GROUP DISABILITY INCOME INSURANCE PLAN APPLICATION

TO APPLY:
Send no money now.
Complete this form and return to:
ADMINISTRATOR
IEEE GROUP INSURANCE PROGRAM
P.O. Box 14533 • Des Moines, IA 50306

For resident of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS?
Call: 1-800-493-IEEE(4333)
ieee.service@getamba.com

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

PLEASE PRINT IN INK OR TYPE ALL ANSWERS. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: _____

Home Phone (_____) _____

Work Phone (_____) _____

E-Mail Address: _____
AMBA will not share your email information.

Member's Date of Birth: _____ Sex: ☐ M ☐ F
MO. DAY YR.

Height: _____ft _____in. Weight _____lbs.

Please check one: ☐ Home address ☐ Business address

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow(ed)

☐ Civil Union* ☐ Domestic Partner*

*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Do you intend to reside outside the U.S. or Canada in the next 12 months?

☐ YES, Countries:_____ For how long? _____ ☐ No

2. Membership Affiliation – Occupational Status:

a. Are you now a Member of The Institute of Electrical and Electronics Engineers, Incorporated? ☐ Yes ☐ No
Membership # _____ Exp._____
(Membership in IEEE is required for participation in this coverage. Affiliate members are not eligible.)

b. What is your occupation? _____ Main Duties: _____

c. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you at "FULL-TIME WORK"? ☐ Yes ☐ No

d. ANNUAL GROSS INCOME form:
Salary $_____Self-Employment $ _____ Self-Employment Start Date _____
(MM/DD/YYYY)

Bonus $_____Commissions $ _____ Total $ _____

Your ANNUAL GROSS EARNED INCOME must be at least $20,000 for you to be eligible for this coverage.

3. Insurance Requested:

Refer to the Policy Information/Details for eligibility, options, and coverage description.

I hereby apply for the following coverage: ☐ New ☐ Additions

Note: If you are increasing or altering present coverage in any way, do not indicate in item a. below, only the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

You may chose any Monthly Benefit Option provided it and other disability income coverage you may have does not exceed 60% of your AVERAGE MONTHLY INCOME (as defined in the Policy Information/Details).

I hereby apply for the coverage indicated below, based upon all my statements made in this Application:

a. Monthly benefit option: $_____

b. Benefit period (choose one): ☐ Career Coverage ☐ Inflation-fighter Career Coverage ☐ Five-Year Coverage

c. Waiting period (choose one): ☐ 30-day ☐ 90-day ☐ 180-day ☐ 365-day

3. Insurance Requested: (continued)

d. Future Purchase Option ☐ Yes - Monthly Benefit Option $_____ ☐ No
(Maximum of $2600, age 46 or under, Not available with the Inflation-Fighter Coverage)

e. Payment option: Quarterly (You will be billed four times a year on February 1, May 1, August 1 and November 1.)

Note: After the first billing, you can select the monthly Preauthorized Check Payment Plan. Call the Plan Administrator for more information.

f. Do you now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability?
☐ Yes (please list below) ☐ No

Proposed Insured Company	Plan	Monthly Benefit	Benefit Period

g. Do you intend to discontinue any of the disability insurance listed in "f," above, if the coverage applied for is approved? ☐ Yes ☐ No
(If "YES," please indicate which coverage and the date it will be terminated.) _____

4. Statement of Health: Please initial and date any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you. YES NO

1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ☐ ☐

2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:

a. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?..... ☐ ☐

b. Other Health or physical impairment including: .....
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?.. ☐ ☐
[Florida residents only – answer the following:] ☐ ☐
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?..... ☐ ☐
(iii) Any other impairment? ..... ☐ ☐

3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?..... ☐ ☐

4. Are you now pregnant? ..... ☐ ☐

5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?..... ☐ ☐

6. During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?..... ☐ ☐

7. Driver's License No.: _____ State in which issued: _____

8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... ☐ ☐

9. **Except for the residents of Minnesota and Connecticut,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ..... ☐ ☐
For residents of Minnesota and Connecticut only, has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years? ..... ☐ ☐

4. Statement of Health: *(continued)*

Please initial and date any changes you make on this form.

10. If you have answered any of the above Questions 1-9 "YES," give complete details below. (if you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	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:

FRAUD NOTICE – ***For residents of all states except those listed below:*** Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO, the following also applies:** Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF CA: 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.

RESIDENTS OF DC, 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 is 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 any insurance company of 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 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 NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF 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 PR: 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 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 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.

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 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, representative or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member **requests** the insurance indicated; and the member a **consents** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, LLC.; and **attests** to having read the IMPORTANT NOTICE attached and the Fraud Notices indicated above, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature X _____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

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.

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

6/23 ed.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income 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.

For Canadian residents the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590.

Information for consumers about MIB may be obtained on its Web site 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 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 **7/15 ed.**

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Group Disability Income Insurance

For IEEE Members
Underwritten by New York Life Insurance Company

INSURE YOUR INCOME – YOUR MOST VALUABLE ASSET

Your most important asset is your ability to earn income. Even if you are young and healthy, a serious illness or injury could put you out of work for months or even years – thus jeopardizing your livelihood. A reliable source of disability income protection is this Group Disability Income Insurance exclusively for IEEE members.

Even if you have some disability insurance through your employer, it may not be enough. Many employers provide only a short-term salary continuation policy or short-term disability income policy. This Policy can be used to supplement benefits provided by your employer coverage or as primary protection.

This Policy is designed to provide you with a regular monthly income when you are totally disabled and unable to work as the result of an illness or injury.

WHO IS ELIGIBLE?

IEEE members under age 70 who are at FULL-TIME WORK are eligible to request coverage, provided their ANNUAL GROSS EARNED INCOME is at least $20,000 for the preceding 12 months. Student members and members who are on active full-time military duty are not eligible.

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are performed.

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

HOW THE COVERAGE WORKS

The policy is designed to pay monthly benefits when you are Totally Disabled. "Totally Disabled" means you are prevented by illness or injury from performing the material and substantial duties of your usual occupation, provided you are not otherwise working for pay or profit.

Benefits begin at the end of the waiting period, provided you are Totally Disabled.

Note: Benefits for disabilities due to mental Disorders or Chemical Dependency are limited to a maximum of 36 monthly payments, regardless of choice.

Choice of Coverage

Career Coverage: If you are Totally Disabled before age 65, benefits are payable up to age 67. There is a two year maximum benefit for Total Disabilities starting at ages 65 through 74.

Five-Year Coverage: Benefits are payable up to five years for Total Disabilities starting before age 60. For Total Disabilities starting at ages 60 through age 62, benefits may continue up to age 65. For Total Disabilities starting at ages 63 through 74, benefits may continue for up to two years.

Inflation-Fighter Career Coverage: This Policy offers disability coverage that, once benefits begin, can help keep pace with the rate of inflation. Monthly benefits will be adjusted annually from the date of disability if you are Totally Disabled prior to age 65. Adjustments may be made to the Monthly Benefit paid in the second and each succeeding year. The Adjustment amount will be based on the Consumer Price Index for Urban Consumers (CPI-U) up to a maximum 5% increase per year and an overall maximum increase of one times the original benefit.* Once you are no longer disabled and benefit payments stop, the Monthly Benefit returns to the original option amount.

Benefits are payable up to age 67 for Total Disabilities starting before age 65. For Total Disabilities starting at ages 65 through 74, benefits will be payable in accordance with the basic Career Coverage (i.e., up to two years maximum).

Choice of Monthly Benefit

You have a wide choice of Monthly Benefit Options, from $130 to $10,010 (in $130 units). However, members age 67 through 69 may not request a Monthly Benefit Option in excess of $4,940. The option you choose, together with any other disability income insurance you may have or for which you are applying , cannot exceed 60% of your AVERAGE MONTHLY INCOME. Also, if you have been self-employed for less than one year, your Monthly Benefit Option is limited to $1,040. Depending on your state of residence, you may be eligible to receive disability benefits under a state policy. You may wish to check if your state offers this type of benefit.

NOTE: On the November 1 anniversary date on or immediately after reaching age 67, coverage in excess of $4,940 reduces to $4,940. On the November 1 anniversary date on or immediately after reaching age 70, coverage in excess of $2,470 reduces to $2,470.

ANNUAL GROSS EARNED INCOME means your wages, salaries, commissions, fees and other amounts received for personal services – before deduction of income or social insurance taxes and after deduction of the normal business expenses which are deductible for income tax purposes – for any 12-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income. AVERAGE MONTHLY INCOME is 1/12 of your ANNUAL GROSS EARNED INCOME.

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*A "catch up" feature allows disabled members to receive benefit increases in excess of the 5% annual maximum if the prior years' compounded rates of inflation were less than 5% annually. Contact the Administrator for additional details on this feature.

Choice of Waiting Period
You also have a choice of four waiting periods: 30, 90, 180, or 365 days. A waiting period is the number of consecutive days that you must be Totally Disabled before benefits commence. You should chose one that will provide benefits when your employer-provided salary continuation policy runs out. Coverage with a longer waiting period is less expensive.

Future Purchase Option
You expect that your salary will increase with time, and that means you'll have more to protect. Reserve a coverage increase now, for future activation, without additional medical underwriting for your future need.

Eligible members, under age 47, may apply for this benefit when requesting initial coverage. You will be underwritten now for the full amount applied for, both your Monthly Benefit for immediate activation upon approval and the future amount to be activated (converted) as an increase to your Monthly Benefit in the future. No medical underwriting will ever be required in the future to activate (convert) an in force FPO amount!

Any approved FPO amount, in $130 increments up to $2,600, even if not activated (converted), is subject to the policy maximum and the 60% of AVERAGE MONTHLY INCOME limitation.

Whether you choose Career Coverage or Five-Year Coverage, the FPO amount is pended in that status until your decision to activate either a portion or the entire amount of the FPO to increase your Monthly Benefit. While pended with FPO status, you pay the very attractive FPO rate. Upon activation/ conversion, the entire amount of the new, increased Monthly Benefit is subject to the full rate basis. The FPO is not available with the Inflation Fighter Coverage.

You may request a conversion of an FPO amount to increase your Monthly Benefit only during the year of your even age, from age 24 to age 50. (Age is determined as attained age on the nearest November 1, except on the initial effective date, which recognizes attained age on that date.) You will need to contact the Administrator to request this conversion/activation. An FPO amount that has not been converted to increase the Monthly Benefit is not eligible for claim payment consideration.

The FPO option will be terminated at age 51 and the eligibility to convert/activate the FPO amount ends.

FEATURES

Premium Credit
Plus, a 30% premium credit currently applies to all premium contributions due. If policy experience warrants, the Trustee may grant premium credits that can reduce your cost to renew coverage.

Waiver of Premium
After you have been Totally Disabled for six consecutive months and you begin to receive benefits for Total Disability, all future premium contributions under this policy will be waived for as long as you receive benefits for that disability.

Benefits for Recurring Disability
Successive periods of disability which are due to the same or related causes will be considered a single period of disability unless separated by return to FULL-TIME WORK for three consecutive months or more.

Rehabilitation Benefit
This benefit is designed to help certain disabled individuals return to the work force. Under this provision, a professional rehabilitation staff reviews case histories and identifies those individuals who appear to have the greatest likelihood of rehabilitation. Individuals selected by New York Life Insurance Company will be offered the option of participating in a rehabilitation program at no cost to them. Participation is voluntary and benefits will not be reduced due to participation in the program.

Residual Disability Benefit
An illness may leave you unable to perform some but not all your job functions. If you are under age 65 and a covered illness or organ donation results in an earnings loss of at least 20% you may receive a residual disability benefit. The benefit is payable after the elimination period and may be paid even if you never receive benefits for a covered total disability. The amount payable is based on a loss of earnings ratio as described in your certificate and ends the earlier of the date your earnings loss ratio is less than 20% or the maximum benefit period, including covered total disability benefits, if any, is reached.

Leave of Absence or Lay-Off Benefit
Many disability policies end as soon as you stop work whether it's time off to take care of a family member, to develop your career or worst yet because you are laid off. IEEE members can continue their coverage for up to 180 days to take a leave of absence or in the event of a lay-off. Leaves must be authorized in writing and all other conditions of coverage must be met.

Organ Donation Benefit
If you have been insured under this Policy for at least six months and undergo a surgical procedure to donate an organ for transplant, you will be considered Totally Disabled. No waiting period will apply, and benefits will be payable from the first day of Total Disability. However, any portion of the Monthly Benefit Option which became effective in the six months immediately prior to such organ donation will not be payable for this Total Disability.

Survivor Benefit
If you die – from any cause – while receiving benefits for Total Disability, a death benefit equal to three times the Monthly Benefit Option in force on the date of your death will be paid to your surviving relative(s) in the following order of survival: your spouse; or your children, equally; or your brothers and sisters, equally; otherwise, if there is no surviving relative, to the executor or administrator of your estate.

ADDITIONAL INFORMATION

Effective Date
Note: Residents of NC: *Any reference to "performing the normal activities of a person in good health of like age" are replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application.*

You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you are actively performing the normal activities of a person in good health of like age on that date. If you are not performing your normal activities as required, coverage will not become effective until the day you are performing such normal activities provided such date is within three months of the date insurance would have been effective and you are still eligible for insurance.

Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date specified by New York Life Insurance Company.

Note: There are instances where New York Life Insurance Company may be able to offer insurance, at the same cost, by eliminating coverage for a specific impairment or disease.

When Coverage Ends

Once coverage is validly in force, it may be continued to the November 1st anniversary date on or immediately after you reach age 75. Coverage will end earlier if: you cease FULL-TIME WORK other than for reasons of disability, cease to be an IEEE member, fail to pay premium contributions when due, enter full-time active duty in the armed forces (coverage may be restored upon termination of active duty status, subject to policy guidelines) or the group policy is modified or terminated by the policyholder or New York Life Insurance Company to end insurance on the group of insureds to which you belong.

Exclusions and Limitations

This coverage does not provide benefits for: any disability that occurs during or is due or related to intentionally self-inflicted injury while sane or insane, declared or undeclared war or any act thereof, a preexisting condition (see below), military service, or your incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; or any disability that is due or related to pregnancy or childbirth (except complications thereof), or any impairment or disease specifically excluded from your coverage. This Policy limits benefits for disabilities due to Mental Disorders and Chemical Dependency to a maximum of 36 monthly payments. No benefits will be paid unless the disability occurs while you are insured under the Policy and you are under the care of a licensed physician or surgeon other than yourself (or member of your immediate family or household) during the period of disability.

Preexisting Condition Limitation

PREEXISTING CONDITION is an injury or sickness for which you consulted a doctor, received any medical services or supplies, or took any medication during the 12 months immediately before becoming insured under this policy. Benefits are not payable for a disability which is classified as a PREEXISTING CONDITION until the end of the earlier of 12 consecutive months during which you have not consulted a doctor, received medical services or supplies, or taken any medication for the condition; 24 consecutive months during which you have been insured under this Policy.

YOUR COST

The insurance cost is based on your attained age when coverage becomes effective and increases on the November 1 anniversary date or immediately after the date you reach a higher age bracket. Premium contributions will vary depending upon the options and amounts chosen. **Manitoba, Ontario, Canada Residents:** Please see tax notice under HOW TO APPLY section.

CURRENT 2026-2027 QUARTERLY PREMIUM CONTRIBUTIONS PER $130 MONTHLY BENEFIT OPTION WITH 30% PREMIUM CREDIT*

Career Policy
Waiting Periods

Member's Age	30-Days	90-Days	180-Days	365-Days
Under 30	$2.65	$1.60	$1.37	$1.18
30-39	3.11	1.89	1.58	1.39
40-49	5.36	3.49	3.00	2.69
50-59	8.25	5.90	4.83	4.20
60-62**	12.10	8.67	7.14	6.22
63-69+	11.05	7.62	5.73	5.10
70-74**+■	16.09	12.87	9.79	8.22

Five-Year Policy
Waiting Periods

Member's Age	30-Days	90-Days	180-Days	365-Days
Under 30	$2.10	$1.18	$0.90	$0.76
30-39	2.42	1.32	0.97	0.84
40-49	3.95	2.37	1.68	1.47
50-59	7.41	5.15	4.01	3.57
60-62**	12.10	8.67	7.14	6.22
63-69+	11.05	7.62	5.73	5.10
70-74**+■	16.09	12.87	9.79	8.82

Inflation-Fighter Career Policy
Waiting Periods

Member's Age	30-Days	90-Days	180-Days	365-Days
Under 30	$3.21	$2.16	$1.91	$1.74
30-39	3.78	2.54	2.23	2.06
40-49	6.22	4.37	3.89	3.57
50-59	9.24	6.89	5.80	5.17
60-62**	13.13	9.68	8.15	7.25
63-69***+	11.05**	7.62**	5.73**	5.10**
70-74**+■	16.09**	12.87**	9.79**	8.82**

FUTURE PURCHASE OPTION PREMIUM CONTRIBUTIONS PER UNIT WITH 30% PREMIUM CREDIT*-CAREER POLICY

Member's Age	30-Days	90-Days	180-Days	365-Days
Under 30	$0.40	$0.23	$0.19	$0.17
30-39	0.46	0.37	0.23	0.21
40-50	0.80	0.53	0.44	0.40

FUTURE PURCHASE OPTION PREMIUM CONTRIBUTIONS PER UNIT WITH 30% PREMIUM CREDIT*-FIVE YEAR POLICY

Member's Age	30-Days	90-Days	180-Days	365-Days
Under 30	$0.32	$0.17	$0.13	$0.11
30-39	0.36	0.19	0.15	0.13
40-50	0.59	0.36	0.25	0.21

*The rates above reflect a 30% premium credit currently in effect. Although not promised or guaranteed, premium credits have been granted for years. Please note, rates may vary slightly due to rounding.

**For disabilities commencing on or after the November 1 anniversary date on or immediately after reaching ages 60 and 63, the maximum benefit period is reduced as previously described.

+On the November 1st anniversary date on or immediately after reaching age 67, coverage in excess of $4,940 will reduce to $4,940; and on the November 1st anniversary date on or immediately after reaching age 70, coverage in excess of $2,470 will reduce to $2,470.

***Inflation-Fighter benefits apply only to disabilities beginning prior to age 63. Starting with age 63, benefits revert back to those provided by the basic Career Policy.

■Renewal only

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insured's.

For example, a class of insureds is a group of people with the same issue age Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustee under Trust Agreement with the IEEE.

How to Calculate the Quarterly Cost

1. Decide on the Policy (Career, Inflation-Fighter Career or Five-Year).
2. Select your waiting period (30, 60, 90, 180 or 365 days).
3. Choose your Monthly Benefit Option (from $130 to $10,010 per month).
4. Determine the number of $130 units, and multiply the cost per $130 unit by the quarterly premium contribution per unit based on the Policy, waiting period and your age.

For example, the rate for a $1,300 Monthly Benefit Option with a 90-day waiting period under Career coverage for a member age 35 is 10 x $2.70 or $27.00 quarterly.

Note: If you wish to pay annually, the premium is four times the quarterly cost; if you prefer to pay semiannually, the premium is two times the quarterly cost. If you wish to pay monthly with the Electronic Funds Transfer (EFT) Option, divide the quarterly cost by three.

HOW TO APPLY

The Group Disability Income Insurance is medically underwritten based on the information provided by you on the application. It is important that you complete the form truthfully and completely; failure to supply accurate information may invalidate coverage. Your application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the insurance.

1. Refer to the Policy description for benefits and premium cost as you fill out the application. Remember, only IEEE members (as described under Who Is Eligible) may apply.

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.

2. Mail the completed application:

IEEE Group Insurance Program
PO BOX 14533
Des Moines, IA 50306
(Residents of Puerto Rico, please see instructions below.)

Residents Of Puerto Rico:
Please send the application to:

Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

CONSIDER YOUR ELIGIBILITY

Before you request coverage, you must be a member in good standing of IEEE. Please wait until your application for membership is accepted before initiating your insurance requests. If you have any questions regarding membership, see the IEEE home page at www.ieee.org or call IEEE membership at 1-800-678-IEEE (4333).

CERTIFICATE OF INSURANCE

When you become insured you will be sent a Certificate of Insurance summarizing your insurance coverage. This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms are set forth in the policy issued by New York Life Insurance Company to the Trustee under Trust Agreement with the Electrical and Electronic Engineers, Inc.

MEDICAL REQUIREMENTS

New York Life reserves the right to request medical information needed to determine an applicant's eligibility for coverage. Based upon the age of the person proposed for insurance and the amount of coverage requested, a physical exam, EKG, blood test or other medical information may be required.

Not all applicants will have to supply additional information. However, if required, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the insurance. Requests for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

HOW TO FILE A CLAIM

To file a claim, write the Administrator for the proper forms.

Send no money now. You will be billed upon approval.

30-DAY FREE LOOK

When you become insured, you will be sent a Certificate of Insurance summarizing your coverage. If you're not completely satisfied with the terms you may return it, without claim, within 30 days and your premium will be promptly refunded. No questions asked! Your insurance will then be invalidated.

This Policy 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.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-12150-2
on Policy Form GMR-FACE/G-12150-2

This Policy is Administered by:

Association Member Benefits Advisors, LLC

IEEE Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

1-800-493-IEEE(4333)
www.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.

Questions?
We're Only a Phone Call Away

If you have questions about your eligibility, what this Policy covers or how to complete the application, just give us a call toll-free at 1-800-493-IEEE(4333) between 7:30 AM and 6:00 PM, Monday through Friday, CST, or you can e-mail us at ieee.service@getamba.com. One of our service representatives will be able to immediately provide you with the information you need.

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

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