Group 20-Year Level Term Life Insurance

IEEE

Negotiated For IEEE Members And Their Families

7 Reasons IEEE Members "Lock In" This Exclusive Member Benefit

1. Rates "lock in" for 20 years. There are no annual premium increases.
2. Benefits "lock in" for 20 years. Your benefit levels do not go down just because you get older.
3. Member-only rates with additional volume discounts make this coverage an exceptional value.
4. Gives you the option of requesting coverage for your spouse and children as well.
5. Can be an ideal supplement to any other coverage you already have.
6. Benefits are paid on a tax-free basis in most cases.
7. 30-DAY NO-RISK FREE LOOK.

Who Can Request This Exclusive IEEE Member Benefit Option?

You can apply for a coverage amount from $100,000.00 up to $2,000,000.00 (in $10,000.00 units) as an IEEE member under age 55. You can also request coverage for your lawful spouse under age 55 for the same coverage amounts, not to exceed 100% of member's coverage; and for your unmarried dependent children ages 14 days through 22 years (24 if a full-time student) a $10,000.00 benefit. In order to become insured, satisfactory evidence of insurability must be provided and the required premium must be paid when due.

A dependent who is also a member is eligible for either member or dependent coverage, but not both.

If both member and spouse are covered as members, neither may insure the other as spouse, and only one may insure any eligible children.

This coverage is available only for residents of the United States (except territories), Puerto Rico and Canada (excluding Quebec).

The total amount of coverage an individual may have under all group life insurance policies underwritten by New York Life Insurance Company may not exceed $2,000,000.00. In addition, the total amount of coverage an individual may have under all group policies issued by New York Life Insurance Company to the Trustee of the IEEE Life Insurance may not exceed the maximum benefit option for any insured person.

Double Lock-In Benefits

1 **Rates**
Lock In For A Full 20 Years

2 **Benefits**
Lock In For A Full 20 Years

What Do "Double Lock-In Benefits" Mean?

In a nutshell, the double lock-in benefits offered through the IEEE Member Group 20-Year Level Term Life Insurance give you valuable peace of mind—for your wallet and for your family's financial future.

First, once your coverage is approved, your member-only rates "lock in" for the entire 20-year term of coverage. Your premium on Day 1 will be the same premium for the 20th year of this coverage. That helps to make budgeting easy.

Plus, you have options to continue your coverage after 20 years if you'd like. (See "What happens after 20 years?" later in this brochure.)

What Do "Double Lock-In Benefits" Mean? (Cont'd.)

Secondly, unlike annually renewable term life insurance (the type so often featured on Internet websites), your IEEE member benefit levels also "lock in" for 20 years.

There are no frustrating benefit decreases just because you had another birthday. The benefit level you set up on the first day of your coverage will still be in full force 20 years later.

Member-only Rates Help Hold Costs Down For IEEE Members

How Do The Rates Compare With Other Level Term Life Insurance?

Like other IEEE-sponsored polices, IEEE members have the advantage of member only rates in this important IEEE member benefit. Those group rates are often lower than you may find on your own through an insurance agent or through an employer insurance policy.

In addition, this IEEE member coverage delivers extra value with significant volume discounts:

- For coverage amounts between $250,000.00 and $490,000.00 you'll receive a volume discount.
- Plus, if you request coverage of $500,000.00 or more, an even bigger volume discount takes effect.

(See the rates shown on the next page for more details.)

No Exclusions

Benefits will be paid in the event of death … anywhere in the world … regardless of cause. The validity of any amount of your insurance that has been in force for two years during your lifetime will not be contested except for insurance eligibility provisions or nonpayment of premium contributions.

Your Choice Of Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. You are the automatic beneficiary for dependent insurance as described in the Certificate of Insurance. If you want to name another beneficiary for spouse or child insurance, please contact the plan administrator.

30-Day Free Look

When your coverage is approved, you will be sent a Certificate of Insurance. Look it over for a full 30 days.

If you're not completely satisfied with the terms of your Certificate, you may return it without claim within those 30 days. Your coverage will be invalidated and you will receive a full refund—no questions asked!

An Important Option If You're Facing A Serious Illness

The Living Benefit or "Accelerated Death Benefit" provides IEEE members with the option to have a portion of a terminally ill insured's life insurance benefit paid while he/she is still alive.

Use the money paid under this feature however you see fit. To help pay medical bills. To help preserve your savings and assets. To help maintain your quality of life.

To qualify for this benefit, a terminally ill insured must provide New York Life Life Insurance Company with proof of terminal illness must be insured under this policy and diagnosed as having a life expectancy of 12 months or less. Proof of terminal illness will consist of a statement from a doctor and any other medical information New York Life Insurance Company deems necessary to confirm the person's status.

You can request payment equal to 50 percent of a qualified terminally ill person's in-force coverage. The request must be made at least 12 months prior to that person's scheduled coverage termination age, and the amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.) Note: An insured will be eligible for only one terminal illness benefit during his/her lifetime.

Please note that receipt of this benefit may affect your eligibility for public assistance programs and may be taxable. You may wish to consult the appropriate social services agency and a qualified tax advisor about how this may affect your personal situation.

See next page for member-only rates & volume discounts

Group 20-Year Level Term Life Insurance

IEEE

Negotiated For IEEE Members And Their Families

Member-only Rates For IEEE Members and Spouses:

Current 2026-2027 "Preferred" and "Select" Monthly† Premium Contributions

The cost of this life insurance is based upon the member's and spouse's gender, amount of insurance requested, usage of tobacco/nicotine products, health status and attained age on the date coverage is issued. Premium contributions will vary depending upon the options chosen. Only Nonsmokers meeting the highest underwriting standards will qualify for these "Preferred" rates. Other Nonsmokers may qualify for the higher "Select" or "Standard" rates. (Note: Smokers may only qualify for "Standard" rates.) Upon approval of your application, you will be notified of the rate classification for each approved person. For standard rates or other benefit levels not listed, visit IEEEInsurance.com. Click on "Personal Insurance" and select the coverage of your choice to get a free, no-obligation quote.

IMPORTANT NOTICE TO RESIDENTS OF MANITOBA AND ONTARIO, CANADA: Manitoba and Ontario, Canada have enacted laws requiring taxation (Manitoba 7% and Ontario 8%) of all group insurance purchased by individuals. This tax will be added to the amount of any premium contributions due (in U.S. dollars), which is then reported and remitted to the province.

Member/ Spouse Issue Age	$250,000.00				$500,000.00				$1,000,000.00			
	Male		Female*		Male		Female*		Male		Female*	
	Preferred	Select	Preferred	Select	Preferred	Select	Preferred	Select	Preferred	Select	Preferred	Select
20	$16.67	$23.96	$13.54	$18.54	$30.83	$45.42	$24.58	$34.58	$61.67	$90.83	$49.17	$69.17
21	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
22	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
23	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
24	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
25	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
26	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
27	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
28	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
29	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
30	16.67	23.96	13.54	18.54	30.83	45.42	24.58	34.58	61.67	90.83	49.17	69.17
31	16.67	23.96	13.75	18.96	30.83	45.42	25.00	35.42	61.67	90.83	50.00	70.83
32	16.67	24.38	13.96	19.79	30.83	46.25	25.42	37.08	61.67	92.50	50.83	74.17
33	16.67	24.79	14.38	20.63	30.83	47.08	26.25	38.75	61.67	94.17	52.50	77.50
34	16.67	25.42	14.79	21.46	30.83	48.33	27.08	40.42	61.67	96.67	54.17	80.83
35	16.67	26.25	15.21	22.71	30.83	50.00	27.92	42.92	61.67	100.00	55.83	85.83
36	17.29	27.29	15.63	23.96	32.08	52.08	28.75	45.42	64.17	104.17	57.50	90.83
37	17.92	28.54	16.25	25.00	33.33	54.58	30.00	47.50	66.67	109.17	60.00	95.00
38	18.96	30.00	16.88	26.46	35.42	57.50	31.25	50.42	70.83	115.00	62.50	100.83
39	20.21	31.88	17.71	28.13	37.92	61.25	32.92	53.75	75.83	122.50	65.83	107.50
40	21.88	34.38	18.75	30.00	41.25	66.25	35.00	57.50	82.50	132.50	70.00	115.00
41	23.96	37.50	20.00	31.67	45.42	72.50	37.50	60.83	90.83	145.00	75.00	121.67
42	26.46	41.46	21.67	33.75	50.42	80.42	40.83	65.00	100.83	160.83	81.67	130.00
43	29.17	46.04	23.33	36.04	55.83	89.58	44.17	69.58	111.67	179.17	88.33	139.17
44	32.29	50.42	25.42	38.54	62.08	98.33	48.33	74.58	124.17	196.67	96.67	149.17
45	35.42	55.42	27.50	41.46	68.33	108.33	52.50	80.42	136.67	216.67	105.00	160.83
46	38.75	59.79	29.79	44.79	75.00	117.08	57.08	87.08	150.00	234.17	114.17	174.17
47	42.50	64.38	32.29	48.75	82.50	126.25	62.08	95.00	165.00	252.50	124.17	190.00
48	46.46	69.17	35.21	53.13	90.42	135.83	67.92	103.75	180.83	271.67	135.83	207.50
49	50.63	75.21	38.13	57.50	98.75	147.92	73.75	112.50	197.50	295.83	147.50	225.00
50	55.00	82.71	41.46	62.29	107.50	162.92	80.42	122.08	215.00	325.83	160.83	244.17
51	59.38	92.50	45.00	66.67	116.25	182.50	87.50	130.83	232.50	365.00	175.00	261.67
52	63.54	103.75	48.54	71.25	124.58	205.00	94.58	140.00	249.17	410.00	189.17	280.00
53	68.33	116.88	52.50	76.25	134.17	231.25	102.50	150.00	268.33	462.50	205.00	300.00
54	74.38	131.04	57.08	82.71	146.25	259.58	111.67	162.92	292.50	519.17	223.33	325.83

† Payable quarterly, semiannually, annually or via monthly Electronic Funds Transfer (EFT).

* Male rates apply to all coverage issued to Montana residents, regardless of a person's sex. The current annual premium contribution for all eligible children is $6.00 for $10,000.00 of life insurance.

Rates may vary due to rounding.

Note: Premiums are guaranteed to remain level for the first 20 years of coverage. Then, if still eligible, you may reapply for 20-year level rates in effect for a subsequent 20-year term; rates for the subsequent term would be determined based on your then-current age, health and tobacco/nicotine use status and guaranteed for 20 years. If you're not approved for a subsequent 20-year term of guaranteed rates, or do not apply for a subsequent 20-year term, coverage will continue in force on a nonguaranteed rate basis with increasing premiums as the insured ages.

QUESTIONS?

1-800-493-IEEE (4333)

IEEE.service@getamba.com

IEEEInsurance.com

What Happens After 20 Years?

After you have been covered for 20 years, you have the option to reapply for a subsequent 20-year term of coverage as long as you're under age 55 and otherwise eligible.

If your application for an additional 20-year term of guaranteed rates is approved, your premium contribution will be based upon the insured person's age, health and tobacco/nicotine use status at the time coverage becomes effective and will be guaranteed for a new 20-year term.

If you or your spouse are not approved for a subsequent 20-year term or you do not apply for a subsequent 20-year term, your coverage will continue in force on a non-guaranteed rate basis, where premium contributions increase as the insured ages.

Effective Date

Your coverage will take effect on the date your application is approved by New York Life Insurance Company as long as your first premium payment is paid within 31 days after the date you are billed (send no money now) and any person to be insured is performing the normal activities of a person in good health of like age on the date of approval. Insurance for any person who is not performing his/her normal activities as required on the date insurance would otherwise have taken effect will not become insured until the day he/she is performing such activities; provided such date is within three months of the date insurance would otherwise have taken effect and the person is still eligible. Dependent insurance will not take effect unless the member is insured on a premium-paying basis.

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 state of any proposed insured person remains the same as stated in your application.

When Coverage Ends

Coverage will stay in full force until you or your spouse reach age 75 (23 for children or 25 for children who are full-time students) unless you do not remain an active member in good standing of IEEE, premium payments are not paid when due, the group policy is terminated or modified by the policyholder to end insurance for the group of insureds to which you belong, or the insured person requests to terminate insurance. In addition, dependent coverage will terminate when the dependent spouse or child ceases to be an eligible dependent (although an insured spouse's coverage will not terminate until the end of his/her initial 20-year period). Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance.

Mail Your Completed Application To:

IEEE Member Group Insurance Program
PO BOX 14533
Des Moines, IA 50306

Residents Of PR:

Please send your application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan PR 00902-3918

This Group 20-Year Level Term Life Insurance Is Administered by:

AMBA

Association Member Benefits Advisors, LLC (AMBA)
IEEE Member Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

Call: 1-800-493-IEEE (4333)
Email: IEEE.service@getamba.com
Web: IEEEInsurance.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

This coverage is available to residents of Canada (except Quebec). AMBA does not act as broker with respect to Canadian residents and acts solely as an Administrator on behalf of New York Life.

This Group 20-Year Level Term Life Insurance Is Underwritten by:

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company, registered in the United States and other countries. Other trademarks used herein are the property of their respective owners.

51 Madison Avenue
New York, NY 10010
On Policy Form GMR
Under Group Policy No. G-29215-0/FACE

Other Important Information

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustee of the IEEE Life Insurance. When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Policy.

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

LY113P-42714

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QUESTIONS?

1-800-493-IEEE (4333) | **IEEE.service@getamba.com** | **IEEEInsurance.com**

Group 20-Year Level Term Life Insurance Plan

IEEE

Negotiated For IEEE Members And Their Families

NEW YORK LIFE

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

To Apply:

Complete this form and return to:
IEEE-sponsored Insurance Program Administrator
P.O. Box 14533
Des Moines, IA 50306

For residents of Puerto Rico, the address is:
Global Insurance Agency
P.O. Box 9023918
San Juan, PR 00902-3918

Questions? 1-800-493-IEEE (4333)

Send No Money Now

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.
(Please make any necessary corrections to your preprinted name, address and member number.)

1 MEMBER INFORMATION

Name

Address

City State ZIP

Please check one:
☐ Home address
☐ Business address

Preferred Phone ( )

Email (For internal use only for important announcements, time-sensitive bulletins or member notifications. Neither IEEE nor the Plan Administrator will sell or rent your email address under any circumstances.)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union† ☐ Domestic Partner†

†Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Are you presently insured under any IEEE Member Group Life Insurance Plans? ☐ Yes ☐ No

If "Yes," indicate which plan(s) and provide details (person insured and amount of insurance):

☐ Term Life ☐ Level Term Life to Age 65 ☐ Universal Life ☐ Permanent Whole Life
☐ 10-Year Level Term Life ☐ 20-Year Level Term Life

Details

Does any person proposed for insurance intend to reside outside the United States and Canada within the next 12 months?

Member: ☐ Yes, Countries For How Long? ☐ No

Spouse: ☐ Yes, Countries For How Long? ☐ No

		DATE OF BIRTH	HEIGHT	WEIGHT	SEX
MEMBER		MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
SPOUSE*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
CHILD(REN)*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F

*See plan information/plan details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

G-29215-0

Please complete all pages and sign on page 4

2 MEMBERSHIP INFORMATION

Are you now a member of The Institute of Electrical and Electronics Engineers, Incorporated?

☐ Yes ☐ No

Membership # _____

Expiration Date _____

(Membership in IEEE is required for participation in the plan. Affiliate members are not eligible.)

3 PAYMENT OPTION SELECTED

☐ **Electronic Funds Transfer (EFT):** I request and authorize the Administrator, IEEE Member Group Insurance Program, to make ☐ monthly ☐ semiannual withdrawals against the account specified on the attached check or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions under this plan. (Enclose a VOIDED check.)

X _____ _____

SIGNATURE(S) AS REQUIRED ON CHECKS/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

☐ **Periodic Billing:** Quarterly (March 1, June 1, September 1 and December 1)

4 INSURANCE REQUESTED (Refer to the enclosed brochure for eligibility, options and coverage description.)

A. I HEREBY APPLY FOR THE FOLLOWING COVERAGES

Total Member Insurance Amount Requested ☐ $250,000.00 ☐ $500,000.00 ☐ $1,000,000.00 $ _____ **Other Amount**

Total Spouse Insurance Amount Requested ☐ $250,000.00 ☐ $500,000.00 ☐ $1,000,000.00 $ _____ **Other Amount**

Spouse coverage cannot exceed 100% of member's coverage.

Total Child Insurance Amount Requested ☐ $10,000.00 ☐ None

Note: Member coverage must be in force to request dependent coverage.

B. Other Insurance: Do you have other life insurance in force? ☐ Yes ☐ No

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

Do you have other insurance applications pending? ☐ Yes ☐ No

If "Yes," indicate amount and company: Member $ _____ Company _____

Spouse $ _____ Company _____

C. Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum or electronic cigarettes)?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

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

Member _____ (MO/YR) _____ (Product) Spouse _____ (MO/YR) _____ (Product)

D. Insurance Replacement

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 be 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 NEW YORK: I have read the Important Replacement Information above. Is the life 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

5 BENEFICIARY DESIGNATION

Death benefit will be paid as designated in the certificate. Contact the Administrator for a form to designate a different beneficiary.

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

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

A. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits, or on waiver of premium for life or health insurance? ☐ Yes ☐ No

B. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No

C. 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? ☐ Yes ☐ No

D. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ Yes ☐ No

E. Is any person to be insured now pregnant? ☐ Yes ☐ No

F. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ☐ Yes ☐ No
2. Arthritis, back trouble, bone or joint disorder? ☐ Yes ☐ No
3. Fainting spells, convulsions or epilepsy? ☐ Yes ☐ No
4. Sugar, blood, albumin or pus in urine? ☐ Yes ☐ No
5. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ Yes ☐ No
6. Disorder of the breasts or reproductive organs or functions? ☐ Yes ☐ No
7. Nervous or mental disorder, emotional condition or psychiatric care? ☐ Yes ☐ No
8. Cancer, tumor or cyst? ☐ Yes ☐ No
9. Varicose veins, hemorrhoids or hernia? ☐ Yes ☐ No
10. Disorder of eyes, ears, nose or sinuses? ☐ Yes ☐ No
11. Thyroid, liver or respiratory disorder? ☐ Yes ☐ No
12. Alcoholism or drug habit? ☐ Yes ☐ No
13. Disorder of the blood? ☐ Yes ☐ No
14. Other health or physical impairment including:
    a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
    b. Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past five years? ☐ Yes ☐ No
    c. Any other impairment? ☐ Yes ☐ No

G. Have you or your spouse (if proposed for insurance) 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, neuromuscular or mental illness? [Note: This question is not applicable to MD residents.] ☐ Yes ☐ No

H. Within the past two years, have you or your spouse (if proposed for insurance) participated in, or do either of you, in the next two years, plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; hang-gliding; parasailing; bungee jumping; organized motorcycle racing, or any type of organized motorized racing? ☐ Yes ☐ No

I. Driver's License No.: Member _____ Spouse _____

State in which issued: Member _____ Spouse _____

Have you or your spouse (if proposed for insurance) had a driver's license suspended or revoked, or had any moving violations within the past five years? ☐ Yes ☐ No

J. Except for residents of CT and MN, 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 have an arrest pending? ☐ Yes ☐ No

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? ☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS, GIVE COMPLETE DETAILS BELOW.
(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various" or "miscellaneous.")

Question Letter/No.	Name of Proposed Insured	Illness or Condition—Date of Onset—Duration—Treatment—Operation—Degree of Recovery and Date	Name and Address of Physicians or Other Practitioners and Hospitals Where Confined or Treated

Please complete all pages and sign on page 4

7 AUTHORIZATION AND SIGNATURE

I understand that New York Life 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 or MIB, LLC. ("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 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 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 above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC.; and attest to having read the IMPORTANT NOTICE and Fraud Notices enclosed, 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'S SIGNATURE X _____ **DATE** _____
(PLEASE SIGN AND DATE IN INK.)

SPOUSE'S SIGNATURE X _____ **DATE** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED. PLEASE SIGN AND DATE IN INK.)

Owner Information is required if owner is other than Applicant
(If Owner is a Trust, please submit a copy of the document with this application.)

Full Name: Last First Middle Initial | Relationship to Proposed Insured | Daytime Phone

Mailing Address: Street | City | State (or Province) | ZIP Code (or Postal Code)

Tax ID# | Date of Birth | Social Security Number (or Soc. Ins. #)

OWNER'S SIGNATURE X _____ **DATE** _____
(NECESSARY ONLY IF OTHER THAN MEMBER)

For purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada.

FRAUD NOTICES

FRAUD NOTICE—For residents of all states <u>except</u> those listed below <u>and</u> New York: 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.

FOR 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 applicant.

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 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 MD: Any person who knowingly or willfully presents a false and 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 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 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 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.

IMPORTANT NOTICE:

How New York Life Obtains Information And Underwrites Your Request For The Group 20-Year Level Term Life Insurance Plan

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 or 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 application 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, LLC., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. Information for consumers about MIB may be obtained on its Web site at www.mib.com. **For Canadian residents the address is:** 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 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 family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8/12 ed.**