

**TO APPLY:**  
 Complete this form and return to:  
 Administrator, AIChE Group Insurance  
 Program  
 PO BOX 10374  
 Des Moines, IA 50306  
**QUESTIONS?**  
 Call: 1 800 98-AIChE (982-4243)  
 Email: aiche@marshpm.com

# GROUP 10-YEAR LEVEL TERM LIFE APPLICATION

FOR MEMBERS OF THE AMERICAN INSTITUTE OF CHEMICAL ENGINEERS



The Company You Keep®

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.

## 1. Member Information:

FULL NAME: LAST \_\_\_\_\_ FIRST \_\_\_\_\_ MIDDLE INITIAL \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_

CITY \_\_\_\_\_

STATE (OR PROVINCE) \_\_\_\_\_ ZIP CODE \_\_\_\_\_

Social Security #:    -   -

**Phone Numbers:**

Home ( \_\_\_\_\_ ) \_\_\_\_\_

Work ( \_\_\_\_\_ ) \_\_\_\_\_

Fax ( \_\_\_\_\_ ) \_\_\_\_\_

Email Address \_\_\_\_\_

Marital Status:  Married/Date of Marriage: \_\_/\_\_/\_\_  Divorced  Single  Widowed

Are you presently insured under the AIChE Term Life Plan?  Yes  No

If yes, provide details (person insured and amount of insurance):

Member \$ \_\_\_\_\_  Spouse \$ \_\_\_\_\_

Child(ren) \$ \_\_\_\_\_

In the last two years, have you or your spouse (if proposed for insurance) traveled or resided outside the U.S. or Canada for more than six weeks per year or do you or your spouse intend to do so within the next 12 months? If yes, please provide the names of the person(s) and country(ies) involved: \_\_\_\_\_

	Date of Birth:	Height:	Weight:	Sex:
	MO. DAY YR.	ft. in.	LBS.	
Member: _____	____/____/____	____ft. ____in.	____	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse*: _____	____/____/____	____ft. ____in.	____	<input type="checkbox"/> M <input type="checkbox"/> F
<small>Name if Proposed for Insurance</small>				
Child(ren)*: _____	____/____/____	____ft. ____in.	____	<input type="checkbox"/> M <input type="checkbox"/> F
<small>Name if Proposed for Insurance</small>				
_____	____/____/____	____ft. ____in.	____	<input type="checkbox"/> M <input type="checkbox"/> F

\*See Plan Information for definition of eligible dependents. 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 member of AIChE?  Yes  No Membership # \_\_\_\_\_ Exp. Date \_\_\_\_\_

## 3. Payment Option Selection: Choose only one

**Automatic Payment:** I request and authorize the AIChE Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached  voided check  statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this 10-Year Level Term Life Plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X \_\_\_\_\_  
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED AGAINST THIS ACCOUNT DATE

**Periodic Billing:** Semi-Annually

**4. Insurance Requested:**

Refer to Plan Information for eligibility, options and coverage description.

**I HEREBY APPLY FOR THE FOLLOWING COVERAGE:**

**A. FOR MEMBERS NOT CURRENTLY INSURED UNDER THIS 10-YEAR LEVEL TERM LIFE PLAN:**

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 CURRENTLY INSURED UNDER THIS 10-YEAR LEVEL TERM LIFE PLAN:**

I wish to INCREASE amounts of insurance as follows: I wish to ADD dependent coverage as follows:  
from: \$\_\_\_\_\_ to: \$\_\_\_\_\_ for myself for my spouse,\* in the initial amount of \$\_\_\_\_\_  
from: \$\_\_\_\_\_ to: \$\_\_\_\_\_ for my spouse\* for my eligible dependent child(ren)  Yes  No

\* Spouse coverage cannot exceed 100% of member's coverage.

**C. TOBACCO/NICOTINE USE:** Have you and/or your spouse (if proposed for insurance) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 months?

Member:  Yes  No Spouse:  Yes  No

If yes, when did such person last use tobacco or nicotine products? Member: \_\_\_\_/\_\_\_\_ Spouse: \_\_\_\_/\_\_\_\_  
MONTH/YEAR MONTH/YEAR

**D. INSURANCE REPLACEMENT:**

RESIDENTS OF NEW YORK: *I have read the Important Replacement Information in the Plan Information. Is the Life 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

**ALL RESIDENTS: IF EITHER OF THE ABOVE ARE ANSWERED YES, PLEASE COMPLETE BELOW.**

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:

Member: \$\_\_\_\_\_ Company \_\_\_\_\_ Spouse: \$\_\_\_\_\_ Company \_\_\_\_\_

**5. Beneficiary Designation:**

Insert name, relationship and address.

I make the following beneficiary designation with respect to all the member insurance requested in this application for Group 10-Year Level Term 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—or owner of the coverage if other than the member—as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage or change the beneficiary for any existing AICHe 10-Year Level Term Life certificate, 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. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Member & Social Security No.

Street Address City State Zip Code



**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: (a) insurance will become effective on 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, and (b) 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.

**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 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 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 or 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 knowingly 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 this AUTHORIZATION, for New York Life's use in considering this request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for insurance will not be accepted unless this AUTHORIZATION is signed. I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information 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). 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 \_\_\_\_\_ **Date** \_\_\_\_\_  
(PLEASE SIGN AND DATE IN INK)

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

**Spouse's Signature** X \_\_\_\_\_ **Date** \_\_\_\_\_  
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) 8/04 ed.

**Owner Information is required if owner is other than member**  
(If the 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

COUNTRY OF RESIDENCE COUNTRY OF CITIZENSHIP TAX ID#

DATE OF BIRTH SOCIAL SECURITY NUMBER

**Owner's Signature** X \_\_\_\_\_ **Date** \_\_\_\_\_  
(NECESSARY ONLY IF OTHER THAN MEMBER)