NJCPA
• PREMIER PARTNER •

Group Term Life Insurance

for Members of the New Jersey Society of Certified Public Accountants

USI AFFINITY

Underwritten by
New York Life Insurance Company

G-29464-0

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 an important issue 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 Certified Public Accountants, you have an opportunity others don't. The NJCPA Insurance Program has put together Group Term Life Insurance features to help protect your family, your assets and your legacy.

Group Rates

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 policy, you can never be singled out for a rate increase.

Advocacy

For decades, the NJCPA Insurance Program has been sponsoring customized policies to meet the needs of accountants. 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 accountant.

Stability

The NJCPA Insurance Program and USI Affinity have gone through the paces of due diligence to ensure that you're getting coverage from a respected insurance carrier. This policy 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

Eligibility

Members of NJCPA who are under age 61 and residents of the U.S. may apply for coverage. Members may also apply for coverage for their lawful spouses who are under age 61 and residents of the U.S., and for unmarried dependent children ages 15 days to 21 years (25, if full-time student) and not in military service.

A dependent who is also an NJCPA member may only be covered as a member. If both member and spouse are covered as members, only one may insure any eligible children.

Employees of NJCPA members who are working FULL-TIME[3] may also apply for coverage for themselves and their eligible dependents.

Your Choice of Coverage Amount

NJCPA members and their spouses may apply for coverage amounts from $50,000 to $500,000 in $25,000 increments.[2]

You may apply for $1,000 of coverage for eligible dependent children ages 15 days to 6 months. You may also apply for $10,000 of coverage for eligible dependent children over age 6 months.

Features Included

Accelerated Death Benefit

Sometimes there are circumstances when you may need added financial support while you're still living,

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

and the Accelerated Death Benefit in this plan could help. If you, your insured spouse, or insured dependent child are diagnosed with a terminal illness (less than 12 months to live), you can request a one-time advanced payment of 50% of the in-force coverage.[4]

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 one year or less. Premiums will not reduce.

Waiver of Premium

It's good to know that your insurance will continue should you become totally disabled. If you become totally disabled as defined in the Certificate of Insurance for at least six months, insurance including coverage for eligible dependents will be continued at no cost provided you remain totally disabled. Please refer to your Certificate of Insurance for applicable conditions.

Handicapped Child Benefit

This insurance gives important consideration to parents with special needs children. Once coverage is effective for your dependent child, it will remain in force for your dependent beyond his or her age termination date if your dependent child 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 insurance is through your association membership. Unlike employer-based coverage, this insurance is portable which means that if you change jobs or move residences, your coverage does not terminate. Just maintain your NJCPA membership to keep your coverage. See "When Coverage Ends".

1: Third Party Ratings Report as of 10/18/2022.
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: FULL-TIME means the active performance for pay or profit of the regular duties of one's normal occupation on a basis of at least 24 hours each week at a place where such duties are normally performed or other locations to which travel is required.
4: 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.
5: NCHS Data Brief #355: Mortality in the U.S., January 2020, U.S. Dept. of Health and Human Services Center for Disease Control and Prevention.
6. Subject to U.S. government regulations on restricted countries.

Optional Feature

Accidental Death & Dismemberment

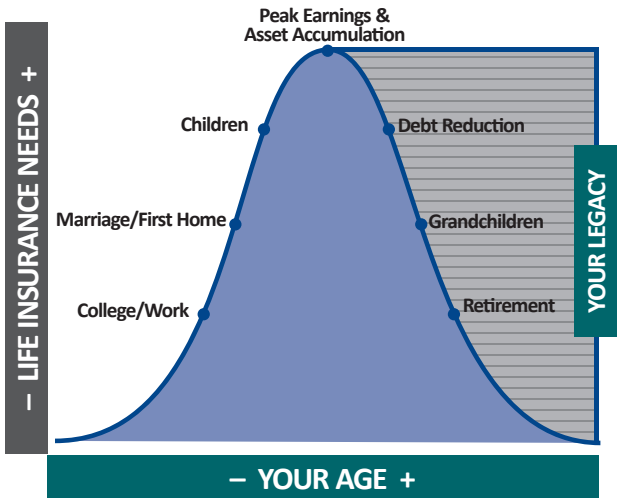
No one likes to think it will happen to them, yet unintentional injuries are the third leading cause of death in the U.S.[5] For an added premium, this optional NJCPA members-only benefit helps protect you anytime, anywhere in the world.[6] If selected, the AD&D benefit will equal your life insurance benefit.

Total benefits or a portion thereof is payable for accidental loss of life, limbs, sight, speech or hearing due to a covered injury. 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



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

For NJCPA members and their spouses, coverage becomes effective on the first day of the month following the date your application is approved by New York Life, provided you pay the initial premium within 31 days after billing. You must also be performing the normal activities of a person in good health of like age (Residents of NC: the requirement is "a person of like age" only) on the approval date. Payment of a premium contribution does not mean coverage is in force.

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

When Coverage Ends

Your coverage will remain in force until the earlier of the following occurrences: a) you reach age 70; b) you fail to pay premiums when due; c) you discontinue your membership in the association; d) the Group Policy is terminated by New York Life or the Policyholder; e) the Group Policy is modified to exclude the class of insured in which you belong; f) if an employee, you are no longer working FULL-TIME[3] for an NJCPA member, or; g) you elect to end coverage.

In addition to the above reasons, your AD&D coverage will end if: you begin active duty in the armed forces of any country, or; the principle sum has been paid.

Spouse coverage ends on the premium date which coincides with or follows the earlier of: the date the member's insurance is terminated or the end of the premium-paying period during which a) the marriage ends in divorce or annulment; b) the spouse becomes an insured member; or c) the spouse turns age 70.

Dependent child coverage will end when the member's coverage ends (for reasons other than attainment of age 70). In addition, dependent child coverage will terminate when the child ceases to be an eligible dependent.

Upon the member's death, coverage for your insured spouse or dependent child may continue as described in the Certificate of Insurance.

Life Coverage Exclusion

The life insurance 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.

AD&D Coverage Exclusions

No AD&D benefits will be payable for any loss that occurs during or is due/related to: a) suicide/attempted suicide or intentionally self-inflicted injury, while sane or insane; b) insurrection, riot, war, or while in service as a full-time member of military service for any country; c) the committing of/attempt to commit an assault or felony or participation in (except as a victim) or incarceration resulting from an illegal occupation or activity; d) disease or disorder of the body or mind; e) medical or surgical treatment, diagnosis, or preventive care; f) bacterial infection, except when resulting from purely accidental circumstances; g) the taking of i) drugs (except those taken as prescribed by a doctor) and intoxicants or ii) poison or inhaling of gas (except losses which are the result of accidental ingestion of poison or inhalation of poisonous gas); h) travel in/on, fall or descent from any aircraft, unless while traveling solely as a passenger.

30-Day Free Look

Once your coverage is approved, you will be sent a Certificate of Insurance summarizing your benefits under the Policy. 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 premium and invalidate your coverage.

Current 2023 Annual Premium Rates per $1,000 in Coverage for Non-Smokers*

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$50,000 to $149,000	$ 0.92	$ 0.97	$ 1.40	$ 2.39	$ 4.14	$ 6.62	$ 10.65	$ 16.17	$ 26.57
$150,000 to $300,000	$ 0.87	$ 0.90	$ 1.25	$ 2.05	$ 3.50	$ 5.57	$ 9.32	$ 16.17	$ 26.57

Current 2023 Annual Rates per $1,000 in Coverage for Smokers*

Age	Under 30	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69
$50,000 to $149,000	$ 1.24	$ 1.33	$ 1.93	$ 3.29	$ 5.66	$ 8.97	$ 14.31	$ 21.48	$ 34.96
$150,000 to $300,000	$ 1.17	$ 1.24	$ 1.73	$ 2.83	$ 4.76	$ 7.54	$ 12.44	$ 21.48	$ 34.96

Optional AD&D Benefit: The annual rate is $0.55 per $1,000 of coverage. This benefit can only be purchased in an amount equal to your Group Term Life coverage.

Dependent Rate per Child: The annual rate is $27.60 per child.

If paying semi-annual, a $1.00 billing fee will be added. Select the annual mode to avoid this fee.

*The cost of this life insurance is based on amount of life insurance requested, usage of tobacco/nicotine products, and age attained on the date coverage is issued. The initial premium is determined by current age (nearest birthday) which precedes or coincides with the certificate effective date.

Premium contributions will vary depending on options chosen. 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. 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.

How to calculate your annual premium cost:

1) Desired Coverage Amount: $ _____

2) Divide by 1,000: _____ Units

3) Enter the Rate for Your Age: $ _____

4) Multiply Lines 2 and 3: $ _____

5) *Optional* AD&D Coverage *(must be an equal amount to your life insurance benefit):* $ _____

6) Divide by 1,000: _____ Units

7) Multiply Line 6 x 0.15: $ _____

8) Add Lines 4 and 7: $ _____

This is your Annual Premium.

How much life insurance should you consider?

Everyone's situation is different, but according to an independent certified financial planner, the simplest formula for calculating the minimum life insurance you need is to multiply your gross annual salary by 10. However, you may find that you need more than 10 times your annual salary if you have other long-term financial goals and responsibilities. At the very least, you want to leave enough money so that your spouse can pay the bills after your death. The more money you leave can help protect your loved ones for a longer period of time.

For You

Enter Your Gross Annual Income: $ _____

Multiply by 10: X $ _____

Subtract any Existing Life Insurance Protection: - $ _____

Suggested Coverage Amount: $ _____

For Your Spouse

Enter His/Her Gross Annual Income: $ _____

Multiply by 10: X $ _____

Subtract any Existing Life Insurance Protection: - $ _____

Suggested Coverage Amount: $ _____

Source: http://www.consumerreports.org/cm/203/02/parent-a-guide-to-every-kind-of-insurance/index.htm

How New York Life Obtains Information and Underwrites Your Request for Group 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, LLC. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, 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 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 (TTY 866-346-3642). Information for consumers about MIB may be obtained on its website at www.mib.com. For Canadian residents, the address is MIB, LLC., MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590.

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 Insurance Company to the Trustees of the New Jersey Society of Certified Public Accountants, and each insured will receive a Certificate of Insurance summarizing all the benefits and coverage provisions provided under Group Policy G-29464-0 on policy form GMR-FACE/G-29464-0.

The NJCPA incurs costs in connection with this sponsored Program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs.

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:
1.855.874.0278 • 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 Lic # is 325944
CA Insurance Lic # is 0G11911

Underwritten By:
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue | New York, NY 10010
Under Group Policy G-29464-0
on Policy Form G-29464-0/GMR-FACE

Group 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. NJXKAAACH

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 a member of the New Jersey Society of Certified Public Accountants, or a Full-Time Employee of such a member?

☐ 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?

Applicant: ☐ 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.

☐ 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.

G-29464-0

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED.

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: **GROUP 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 $50,000 and $500,000 in $25,000 increments. Spouse coverage cannot exceed member coverage.

c) ☐ **Dependent Child Coverage**

d) **Optional Benefit: Accidental Death & Dismemberment** ☐ Applicant (Amount equal to Term Life Insurance)

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

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

Applicant: ____ /____ 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? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy? Applicant: ☐ 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: Applicant: $ _____ Spouse: $ _____

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

Applicant: $ _____ Company:_____ Spouse: $ _____ Company:_____

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life 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:

	Applicant		Spouse	
	Yes	No	Yes	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:

	Applicant		Spouse	
	Yes	No	Yes	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?	☐	☐	☐	☐

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 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.

7. AUTHORIZATIONS AND SIGNATURES: (Continued)

By signing and dating this application, the applicant **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.

Applicant 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 applicant. (If owner is a trust, please submit a copy of the document with this ap
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 except 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: For your protection California law requires the following to appear on this form. Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR RESIDENTS OF 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 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.