Group Life Insurance

Exclusive Coverage for Attorneys

APPLY ON THE FLY™ APPLICATION

Thank you for applying for coverage! Please print in black or blue non-erasable ink. If you should make a mistake, simply write the correct information and initial all changes. ***Most importantly***, please be sure to let us know if you have any questions while completing your application.
THANK YOU!

Request for Group Insurance from
New York Life Insurance Company,
New York, NY 10010
Policyholder: Attorneys Group Insurance Trust

ATTORNEY INFORMATION

Name_____ Social Security Number_____

Address_____ City_____ State_____ Zip_____

Phone (Day)_____ (Home)_____ Email_____

☐ Male ☐ Female Date of Birth____/____/_____ Height:_____ ft. _____ in. Weight_____lbs.

Occupation _____

SPOUSE INFORMATION if applying for an increase in coverage

Name_____ Social Security Number_____

☐ Male ☐ Female Date of Birth____/____/_____ Height: ____ ft. _____ in. Weight_____lbs.

Occupation _____

Do you (and/or your spouse, if applying for more coverage) intend to reside outside the U.S. or Canada in the next 12 months?

Attorney: ☐ No ☐ Yes If yes, how long?_____ Country_____

Spouse: ☐ No ☐ Yes If yes, how long?_____ Country_____

Have you or your spouse (if applying for more coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? Attorney: ☐ No ☐ Yes Spouse: ☐ No ☐ Yes

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

Attorney: (MM/YY)____/____ Product_____

Spouse: (MM/YY)____/____ Product_____

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

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

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☐ New ☐ Additional

Attorney: Current Benefit $_____ Total Benefit Desired $_____

Spouse: Current Benefit $_____ Total Benefit Desired $_____

(Spouse coverage cannot exceed Attorney's)

Is the insurance applied for intended to replace, discontinue, or change an existing policy? Attorney: ☐ No ☐ Yes Spouse: ☐ No ☐ Yes

Do you have other life insurance in force? ☐ No ☐ Yes

If "yes," total amount in all companies: Attorney $_____ Spouse $_____

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

Attorney $_____ Company_____

Spouse $_____ Company_____

We have made special arrangements for a private consultation with New York Life's Service Provider to talk with you about your medical history ... at your convenience. A member of the Service Provider will be in touch with you soon!

BENEFICIARY DESIGNATION I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. If naming more than one beneficiary, please note if each is to be primary and/or secondary, and the percentage of your life insurance benefit to be distributed to each. If naming a trust, please indicate the full name and date of the trust.

ATTORNEY Beneficiary Name:_____

Last | First | Middle Initial | Relationship to You | Social Security #

SPOUSE Beneficiary Name:_____

Last | First | Middle Initial | Relationship to You | Social Security #

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically-related facility, laboratory, insurance company, MIB, 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 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 my ('our', if spouse is also applying) protected health information to MIB, LLC.; and attest to having read the IMPORTANT NOTICE and Fraud Notices included herein, including how my ('our', if spouse is also applying) information is exchanged with MIB, and that to the best of my ('our', if spouse if also applying) knowledge and belief, the answers provided to the questions are true and complete.

ATTORNEY'S SIGNATURE **X:**_____ DATE:_____

SPOUSE'S SIGNATURE **X:**_____ DATE:_____

(necessary only if Spouse is applying for an increase in coverage)

FRAUD NOTICES For Residents of all states except those listed below and 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. **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 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 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 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.

Thank you for taking the time to complete your application!

For your convenience, we've included a postage-paid envelope for you to use when returning your application. Send us your application today. We'll be in touch with you shortly!

Please mail your application in the enclosed envelope to:
Attorneys Group Insurance Plans, P.O. Box 3930, Peoria Heights, IL 61612-3930

Please call us with ANY questions.

(800) 323-4487

9AM to 5PM Central Time, every business day.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For Group Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, 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 applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for 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, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901. Information for consumers about MIB may be obtained on its website 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 person or prospective insured person.*

*[2]**CONFIDENTIAL ABUSE INFORMATION** means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company 7/15 ed.