You must be under the care of a licensed physician for your covered disability and not engaged in any occupation for pay or profit. Benefits are paid regardless of other insurance coverage you may have, and this coverage automatically renews for all insured persons, as long as applicable terms and conditions are met.

If your disability is the result of an injury, said injury must occur while you are covered under the Policy and result in a Total Disability within 365 days.

Your Choice of Monthly Benefit Amount

If you are under age 50, you can apply for monthly benefit amounts between $500 and $4,000 in $100 increments. If you are age 50 to 54, you can apply for a monthly benefit amount between $500 and $3,000.

Your Choice of Coverage Options

You have two options to choose from on benefit duration—Plan 5/2 or Plan 65-65. Select the one that best suits your needs and budget.

Plan 5/2	
Accident Benefits	
If your Total Disability begins:	*Benefits paid:*
Prior to Age 60	Up to 5 years
Between Age 60 and 63	Up to Age 65
On or after Age 63	Up to 2 years
Sickness Benefits	
Benefits paid up to 2 years	

Plan 65-65*	
Disability Benefits	
If your Total Disability begins:	*Benefits paid:*
Prior to Age 60	Up to Age 67
Between Age 60 and 63	Up to Age 65
On or after Age 63	Up to 24 months

**The maximum benefit period for all covered disabilities for a person insured under Plan 65-65 due to mental disorders and/or chemical dependency (whether insurance has been continuous or interrupted) is either: a) 24 months, if the covered disability begins on or after Age 63; or b) the greater of 12 months or Age 65, if the covered disability begins on or after Age 63. This limitation does not apply to any period during which the insured person is institutionalized.*

Standard Plan Features

Waiting Period

The Waiting Period is the number of consecutive days you must be Totally Disabled by a covered illness or accident before benefits begin. This plan gives you the flexibility to choose a Waiting Period that's most comfortable for you—30, 60, 90, 180, or 365 days. Premiums reduce if you choose a longer waiting period.

Accidental Death & Dismemberment

This plan includes a $1,000 Accidental Death and Dismemberment benefit, which all or a portion of is payable for accidental loss of life, limbs, sight, speech or hearing due to a covered injury.

Survivorship Benefit

Your beneficiary will receive additional benefit payments for up to 3 months, subject to the maximum benefit period, if you die while you are receiving monthly benefits for a total disability that has been in effect for at least 12 consecutive months.

Worldwide Coverage

Once your coverage is effective, you are protected wherever you travel—whether for business or personal—as long as you remain a US resident[3].

Tax-Free Benefits

The benefits paid to you are tax-free, as long as you pay your own premiums with after-tax dollars. This is different than employer-paid coverage, which is considered earned income and is taxable at your normal tax rate. You should consult with your personal tax advisor for further information.

Waiver of Premium

It's good to know that your insurance will continue should you become totally disabled. Premium payments for your coverage will be waived if you become totally disabled prior to turning age 60 for a period of at least six months. Please refer to your Policy for applicable conditions.

1: Third Party Ratings Report as of 9/12/2019.
2: FULL-TIME WORK is defined as actively performing the regular duties of your occupation, for pay or profit, on a basis of at least 30 hours per week at a place where such duties are normally performed or other location to which travel is required.
3: Subject to U.S. government regulations on restricted countries.

Applying for this coverage is easy.

Fill out an application, including all persons to be insured.

Drop your signed application and any required documents in the mail.

No payment is required now. We will bill you upon acceptance.

Once approved, you have 30 days to review your coverage, risk free.

Summary of Terms & Conditions

When Coverage Begins

Coverage becomes effective on the first day of the month following the date the application is approved by New York Life Insurance Company, provided the initial premium is paid within 31 days after billing and any person proposed for insurance is at FULL-TIME WORK. If you are not at FULL-TIME WORK on the date your application is approved, coverage will not go into effect until the date you return to FULL-TIME WORK, provided you are still eligible and the date is within three months of the date the insurance would have otherwise taken effect. Payment of a premium contribution does not mean coverage is in force. Pregnancy will be treated as any other illness if the pregnancy begins after the first 30 days following the effective date of the policy and such pregnancy or childbirth results in continuous total disability.

When Benefits End

Benefits will cease at the earlier of the following: a) your covered disability ends; b) the maximum benefit period ends; c) if required proof of continuing disability is not provided; or d) you die, except for Survivorship Benefits. You will remain insured after your benefits end.

Benefits for Recurring Disability

Successive periods of disability due to the same or a related cause will be considered a single period of disability unless separated by a return to FULL-TIME WORK for three consecutive months or longer.

When Coverage Ends

Coverage will remain in force until the earlier of: a) you reach age 70; b) failure to pay premiums when due; c) you cease to be at FULL-TIME WORK, except for reasons of Total Disability; d) the Group Policy ends or is modified to exclude the class of insured in which you belong; e) you are no longer an employee of an NJCPA member; g) or you elect to end coverage.

Reductions, Limitations and Exclusions

Disabilities that are due or related to the following are excluded from coverage: air travel (except when a fare-paying passenger on a licensed commercial, non-military aircraft); military service; suicide, attempted suicide or self-inflicted injury while sane or insane; your incarceration for or your participation in (except as a victim) a crime or illegal activity; any disability that is due or related to a pregnancy or childbirth (except complications thereof); declared or undeclared war or act of war. Moreover, no coverage is available for any disability which does not require a doctor's regular care (regular care of doctor does not include yourself, a close relative, or a household member). *NOTE—Residents of MO: the exclusion for self-inflicted injuries is not applicable to injuries caused by an attempted suicide while insane. The benefit period for disabilities in connection with mental disorders and/or chemical dependency is limited to two years.*

Monthly Benefits in excess of $2,000 will reduce to $2,000 at age 65 with premiums adjusted accordingly.

Exclusions – No AD&D benefits will be payable for any loss that occurs during or is due or related to military service, your incarceration or participation except as a victim, in an illegal occupation/activity or the commission of a crime, your voluntary intake of drugs, narcotics or alcohol (unless prescribed by a physician), any declared or undeclared war or act thereof, or operating, riding in or descending from any aircraft except when riding as a passenger on a licensed, commercial non-military aircraft; or for any loss that is due or related to: a physical or mental sickness or medical/surgical treatment thereof, or suicide or intentionally self-inflicted injury while sane or insane.

30-Day Free Look

Once your coverage is approved, you will be sent a Certificate of Insurance summarizing your benefits under the Plan. If you are not completely satisfied with the terms of the Certificate, you may return it, without claim, within 30 days. We will refund your entire premium contribution and invalidate your coverage.

Current 2020Annual Premiums per $100 of Monthly Benefits*

Plan 5/2				
Waiting Period	*30 Days*	*60 Days*	*90 Days*	*180 Days*
< Age 20	$ 14.38	$ 9.78	$ 6.06	$ 3.39
Ages 20 -29	$ 15.17	$ 10.31	$ 6.39	$ 3.58
Ages 30 - 39	$ 21.33	$ 14.50	$ 8.99	$ 5.04
Ages 40 - 49	$ 31.92	$ 21.70	$ 13.46	$ 7.54
Ages 50 - 59	$ 43.29	$ 29.44	$ 18.25	$ 10.22
Ages 60 - 64	$ 43.29	$ 29.44	$ 18.25	$ 10.22

Plan 65-65				
Waiting Period	*30 Days*	*60 Days*	*90 Days*	*180 Days*
< Age 20	$ 15.72	$ 10.69	$ 6.63	$ 3.71
Ages 20 - 29	$ 18.41	$ 12.52	$ 7.76	$ 4.35
Ages 30 - 39	$ 28.76	$ 19.55	$ 12.12	$ 6.79
Ages 40 - 49	$ 46.22	$ 31.43	$ 19.48	$ 10.91
Ages 50 - 59	$ 52.22	$ 35.51	$ 22.02	$ 12.33
Ages 60 - 64	$ 59.49	$ 40.45	$ 25.08	$ 14.04

How to Calculate Your Annual Premium Cost:

1) Monthly Benefit Amount: $

2) Divide by 100: Units

Choose Your Plan and Waiting Period

3) Premium Rate: $

4) Multiply Lines 2 and 3: $

This is your Annual Premium.

If you wish to pay semi-annually, divide Line 4 by two, and add a **$1.00 Administrative Fee**. This is your semi-annual premium. To avoid this fee, elect to pay annually.

The premium contributions shown reflect the current rates and benefit structure. Premiums increase as you grow older. Your initial premium is based on your attained age on the effective date of your coverage and increases on the premium due date on or immediately after the date you reach a higher age bracket. New York Life Insurance Company may change premiums on any premium due date or on 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 all others with the same issue age, waiting period and plan. Benefit options are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the NJCPA.

How New York Life Obtains Information and Underwrites Your Request for Group Disability Income 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, Inc. ("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, 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 applications 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, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. Information for consumers about MIB may be obtained on its website 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 person 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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8.12 ed**

This Summary contains a brief description of some of the principal provisions of the proposed insurance coverage. Complete terms and conditions are set forth in the group policy issued by New York Life to the New Jersey Society of Certified Public Accountants. Once coverage has been approved, each insured will receive a Certificate of Insurance summarizing all the benefits and coverage provisions provided under Group Policy G-29461-0 on policy form GMR-FACE/G-29461-0. The group disability policy is available only in the U.S.

NJCPA is compensated in connection with this sponsored group plan to provide and maintain this valuable membership benefit.

Do you have questions about this coverage? Or do you need to file a claim?
Call our customer care center for more information or for the necessary forms:
855.874.0278 • Monday - Friday, 9 a.m. to 5 p.m. (ET)

USI AFFINITY

Administered By:
USI AFFINITY
14 Cliffwood Avenue, Suite 310
Matawan, NJ 07747 | 1.855.874.0278
AR Insurance License # 325944
CA Insurance License # 0G11911

Underwritten By:
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue | New York, NY 10010
Under Policy G-29461-0
on Policy Form G-29461-0/GMR-FACE

Group Disability Insurance Income Application for Employees of Members of the New Jersey Society of CPAs

Request for Group Disability Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

TO APPLY: Complete this form and return it to USI AFFINITY, 14 Cliffwood Avenue, Suite 310, Matawan, NJ 07747
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

NJXHNAACH

1. APPLICANT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Fax Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - _____ Date of Birth: ____/____/____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

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

Are you now an employee of a member of the New Jersey Society of Certified Public Accountants? ☐ Yes ☐ No

Member/Firm Name: _____ Employment Date: _____

Are you presently insured by any other NJCPA-sponsored plan? ☐ Yes ☐ No
If yes, provide details: _____

Do you plan to reside outside the U.S. or Canada within the next 12 months?
☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. OCCUPATIONAL STATUS:

a) Occupation: _____ Main Duties: _____

b) "FULL TIME WORK" means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week. Are you at FULL TIME WORK? ☐ Yes ☐ No

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually* ☐ Charge My Credit Card (see below):

I request and authorize NJCPA Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual ☐ monthly charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

*There is a $1.00 administrative fee for semi-annual billing. You can select annual billing to avoid this fee.

4. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE, based upon all my statements made in this Request Form:

a) **Monthly Benefit Amount* Desired:** $_____

*NOTE: If you are increasing or altering present coverage in any way, do NOT indicate just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting. If you are under Age 50, choose an amount between $500 and $4,000 in $100 increments. If you are Age 50 to 54, choose an amount between $500 and $3,000.

b) **Benefit Period:** ☐ Plan 5/2 ☐ Plan 65-65

c) **Waiting Period**: ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days

d) **Tobacco/Nicotine Use:** Have you used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum and electronic cigarettes)?

☐ Yes ☐ No

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

Member _____ _____
MO/YR Product

e) Do you now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability? ☐ Yes ☐ No If yes, provide details (insurance company, plan, monthly benefit, benefit period):

_____

f) Do you intend to discontinue any of the disability insurance listed in e) above, if the coverage applied for is approved? ☐ Yes ☐ No If yes, indicate which coverage and the date of termination:

_____

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the Accidental Death & Dismemberment benefit under this Group Disability Income Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation: 1) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2) If naming a Trust, please indicate the full name and date of the Trust. (Attach a separate sheet if necessary, then sign and date.)

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #		Benefit %
				☐ Primary ☐ Secondary	
				☐ Primary ☐ Secondary	

6. STATEMENT OF HEALTH (Please initial any changes you make on this form.)

To the best of your knowledge and belief, please answer these questions as they apply to you:	Yes	No
1) Are you now ill or taking any 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 trouble/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 health 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 have five years you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐	☐

6. STATEMENT OF HEALTH: (Continued)

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 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, or revoked, or had any moving violations? ☐ ☐

9) Except for residents of CT and MN, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ☐ ☐

For residents of CT and MN only, have you been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason during the past 15 years? ☐ ☐

If you have answered 'yes' to any questions, give complete details below. (Attach a separate sheet if necessary, then sign and date it.)

Name of Proposed Insured	Details

7. AUTHORIZATIONS AND SIGNATURES:

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, MIB, Inc. ("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 representative, 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 applicant **requests** the insurance indicated; and the applicant and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below 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.

Applicant Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

FRAUD NOTICE – *For Residents of all states except 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.

RESIDENTS OF CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR RESIDENTS OF D.C.: 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 member.

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 may be guilty of insurance fraud as determined by a court of law.

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 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 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 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 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 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.