USI AFFINITY

NEW YORK LIFE

Group 10-Yr. Level Term Life

Insurance Plan

FOR NEW JERSEY SOCIETY OF CPAS MEMBERS, & THEIR FAMILIES

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

New York Life Insurance Company?

NJCPA MEMBER BENEFIT PROVIDER

Whether you're just starting your career and family or looking forward to enjoying the fruits of your hard work in retirement, the role that life insurance can play in a family's security and financial well-being is important to consider.

Nothing can replace the loss of a loved one. But life insurance could help provide the resources your family needs for a secure and comfortable future.

As a member of the New Jersey Society of CPAs, you have an opportunity others don't. The NJCPA Insurance Program has put together quality features on Group 10-Year Level Term Life Insurance to help protect your family, your assets, and your legacy.

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 & Coverage Amounts

Eligiblity

Members of the New Jersey Society of CPAs who are under age 65 and residents of the U.S. may apply for coverage. Members may also apply for coverage for their lawful spouses who are under age 65 and residents of the U.S., and for unmarried dependent children who are ages 15 days to 19 years (age 25, if a full-time student).

Your Choice of Coverage Amount

NJCPA members and their spouses may apply for coverage amounts between $100,000 and $1,000,000 in $50,000 increments[2].

You may cover your eligible dependent children for $2,500 each ($500 for eligible children under age 6 months). The annual premium covers all eligible dependent children, regardless of the number covered.

How much life insurance should I consider?

Many experts recommend at least

10x { Your Gross ANNUAL INCOME }

Consider these factors in deciding coverage amount:

- EXISTING DEBTS OF THE INSURED
- FINAL EXPENSES FOR THE INSURED
- FUTURE INCOME OF THE INSURED
- FUTURE NEEDS OF THE BENEFICIARY
- SPAN OF YRS. TO SUPPORT BENEFICIARY

Standard Plan Features

Accelerated Death Benefit

Sometimes there are circumstances when you may need added financial support while you're still living, and the Accelerated Death Benefit in this plan could help. If you are diagnosed with a terminal illness, you can request a one-time advanced payment of 50% of the in-force coverage[3].

Use this benefit payment for any purpose you choose—including additional medical expenses, personal care, and household expenses. Your beneficiaries still receive the remaining 50% of your death benefit. To qualify you must provide proof of terminal illness and have a life expectancy of a year or less.

Handicapped Child Benefit

This plan gives important consideration to parents with special needs children. Once coverage is effective for your dependent, it will remain in-force for your dependent beyond the age termination date if your dependent has a physical or mental handicap which renders him or her incapable of self-sustaining employment and requires dependency on you or other care providers for support. Coverage for a special needs child can help cover final expenses and make up for lost income opportunities while the parent provided very important care to their child.

Portability

Access to this plan is through your association membership. Unlike employer-based coverage, this plan is portable which means that if you change jobs, your coverage does not terminate.

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.

Optional Plan Feature

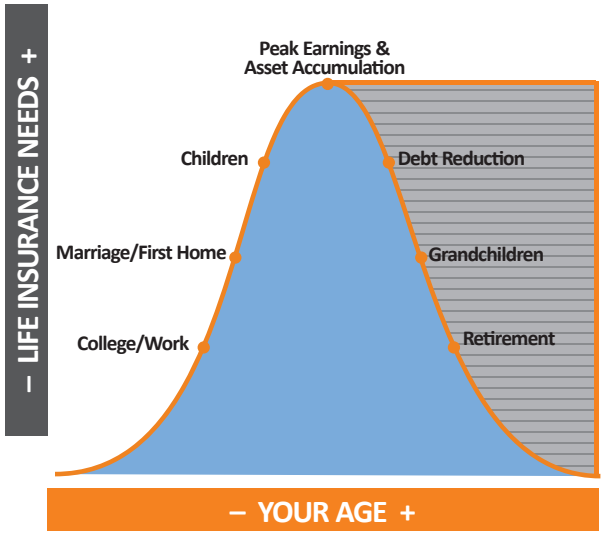
Waiver of Premium

It's good to know that your insurance will continue should you become totally disabled. For an additional cost, premium payments for your coverage will be waived if you become totally disabled prior to age 60 and remain so for at least six months. You must be under age 55 to apply. Please refer to your Certificate of Insurance for applicable conditions.

Will my needs ever change?

Your life insurance needs can change over time. It's important to review your coverage on a regular basis to be sure it has kept pace with your changing life, lifestyle, and legacy. Here are a few typical events that should trigger an insurance review, whether it's your milestone or a family member's:

- GRADUATIONS
- MARRIAGES OR DIVORCES
- HOME SALES & PURCHASES
- BIRTH OF A CHILD/GRANDCHILD
- JOB CHANGE OR RETIREMENT



1: Third Party Ratings Report as of 10/15/2020.
2: Total coverage in force through all NJCPA-endorsed life insurance underwritten by New York Life cannot exceed $2,000,000 per insured member. Spouse coverage may not exceed the member's coverage.
3: Receipt of this benefit may affect your eligibility for public assistance programs and may be taxable. Prior to your request, you should consult with appropriate social service agencies and your tax advisor.

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.

You have 30 days to review your coverage, risk free.

Summary of Terms & Conditions

When Coverage Begins

For NJCPA members and their spouses, coverage becomes effective on the first day of the month following the date the application is approved, provided the initial premium is paid within 31 days after billing and any person proposed for insurance is performing the normal activities of a person in good health of like age on the approval date. Payment of a premium contribution does not mean coverage is in force. *NOTE—Residents of NC: Any reference to "performing normal activities of a person in good health of like age" is replaced by the requirement that the health status of any proposed insured person remain the same as stated in your application.* If the person proposed for insurance is not performing the normal activities of a person in good health on the effective date, coverage will become effective on the day that person is performing normal activities, provided such day is within three months of the date insurance would otherwise have taken effect.

Dependent coverage will become effective on the date yours does or on the first day of the policy month following the date of approval of dependent's coverage by New York Life, whichever is later.

When Coverage Ends

Coverage will remain in force until the earlier of: a) you or your spouse reaches age 75; b) failure to pay premiums when due; c) the Group Policy is terminated by New York Life or the Policyholder; d) the Group Policy is modified to exclude the class of insured in which you belong; e) or you elect to end coverage.

Dependent coverage will end when the Member's coverage ends (for reasons other than attainment of age 75.) In addition, dependent coverage will terminate when the dependent spouse or child ceases to be an eligible dependent. Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance.

Continuing Coverage After The Term

If you continue to meet the eligibility requirements, you and your spouse can apply for a subsequent term of guaranteed rates then in effect. If your application is approved, your premium contribution will be based on age, health and tobacco/nicotine use at the time the new rate becomes effective and will be guaranteed for a new 10-year term.

If you are not approved for a subsequent 10-year term of guaranteed rates, or you choose not apply, you may continue your existing coverage until age 75, but on a non-guaranteed rate basis. Your premium will increase according to your age.

Reductions, Limitations and Exclusions

Total coverage in-force through all association-endorsed life insurance underwritten by New York Life cannot exceed $2,000,000 per insured member/spouse. Total coverage amount for the spouses and dependents may not exceed the member's.

The death benefit will be limited to the total sum of the premiums paid if the insured person's death is due to suicide, whether sane or insane, within two years of the date coverage was issued. In addition, the validity of any amount of insurance which has been in force for two years during your lifetime will not otherwise be contested except for insurance eligibility provisions or non-payment of premium contributions.

Current 2021 Annual Preferred Premiums per $1,000 of Coverage

The cost of this life insurance is based on the insured member or spouse's gender, amount of insurance requested, use of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Only non-tobacco/nicotine users meeting the highest underwriting standards may qualify for the Preferred Rates shown here. Depending on your situation, you may qualify for Select or Standard rates. Premium contributions will vary depending options chosen. Upon approval of your application, you will be notified of the rate classification for each approved person. The annual premium for dependent children is $12.00, regardless of the number insured.

	$100,000 - $249,000		$250,000 - $499,999		$500,000 - $1,000,000	
Age	*Male*	*Female*	*Male*	*Female*	*Male*	*Female*
35 & Under	$ 1.10	$ 0.99	$ 0.74	$ 0.64	$ 0.66	$ 0.56
36	$ 1.12	$ 1.01	$ 0.75	$ 0.66	$ 0.67	$ 0.58
37	$ 1.15	$ 1.07	$ 0.77	$ 0.69	$ 0.70	$ 0.62
38	$ 1.22	$ 1.12	$ 0.82	$ 0.75	$ 0.74	$ 0.67
39	$ 1.28	$ 1.17	$ 0.85	$ 0.82	$ 0.77	$ 0.74
40	$ 1.34	$ 1.23	$ 0.91	$ 0.86	$ 0.83	$ 0.78
41	$ 1.41	$ 1.31	$ 0.98	$ 0.94	$ 0.91	$ 0.86
42	$ 1.50	$ 1.39	$ 1.10	$ 1.02	$ 1.02	$ 0.94
43	$ 1.60	$ 1.50	$ 1.22	$ 1.12	$ 1.14	$ 1.04
44	$ 1.70	$ 1.60	$ 1.33	$ 1.22	$ 1.25	$ 1.14
45	$ 1.86	$ 1.68	$ 1.47	$ 1.31	$ 1.38	$ 1.23
46	$ 2.02	$ 1.79	$ 1.60	$ 1.41	$ 1.52	$ 1.33
47	$ 2.19	$ 1.87	$ 1.74	$ 1.49	$ 1.65	$ 1.41
48	$ 2.35	$ 1.97	$ 1.87	$ 1.58	$ 1.78	$ 1.49
49	$ 2.58	$ 2.08	$ 2.05	$ 1.68	$ 1.95	$ 1.58
50	$ 2.80	$ 2.21	$ 2.24	$ 1.79	$ 2.14	$ 1.71
51	$ 3.04	$ 2.35	$ 2.48	$ 1.94	$ 2.37	$ 1.84
52	$ 3.26	$ 2.53	$ 2.75	$ 2.11	$ 2.64	$ 2.02
53	$ 3.52	$ 2.70	$ 3.04	$ 2.27	$ 2.93	$ 2.18
54	$ 3.84	$ 2.90	$ 3.36	$ 2.48	$ 3.25	$ 2.37
55	$ 4.14	$ 3.09	$ 3.71	$ 2.67	$ 3.58	$ 2.56
56	$ 4.51	$ 3.26	$ 4.06	$ 2.85	$ 3.94	$ 2.74
57	$ 4.86	$ 3.46	$ 4.43	$ 3.01	$ 4.29	$ 2.91
58	$ 5.31	$ 3.63	$ 4.85	$ 3.22	$ 4.72	$ 3.09
59	$ 5.81	$ 3.87	$ 5.34	$ 3.44	$ 5.18	$ 3.33
60	$ 6.38	$ 4.16	$ 5.90	$ 3.73	$ 5.74	$ 3.62
61	$ 7.04	$ 4.54	$ 6.56	$ 4.11	$ 6.38	$ 3.98
62	$ 7.74	$ 4.98	$ 7.31	$ 4.56	$ 7.14	$ 4.43
63	$ 8.58	$ 5.49	$ 8.14	$ 5.09	$ 7.95	$ 4.94
64	$ 9.55	$ 6.05	$ 9.09	$ 5.63	$ 8.88	$ 5.47

Rates for Optional Waiver of Premium Benefit					
Age	*Male*	*Female*	*Age*	*Male*	*Female*
20	$ 0.08	$ 0.10	38	$ 0.14	$ 0.19
21	$ 0.08	$ 0.11	39	$ 0.16	$ 0.20
22	$ 0.08	$ 0.11	40	$ 0.17	$ 0.22
23	$ 0.08	$ 0.11	41	$ 0.18	$ 0.24
24	$ 0.08	$ 0.11	42	$ 0.19	$ 0.25
25	$ 0.10	$ 0.12	43	$ 0.22	$ 0.26
26	$ 0.10	$ 0.12	44	$ 0.24	$ 0.29
27	$ 0.10	$ 0.12	45	$ 0.26	$ 0.32
28	$ 0.10	$ 0.12	46	$ 0.31	$ 0.36
29	$ 0.10	$ 0.12	47	$ 0.36	$ 0.41
30	$ 0.10	$ 0.12	48	$ 0.42	$ 0.46
31	$ 0.10	$ 0.12	49	$ 0.50	$ 0.53
32	$ 0.10	$ 0.13	50	$ 0.59	$ 0.56
33	$ 0.11	$ 0.13	51	$ 0.63	$ 0.57
34	$ 0.11	$ 0.14	52	$ 0.68	$ 0.59
35	$ 0.12	$ 0.16	53	$ 0.72	$ 0.60
36	$ 0.12	$ 0.17	54	$ 0.77	$ 0.62
37	$ 0.13	$ 0.18			

How to Calculate Your Annual Premium Cost:

A) Coverage amount: $

B) Divide by 1,000: Units

C) Your Premium rate: $

D) Waiver of Premium rate: *(Optional)* $

E) Total of Lines C and D: $

F) Multiply Lines B and E: $

This is your Annual Premium.

The premium contributions shown reflect the current rates and benefit structure. Premium contributions may be changed by New York Life on any premium due date and any date on which premiums are changed. However, your rates may change only if they are changed for all others in the same class of insureds under this group policy. For example, a class of insured is a group of people all with the same issue age. Rates increase when you enter a new age bracket. Renewal premiums are monthly. Each renewal premium is determined by your age on that renewal date. Please call the administrator for rates and/or coverage amounts not shown in this brochure.

Your initial premium is determined by your current age (nearest birthday) on the first day of December which precedes or coincides with the certificate effective date. Thereafter, for purposes of determining premium, your age will increase one year every December 1st.

Rates are guaranteed to remain level for the initial 10-year term. Then, if still eligible, you may re-apply for 10-year level rates in effect for a subsequent 10-year term; rates for the subsequent term would be determined on then current age, health and tobacco/nicotine use and guaranteed for 10 years. If you're not approved for a subsequent 10-year term of guaranteed rates or do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis with increasing premium as the insured ages.

How New York Life Obtains Information and Underwrites Your Request for Group 10-Yr. Term Life 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, and each insured will receive a Certificate of Insurance summarizing the benefits and coverage provisions provided under Group Policy G-29469-0 on policy form GMR-FACE/G-29469-0. This group life 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 Group Policy G-29469-0
on Policy Form G-29469-0/GMR-FACE

Group 10-Yr Level Term Life Insurance Application for Members of the New Jersey Society of CPAs

Request for Group 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.

NJXJBATCH

1. MEMBER 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 a member of the New Jersey Society of Certified Public Accountants?

☐ Yes ☐ No If yes, Member ID#: _____

Are you presently insured by any other NJCPA-sponsored plan? ☐ Yes ☐ No

If yes, provide details: _____

Do you or your spouse plan to reside outside the U.S. or Canada within the next 12 months?

Member: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

Spouse: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. DEPENDENT INFORMATION

If you intend to apply for spouse or dependent child coverage, please fill out the following:

Full Name (First, MI, Last)	DOB (mm/dd/yy)	Height (ft. in.)	Weight (lbs.)	Sex
Spouse:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female

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. Please note, the charge will be listed as "USI Insurance Services" on your statement.

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

Cardholder's Name: _____ Signature: _____

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: **GROUP 10-YR. LEVEL TERM LIFE INSURANCE**

a) ☐ **Total Amount* Desired for Member Coverage:** $_____

b) ☐ **Total Amount* Desired for Spouse Coverage:** $_____

*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. For Member and Spouse coverage, choose an amount between $100,000 and $1,000,000 in $50,000 increments. Spouse coverage cannot exceed member coverage.

c) ☐ Dependent Child Coverage

d) **Optional Benefit Rider:** Waiver of Premium ☐ Member ☐ Spouse

e) **Tobacco/Nicotine Use:** Has any person proposed for insurance used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If Yes, please indicate the date the member/spouse last used such product and indicate the product used:

Member: ____ /____ Product: _____ Spouse: ____ /____ Product: _____

(mo. / yr.) (mo. / yr.)

RESIDENTS OF NEW YORK—IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help you decide whether the replacement is in your best interest.

RESIDENTS OF NY: I have read the Important Replacement Information above. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy? Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

RESIDENTS OF ALL STATES: Do you have other life insurance in force? ☐ Yes ☐ No

If yes, total amount in all companies: Member: $ _____ Spouse: $ _____

Do you have other life insurance applications pending? ☐ Yes ☐ No If yes, indicate amount and company:

Member: $ _____ Company:_____ Spouse: $ _____ Company:_____

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to only the insurance requested in this application for this Group 10-yr Level Term Life Insurance Plan. 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:	**Member** Yes	**Member** No	**Spouse** Yes	**Spouse** No
1) Is any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐	☐	☐	☐
2) Is any person to be insured now ill, or receiving medical attention or surgical treatment?	☐	☐	☐	☐
3) During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease, or injury?	☐	☐	☐	☐
4) Is any person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐	☐	☐

6. STATEMENT OF HEALTH: (continued)

To the best of your knowledge and belief, please answer these questions as they apply to you:	Member Yes	Member No	Spouse Yes	Spouse No
5) Is any person to be insured now pregnant?	☐	☐	☐	☐
6) During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:	☐	☐	☐	☐
a) Heart or circulatory trouble, high blood pressure, pain or pressure in the chest?	☐	☐	☐	☐
b) Arthritis, back trouble, bone or joint disorder?	☐	☐	☐	☐
c) Fainting spells, convulsions or epilepsy?	☐	☐	☐	☐
d) Sugar, blood, albumin or pus in urine?	☐	☐	☐	☐
e) Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐	☐	☐
f) Disorder of breast or reproductive organs or functions?	☐	☐	☐	☐
g) Nervous or mental disorder, emotional conditions or pyschiatric care?	☐	☐	☐	☐
h) Cancer, tumor or cyst?	☐	☐	☐	☐
i) Varicose veins, hemorrhoids or hernia?	☐	☐	☐	☐
j) Disorder of eyes, ears, nose or sinuses?	☐	☐	☐	☐
k) Thyroid, liver or respiratory disorder?	☐	☐	☐	☐
l) Alcoholism or drug habit?	☐	☐	☐	☐
m) Disorder of the blood?	☐	☐	☐	☐
n) 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?	☐	☐	☐	☐
7) **Except for residents of MD,** has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuro-muscular or mental illness?	☐	☐	☐	☐
8) Within the past two years, have you or your spouse participated in, or do either of you within the next two years, plan to participate in: aircraft flying (other than as a passenger), scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	☐	☐	☐	☐
9) Driver's License No: Member: _____ State: _____ Spouse: _____ State: _____ Have any person to be insured had a driver's license suspended or revoked or had any moving violations within the last five years?	☐	☐	☐	☐
10) **Except for residents of CT and MN,** in the last seven years, have you and/or your spouse 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, in the last seven years, have you and/or your spouse, if proposed for insurance, been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	☐	☐	☐	☐

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.

7. AUTHORIZATIONS AND SIGNATURES: (Continued)

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 may be used for a period of 24 months from the date signed, unless sooner revoked. 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 in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

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

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

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

Owner Information – Required if owner is other than member. (If owner is a trust, please submit a copy of the document with this application). For members not yet insured under this Group Policy, who wish to have initial ownership of any Certificate of Insurance resulting from this application owned by an individual or entity other than him/herself, complete this section.

Full Name (Last, First MI)	Relationship	Daytime Phone

Mailing Address	City	State	Zip Code

Tax ID	DOB	Social Security #

Owner's Signature (Necessary only if other than member.) Date

FRAUD NOTICES

FRAUD NOTICE – For Residents of all states <u>except</u> those listed below and NY: 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.: <u>WARNING:</u> 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: <u>WARNING:</u> 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 OK: <u>WARNING:</u> 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.