

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:

a) **For Members and Spouses Not Currently Insured**

I request Term Life Insurance in the INITIAL amount of \$ _____ for myself; \$ _____ for my spouse*.

I also request coverage for my eligible child(ren): Yes No

b) **For Members and Spouses Currently Insured**

I request to INCREASE amounts of insurance as follows:

From \$ _____ to \$ _____ for myself;

From \$ _____ to \$ _____ for my spouse*.

I also request coverage for my eligible child(ren): Yes No

* Spouse's coverage may not exceed member's coverage.

c) **Insurance Replacement**

Residents of New York: Please read the following BEFORE you apply for coverage under this Plan
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forfeited, assigned, terminated, changed or modified into paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

Residents of New York: I have read the Important Replacement Information above. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: Yes No Spouse: Yes No

Residents of Other States: Is the insurance applied for intended to replace, discontinue or change an existing policy?

Member: Yes No Spouse: Yes No

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

ALL Residents: Do you have other life insurance in force? If "yes", total amount in all companies:

Member: \$ _____ Spouse: \$ _____

Do you have other insurance applications pending? If "yes" indicate: Amount: \$ _____ and Company: _____

d) **Payment Information** (Select One of the Two Options Below)

1. Please send me a bill: Quarterly Semiannually Annually

2. Please withdraw premiums from my checking or savings account. (Be sure to complete and return the *Automatic Payment Option* form provided.) Monthly Quarterly Semiannually Annually

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Beneficiary Name: Last First Middle Initial Relationship Social Security #

Beneficiary Address: Street City State Zip Code

6. STATEMENT OF HEALTH: (Please initial any changes you make on this form.) Answer the following questions as they apply to you and all dependents to be insured.

- | | YES | NO |
|--|--------------------------|--------------------------|
| 1. Are you or any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver or premium for life or health insurance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any person to be insured now ill, or receiving medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past five years, has any person to be insured consulted any physician or 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 | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person to be insured now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having been treated for: | | |

- | | YES | NO | | YES | NO |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| a) Heart or circulatory trouble, high blood pressure, pain or pressure in chest?..... | <input type="checkbox"/> | <input type="checkbox"/> | k) Thyroid, liver or respiratory disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b) Arthritis, back trouble, bone or joint disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> | l) Alcoholism or drug habit?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c) Fainting spells, convulsions or epilepsy?..... | <input type="checkbox"/> | <input type="checkbox"/> | m) Disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d) Sugar, blood, albumin or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> | n) Other health or physical impairment including: | | |
| e) Diabetes, kidney trouble, ulcers or digestive disorder? | <input type="checkbox"/> | <input type="checkbox"/> | i. Being medically diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f) Disorder of breasts or reproductive organs or functions? | <input type="checkbox"/> | <input type="checkbox"/> | ii. Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| g) Nervous or mental disorder, emotional condition or psychiatric care? | <input type="checkbox"/> | <input type="checkbox"/> | iii. Any other impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| h) Cancer, tumor or cyst?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| i) Varicose veins, hemorrhoids or hernia? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| j) Disorder of eyes, ears, nose or sinuses?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |

If you have answered any Questions “Yes” give complete details below. (Attach a separate sheet, if necessary, then sign and date it).

Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

7. DECLARATIONS

I request the group insurance shown above. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that insurance will become effective on the date approved by New York Life if the initial contribution has been paid and I and any approved dependents are alive on the approval date. I understand that: (a) dependent insurance will not take effect unless my insurance is in effect on a paying basis; and (b) any dependent confined at home, in a hospital or other medical institution or incapacitated so as to be unable to perform his/her normal daily activities as required will not become insured until the day he/she is no longer so confined/incapacitated, provided I am then insured and the dependent is still eligible. I understand that any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan.

Fraud Warning Statements

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 is a crime and subjects such person to criminal and civil penalties

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. **For 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. **For residents of DC, the following also applies:** An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **Residents of LA:** 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 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.

AUTHORIZATION: I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. ■ I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratories, insurance company or the MIB to release information maintained by physicians, pharmacy benefit managers, and other sources to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. ■ New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). ■ This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. My 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

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

To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Spouse's Signature X _____
(Necessary only if spouse coverage is requested) DATE

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