To Apply: Complete this application and return to USI Affinity, 100 Matawan Road, 2nd Floor, Matawan, NJ 07747.

No premium payment is needed now. If approved for coverage, you will be billed at the premium contribution level (Preferred, Select, Standard) determined by medical underwriting of your application. We will notify you of your effective date and premium contribution level with your billing notice. iIf you have any questions, call USI Affinity at 800-727-2525.

10–YEAR LEVEL GROUP TERM LIFE INSURANCE APPLICATION

For New York State Bar Association Members, Spouses/Domestic Partners and Children

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

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes. WB08

1. MEMBER INFORMATION

Full Name ______________________________
First Middle Initial Last

Address ______________________________

____

City ______________________________

State ________________ ZIP ____________

Is address shown at left: ❑ Home ❑ Office

Send correspondence to: ❑ Home ❑ Office

Social Security # ______________________________

Home Phone (   ) ______________________________

Work Phone (   ) ______________________________

Fax ______________________________

Email Address ______________________________

Marital Status: ❑ Married/Date of Marriage ________________ ❑ Divorced ❑ Single ❑ Widowed

Are you presently insured under any other NYSBA Life Plans? ❑ Yes ❑ No

If yes, provide details (person insured and amount of insurance): ❑ Group Term Life ❑ 20-Year Level Group Term Life

____

____

Does any person proposed for insurance intend to reside outside the U.S. or Canada in the next 12 months?

Member: ❑ Yes, Country(ies) ________________ ❑ No If "yes", for how long? ________________

Spouse/ Domestic Partner: ❑ Yes, Country(ies) ________________ ❑ No If "yes", for how long? ________________

	Date of Birth			Height	Weight	Sex
	Mo.	Day	Yr.	ft./in.	lbs.	
Member:						❑ M ❑ F
Spouse/Domestic Partner*: Full Name (First, Middle Initial, Last) if proposed for insurance						❑ M ❑ F
Child†: Full Name (First, Middle Initial, Last) if proposed for insurance						❑ M ❑ F
Child†: Full Name (First, Middle Initial, Last) if proposed for insurance						❑ M ❑ F

* Please submit the Declaration of Domestic Partnership form with your application. Call the Administrator for a copy of the form.

† If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. MEMBERSHIP AFFILIATION

Are you now a New York State Bar Association member? ❑ Yes ❑ No Membership # ______________________________
(Membership in the NYSBA is required for participation in this plan.)

3. PAYMENT OPTION SELECTION

❑ Annual ❑ Semiannual each December 1 and June 1

4. INSURANCE REQUESTED

Refer to product information for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING GROUP LEVEL TERM LIFE INSURANCE COVERAGE:

A. Total Member Amount Desired: ______________________

Total Spouse/Domestic Partner's Amount Desired*: ______________________

I also request coverage for my eligible children: ❑ $25,000 per child (Check if desired)

* Spouse/Domestic Partner coverage cannot exceed 100% of member's coverage.

B. **Tobacco/Nicotine Use**: Have you or your spouse/domestic partner (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?

Member: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

If "Yes," when did you last use tobacco or nicotine products? Member: Month _______ Year ______ Spouse/Domestic Partner: Month ______ Year ______

C. **Insurance Replacement:**

RESIDENTS OF NEW YORK: IMPORTANT REPLACEMENT INFORMATION

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or 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.

INSURANCE QUESTION: Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

RESIDENTS OF OTHER STATES: Is the Life Insurance applied for intended to replace, discontinue or change an existing insurance policy?

Member: ❑ Yes ❑ No Spouse/Domestic Partner: ❑ Yes ❑ No

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

Member: $ ______________________ Spouse/Domestic Partner: $ ______________________

Do you have other insurance applications pending? If "Yes" indicate amount and company:

Member: $ ______________________ Company ______________________

Spouse/Domestic Partner : $ ______________________ Company ______________________

5. BENEFICIARY DESIGNATION

The following beneficiary designation(s) is made for all member and spouse/domestic partner coverage under this 10-Year Level Group Term Life Insurance certificate. The member is automatically the beneficiary for any dependent child coverage, unless initial ownership is by other than the member, as provided in the Group Policy. 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. If naming a trust as a beneficiary, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name	Address	Social Security #	Relationship to Insured	Percent
Member Life:				
Spouse/Domestic Partner Life:				

6. STATEMENT OF HEALTH

Please initial any changes you make on this form.

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured. **Yes** **No**

a. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? ☐ ☐

b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ ☐

c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury? ☐ ☐

d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ ☐

e. Is any person to be insured now pregnant? ☐ ☐

f. During the past 5 years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

1. Heart or circulatory trouble, high blood pressure, pain or pressure in the chest? ☐ ☐
2. Arthritis, back trouble, bone or joint disorder? ☐ ☐
3. Fainting spells, convulsions or epilepsy? ☐ ☐
4. Sugar, blood, albumin or pus in urine? ☐ ☐
5. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ ☐
6. Disorder of breast or reproductive organs or functions? ☐ ☐
7. Nervous or mental disorder, emotional condition or psychiatric care? ☐ ☐
8. Cancer, tumor or cyst? ☐ ☐
9. Varicose veins, hemorrhoids or hernia? ☐ ☐
10. Disorder of eyes, ears, nose or sinuses? ☐ ☐
11. Thyroid, liver or respiratory disorder? ☐ ☐
12. Alcoholism or drug habit? ☐ ☐
13. Disorder of the blood? ☐ ☐
14. Other health or physical impairment including:
    - (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) ☐ ☐
    - (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue or undiagnosed symptoms, in the past 5 years? ☐ ☐
    - (iii) Any other impairment? ☐ ☐

g. Have you or your spouse/domestic partner (if proposed for insurance) had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? ☐ ☐

h. Within the past two years have you or your spouse/domestic partner participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping or organized motorcycle racing, or any type of organized motorized racing? ☐ ☐

i. Driver's License No.: Member ____________________ Spouse/Domestic Partner ____________________

State in which issued: Member ____________________ Spouse/Domestic Partner ____________________

Have you or your spouse/domestic partner (if proposed for insurance) had your driver's license suspended or revoked or had any moving violations within the last five years? ☐ ☐

j. **Except for residents of Connecticut,** in the past 7 years, have you or your spouse/domestic partner (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ☐ ☐

For residents of Connecticut only, in the past seven years, have you and/or your spouse/domestic partner been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? ☐ ☐

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" GIVE COMPLETE DETAILS ON PAGE 4.

6. STATEMENT OF HEALTH (continued)

If you have answered any questions "Yes," give complete details below. (If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Name of Proposed Insured	Illness or Condition — Date of Onset - Duration - Treatment - Operations - Degree of Recovery and Date	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals where confined or treated

I request the group insurance shown on this application. 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: (a) Insurance will become effective on the first day of the month following the date approved by New York Life if I and any approved dependents are performing the normal activities of a person in good health of like age on that date and the initial contribution is paid within 31 days after the date I am billed; (b) any person who is not performing such normal activities as required will not become insured until the date he/she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) at the Owner's option, a dividend, when payable, will be (i) applied toward payment of any premium due if the balance of such premium is paid, or (ii) paid in cash, if the Owner requests it in writing.

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).

FRAUD WARNING STATEMENT

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.

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 applicant.*

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 denial of insurance benefits.*

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 penalities.*

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, 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 MIB to release prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, 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. 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, 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.

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

Member's Signature X ______________________________ Date ______________
(Please sign and date in ink)

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

Spouse/Domestic Partner's Signature X ______________________________ Date ______________
(Necessary only if spouse/domestic partner coverage is requested)

Owner information – Required if owner is other than member.
(If owner is a trust, please submit a copy of the document with this application)

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

Mailing Address: ______________________________
Street City State Zip Code

Tax ID # ______________________________

Date of Birth ______________ Social Security Number ______________

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