ELIGIBILITY
All active members of the Massachusetts Bar Association, who are under age 65 and at Full-Time Work, are eligible to apply for coverage under this Group Disability Income Insurance Plan.

“Full-Time Work” means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed.

This Plan is available to residents of the U.S., excluding territories. (Coverage may not be available in all states at this time. Contact the Administrator for current information.)

MONTHLY BENEFIT
The Plan is designed to pay monthly benefits when you are “Totally Disabled”, as defined below, once you have satisfied the Waiting Period. You may select a Monthly Benefit from $200 to $10,000 ($5,000 if over age 60) in $100 increments. For Total Disabilities beginning before age 63, benefits are payable up to age 65. For Total Disabilities beginning after age 63 but before age 70, benefits are payable up to two years. At age 60, Monthly Benefits are reduced by 50 percent; premium is reduced accordingly. Your Monthly Benefit amount, when combined with other disability coverage you may have or for which you are applying, cannot exceed 60% of your Average Monthly Income, which is your average wages and salary. This figure does not include commissions, fees and any other amounts received for personal services, including the cost of fringe benefits and share of total surplus, income from interest, dividends, rent, royalties, annuities, other insurance and other unearned income.

Average Monthly Income is calculated before deduction of any income taxes or social insurance taxes and after deduction of normal and usual business expenses that are deductible for income tax purposes.

Average Monthly Income is based on the immediately preceding period that produces the highest figure: a) 12 months; b) 24 months; or c) the entire period, if less than 12 months.

WAITING PERIOD
You may select a waiting period of 90 or 180 days; whichever best meets your needs. The waiting period is the number of consecutive days that you must be Totally Disabled before disability benefits become payable.

“TOTAL DISABILITY” DEFINED
Total Disability means you are prevented by injury or sickness from performing the substantial and material duties of your regular occupation after the waiting period, provided you are not working for pay or profit. You will also be considered Totally Disabled if an injury or sickness causes the total and permanent loss of any of the following:

1. the Use of two limbs;
2. the sight of both eyes;
3. speech; or
4. hearing in both ears.

The loss of sight, speech or hearing means the total and permanent loss thereof. The loss of the use of two limbs means total and permanent paralysis of such limbs.

SUCCESSIVE PERIODS OF DISABILITY
Successive periods of Total Disability from the same or related causes will be treated as one period of Total Disability unless separated by return to Full-Time Work of three months or more. Different or unrelated causes that are not separated by return to Full-Time Work of at least one day will also be treated as one period of Total Disability.

RESIDUAL BENEFIT
If you return to work after a Total Disability for which you received benefits for at least three months, and said disability began before age 64, you may be eligible for a Residual Benefit, provided your current earnings do not exceed 80% of your pre-disability income.

The benefit payable is a percentage of your Monthly Benefit amount equal to the percentage reduction in your monthly earnings. See the Certificate of Insurance for conditions and limitations.
WAIVER OF PREMIUM
If you become Totally Disabled before age 60 and receive benefits under the Plan for at least six consecutive months, all further premiums will be waived for as long as you receive benefits for that disability. Continuation of coverage is subject to all other termination provisions.

SURVIVOR BENEFIT
If you die while receiving benefits for a Total Disability, your surviving relative will receive a benefit equal to three times the Monthly Benefit in force when you died, provided you had not reached the Maximum Benefit Period.

ACCIDENTAL DEATH BENEFIT
The Accidental Death Benefit of $7,500 will be paid if you should die due to an accident where:

a) death results from an accidental bodily injury;
b) death occurs within 180 days of such accident;
c) such injury occurs while you are insured under the Plan; andd) such injury is the direct result of the accident and is independent of disease or bodily infirmity.

No Accidental Death Benefit is payable for a loss that occurs during, or due or related to a medical, dental or surgical treatment, unrelated to the accident which would otherwise entitle you to benefits. All other Exclusion and Limitations noted below also apply.

EFFECTIVE DATE
You will become insured on the first of the month on or after the date specified by New York Life Insurance Company provided the first premium contribution is paid within thirty-one days after the date you are billed, satisfactory evidence of insurability has been submitted, and you are at Full-Time Work on that date. If you are not at Full-Time Work as required, coverage will not become effective until the day you are at Full-Time Work, provided such date is within three months of the date insurance would have otherwise become effective and you are still eligible for insurance.

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

There are instances where New York Life may be able to offer insurance (at the same premium contribution) by eliminating coverage for a specific impairment or disease.

TERMINATION OF COVERAGE
Your coverage will terminate on the earliest to occur of: you cease to be an active member of the Massachusetts Bar Association; the premium due date on or next following the date you attain age 70; you cease Full-Time Work, except due to disability covered by the policy; you fail to pay premium when due; you enter full-time active duty in the armed forces (coverage may be restored upon termination of active duty status, subject to policy guidelines); you request to end coverage; or the group policy is terminated or modified by the Policyholder or New York Life to end coverage for the group of insureds to which you belong.

CURRENT ANNUAL PREMIUM RATES AS OF 2014 – PER $100 MONTHLY BENEFIT

<table>
<thead>
<tr>
<th>Member's Age</th>
<th>Waiting Period</th>
<th>90-Day</th>
<th>180-Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under 40</td>
<td></td>
<td>$6.88</td>
<td>$5.85</td>
</tr>
<tr>
<td>40 - 44</td>
<td></td>
<td>11.50</td>
<td>10.47</td>
</tr>
<tr>
<td>45 - 49</td>
<td></td>
<td>17.35</td>
<td>15.18</td>
</tr>
<tr>
<td>50 - 54</td>
<td></td>
<td>26.68</td>
<td>23.29</td>
</tr>
<tr>
<td>55 - 59</td>
<td></td>
<td>32.28</td>
<td>28.82</td>
</tr>
<tr>
<td>60 - 64*</td>
<td></td>
<td>32.28</td>
<td>28.82</td>
</tr>
<tr>
<td>65 - 69*</td>
<td></td>
<td>22.36</td>
<td>18.05</td>
</tr>
</tbody>
</table>

To calculate semi-annual, quarterly, or monthly rates, divide rates shown by 2, 4 or 12, respectively. If you wish to pay monthly, your premiums must be deducted automatically from your checking account. Please complete the Automatic Payment Option Form and return it with your application.

PLEASE NOTE: Cost is based on your age when coverage becomes effective, and increases on the premium due date on or after you enter a higher age bracket. Premium contributions vary depending on the options and amount chosen.

*Benefit periods reduce for Total Disabilities commencing after age 63, as previously described. Rates for ages 60 through 69 are for renewal purposes only. Coverage terminates at age 70.

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 contribution 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 class of insureds to which you belong. For example, a class of insureds is a group of people with the same issue age. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustee of the Preferred Group Trust.
EXCLUSIONS AND LIMITATIONS
The Plan does not provide benefits for any disability that occurs during or is due or related to: suicide, attempted suicide or intentionally self-inflicted injury while sane or insane; pregnancy, except complications thereof; your voluntary intake of drugs, narcotics or alcohol (unless prescribed by a physician); a Preexisting Condition (except as noted below); any declared or undeclared war or any act thereof; military service; incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; or riding in or descending from any aircraft except while riding as a passenger on a licensed commercial carrier. Moreover, no benefits are available for any disability that is due or related to any impairment or disease specifically excluded from your coverage.

The Plan limits benefits for disabilities due to Mental Disorders or Chemical Dependency to a maximum of twenty-four monthly payments. The Plan also limits benefits payable while you are outside the U.S., Puerto Rico, the Virgin Islands and Canada to a maximum of six monthly payments.

No benefits will be paid unless the disability occurs while you are insured and you are under the care of a licensed physician or surgeon other than yourself (or immediate family or household) during the period of Total Disability.

Preexisting Conditions
A Preexisting Condition is defined as an illness or injury for which you received medical care, treatment or supplies within the twelve month period immediately prior to becoming insured under the Plan. Benefits are not payable for such condition until the earlier of: twelve consecutive months during which you have not consulted with any physician or received any medical services or supplies; and twenty-four consecutive months during which you have been insured under the Plan.

HOW TO APPLY
Please complete the enclosed application, sign, date and return it with your first modal premium check to the address below. Please make your check payable to Selman & Company:

MBA MEMBERS' INSURANCE PROGRAM
6110 Parkland Boulevard
Cleveland, Ohio 44124
1-800-556-7614
enrollment@selmanco.com

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.

The Underwriter.
Underwritten by New York Life Insurance Company
51 Madison Avenue, New York, NY 10010,
under Group Policy G-29222-0, on Policy Form GMR-FACE/G-29222-0.

The Administrator
For more than 30 years, associations across the country have looked to Selman & Company for specialized insurance protection. As the administrator for your endorsed insurance plan, our responsibilities are to provide you with a strong valuable plan of benefits, competitive rates, and the personal service you require.

AR Ins. Lic. # 232779
CA Ins. Lic. # 0610394

This brochure contains only a brief description of some of the principal provisions and features of the plan. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustee of the Preferred Group Trust.
Important Notice

How New York Life Obtains Information and Underwrites Your Request for Group Disability Income Insurance

In this notice, references to “you” and “your” include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (“MIB”). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage 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.

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 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 at: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734. Telephone: 866-692-6901 or TTY 866-346-3462 for the hearing impaired.

For NM residents: In addition, PROTECTED PERSONS1 have a right of access to certain CONFIDENTIAL ABUSE INFORMATION2 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.

If we can provide the coverage you requested we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean that there is any insurance in force before the effective date as determined by New York Life.

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 Co. 8/12 ed.
1. **Applicant’s Information** (proposed insured)
   
   Applicant’s Name ________________________________ Date of Birth ___/___/____
   
   Street Address ____________________________________________________________
   
   City __________________________ State _______ Zip Code ______________________
   
   Please list the Insurance Policy you wish to have premium deductions made from the account indicated below:
   
   Policy Number: __________________________ Type of Insurance: __________________

2. **Financial Institution Information**

   Depositor Name (Payor) ______________________________________________________
   
   (As it appears on Financial Institution Records)
   
   Financial Institution Name __________________________ Account Number ______________
   
   (Include Branch Name)
   
   Financial Institution City __________________________ State _______ Zip Code __________

3. **Account Selection:** I authorize an automatic deduction from my (please choose one):
   
   [ ] Checking Account. Attach a sample VOIDED check.
   
   [ ] Savings Account. Account Number: ________________ Routing Number: ________________
   
   Premium deduction should be made:
   
   [ ] Monthly [ ] Quarterly [ ] Semi-Annually [ ] Annually

   Please include your first modal premium check made payable to Selman & Company. All subsequent premium payments will be made as indicated above.

4. **Signature/Authorization**

   In accordance with the agreements and conditions listed below, I hereby request and authorize Selman & Company to initiate debit entries on the Financial Institution account listed herein for the purpose of paying premium. This authorization is to remain in full force and effect until Company and Depository have received written notification from me of its termination in such time and manner as to afford Company and Depository a reasonable opportunity to act on such notification. Written notification must be mailed to: Selman & Company, 6110 Parkland Boulevard, Cleveland, OH 44124-4187.

   Signature of Depositor ______________________________________________________
   
   Print Name of Depositor ___________________________________ Date ___/___/____
   
   Signature of Applicant/Insured (If different from Depositor) __________________________
   
   Print Name of Insured/Applicant _______________________________ Date ___/___/____

5. **Agreements & Conditions**

   Automatic Payment Option (Account Deduction Authorization) is subject to the following conditions:
   
   1. Premium payments will be debited from your account on or about the premium due date.
   2. Additional premium that may be required in order to keep policy(ies)/certificate(s) current may be drawn from your account through the use of multiple debits.
   3. Selman & Company (Company) may revoke the privilege of paying premium under this Automatic Payment Option (APO) if any payment is dishonored.
   4. A service fee of $15.00 may be assessed for each dishonored payment.
   5. Payment of premium under APO may be discontinued by the Company or the undersigned upon thirty (30) days written notice.
   6. If APO is discontinued, an alternate payment mode acceptable to the Company will be used to remit the premiums needed to keep the policy(ies)/certificate(s) in force and current.
   7. The Company will not send premium notices while APO is in effect.
   8. A request for change or adjustment to the APO must be sent directly to the Company’s Customer Service Department.
   9. If you cancel this service, any refund of premium due you will take sixty (60) days to process.

   NOTE: Please keep a copy of this completed document for your record.