GROUP LONG TERM DISABILITY INCOME INSURANCE APPLICATION

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave
New York, NY 10010

Plan Administrator:
Affinity Insurance Services, Inc.
159 East County Line Road
Hatboro, PA 19040-1218
(800) 98-AIChE (982-4243)

1. PLEASE COMPLETE THE INFORMATION BELOW AND RETURN TO THE PLAN ADMINISTRATOR

Group Policy G-29342-0 Certificate # ____________

Name ____

Address ______________________ City ______________ State _____ Zip ________

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed Maiden Name ________________

Age:______ Date of Birth:__________ Home Phone #:______________ Social Security #:______________

Height:______ft. _____in. Weight:________lbs. Gender: ☐ Male ☐ Female Work Phone #:______________

Fax #:______________ Email Address:______________________

Membership Affiliation: Are you now a member of the AIChE? ☐ Yes ☐ No

Membership #: ______________________ Expiration Date ______________
(Membership is required for participation in this plan)

Do you intend to reside outside the U.S. or Canada in the next 12 months? ☐ Yes ☐ No

If yes, Country?______________________ how long? ______________

2. PAYMENT OPTION SECTION: (Send no Money Now. We'll bill you later.)

OPTION 1: Electronic Funds Transfer ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Authorization for Electronic Funds Transfer

I request and authorize Affinity Insurance Services, Inc. (LifeHealth) to make withdrawals based on my selected payment method above 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 plan. **In order to process your electronic payment, both the Account # and Bank Routing # must both appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account, including any increases in premium due to age.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage at the end of the 31 day grace period, effective as of the Due Date if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

X ______________________________________ ______________________

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

OPTION 2: Direct Bill ☐ Quarterly ☐ Semi-Annual ☐ Annual

3. OCCUPATIONAL STATUS:

What is your occupation?______________ Main Duties______________________________

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 each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ☐ Yes ☐ No

Gross Annual Income from: Salary $ __________ Self Employment $__________ (Self Employment Start Date __________)

Bonus $ __________ Commissions $ __________ Total $__________

Your gross annual earned income must be at least $20,000 for you to be eligible for this coverage.

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4. I HEREBY APPLY FOR LONG TERM DISABILITY INSURANCE BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS REQUEST FORM (Refer to the website www.aicheinsurance.com for eligibility, options and coverage descriptions)

☐ New ☐ Additional NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage, instead, indicate the TOTAL amount of coverage you are requesting.

You may choose Monthly Benefit Option provided it and other disability income coverage you may have does not exceed the applicable percent shown below of your AVERAGE MONTHLY INCOME (as defined on the website www.aicheinsurance.com.) If you have been self-employed for less than one year, your monthly benefit is limited to $1,100, with a 90-day waiting period under the Five Year Plan (without the Catastrophic Disability Option).

I hereby apply for the coverage indicated below, based upon all my statements made in this Application:

a. Principal Monthly Benefit Option: $________________________________(not to exceed 60% of your AVERAGE MONTHLY INCOME)

b. Benefit period (choose one): ☐ Career Plan ☐ Five-Year Plan

c. Waiting period (choose one): ☐ 30-day* ☐ 60 day* ☐ 90 day ☐ 180-day ☐ 365-day*
*not available if Catastrophic Disability Option is elected

d. Catastrophic Disability Monthly Benefit Option: ☐ None $______________________
(not to exceed the lesser of: a) your Principal Monthly Benefit Option shown above; b) 40% of your AVERAGE MONTHLY INCOME; and c) together with any other Disability income insurance you may have – including your existing and requested Principal coverage under this Plan – 100% of your AVERAGE MONTHLY INCOME.)

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability:

☐ Yes ☐ No If "Yes," please list:

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, if approved, replace any of the above: ☐ Yes ☐ No

(If so, indicate which, and date it will be terminated)____

5. 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).

1. Are you now ill, or taking any prescribed medication or receiving or contemplating medical attention or surgical treatment? . . . . ☐ YES ☐ NO

2. During the past five years, have you ever been medically diagnosed by a physician or any other medical care practitioner as having been treated for:
   - a. Heart or circulatory trouble, elevated blood pressure, pain or pressure in chest? . . . . ☐ YES ☐ NO
   - b. Arthritis, back trouble/disorder, bone or joint disorder? . . . . ☐ YES ☐ NO
   - c. Fainting spells, convulsions, or epilepsy? . . . . ☐ YES ☐ NO
   - d. Sugar, blood, albumin or pus in urine? . . . . ☐ YES ☐ NO
   - e. Diabetes, ulcers or digestive disorder? . . . . ☐ YES ☐ NO
   - f. Gynecological or genitourinary disorders, disorder of breasts or reproductive organs or functions? . . . . ☐ YES ☐ NO
   - g. Nervous or mental disorder, emotional condition or psychiatric care or psychotherapeutic treatment? . . . . ☐ YES ☐ NO
   - h. Cancer, tumor or cyst? . . . . ☐ YES ☐ NO
   - i. Varicose veins, hemorrhoids or hernia? . . . . ☐ YES ☐ NO
   - j. Disorder of eyes, ears, nose or sinuses? . . . . ☐ YES ☐ NO
   - k. Thyroid, kidney, respiratory or liver disorder (including hepatitis)? . . . . ☐ YES ☐ NO
   - l. Blood disorder, enlarged lymph nodes or immunodeficiency disorder? . . . . ☐ YES ☐ NO
   - m. Unexplained weight loss or accidental injury? . . . . ☐ YES ☐ NO
   - n. Other health or physical impairment including:
     - (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Conditions (ARC)? . . . ☐ YES ☐ NO
     - (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past 5 years? . . . . ☐ YES ☐ NO
     - (iii) Any other impairment? . . . . ☐ YES ☐ NO

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3. During the past 5 years have you been counseled, treated or hospitalized for the use of Alcohol or Drugs? . . . . ☐ YES ☐ NO

4. Are you now pregnant? . . . . ☐ YES ☐ NO

5. Are you now disabled, or have you applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance? . . . . ☐ YES ☐ NO

6. Except for residents of Minnesota and Connecticut, in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending? . . . . ☐ YES ☐ NO

For residents of Minnesota and Connecticut only
In the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? . . . . ☐ YES ☐ NO

7. If you have answered "Yes" to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

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 Practitioners and Hospitals where confined or treated:

6. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY

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 below.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. 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 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member requests the insurance indicated; and consents to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and attest to having read the IMPORTANT NOTICE on the website and Fraud Notices indicated on the next page, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature______________________________ **Date** ______________

(Please sign in ink)

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BEFORE YOU MAIL THIS APPLICATION it will greatly speed action on your application if you will review it carefully. Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strikeouts, these must be initialed by the member.

Please see next page for Fraud Notices before signing this application.

IMPORTANT FRAUD NOTICE

Please read before signing the application

FRAUD NOTICE: for residents of All States except those listed below: 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 AR/LA/MD/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.

FOR RESIDENTS OF DC: 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 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 penalties.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 may include imprisonment, fines or 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.

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Please see next page for compensation disclosure information.

Please complete the application form and return it to:*

AIChE Insurance Program Administrator
159 East County Line Road
Hatboro, PA 19040-9635

Don't let an unanswered question delay your enrollment.

Call toll free: 1-800-98-AIChE (982-4243)
www.aicheinsurance.com

*Residents of Puerto Rico: please send your completed application to Global Insurance Agency, Inc., P.O. Box 9023919, San Juan, PR 00902-3918

COMPENSATION and OTHER DISCLOSURE INFORMATION

Life & Health, a division of Affinity Insurance Services, Inc., exclusively offers the Group Long Term Disability Insurance as an agent of The New York Life Insurance Company and provides services that may include the following: program marketing, underwriting, policy management, billing, risk management and client services on its behalf.

As compensation for the services described above, Affinity receives 25% of your paid premium. In addition, Affinity may charge a fee for administrative services. For mid-term premium bearing coverage endorsements and renewal policies, Affinity is compensated at the same levels as the initial policy commission, unless we notify you otherwise. Your signature on your application, quote form, check, and/or other authorization for payment of your premium, will be deemed to signify your consent to and acceptance of the terms and conditions including the compensation, as disclosed above, that is to be received by Aon.

Other than the commissions described in the preceding paragraph, Affinity will receive no other compensation from the insurer.

In addition, premiums paid by Clients to Affinity for remittance to insurers, Client refunds and claim payments paid to Affinity by insurance companies for remittance to Clients are deposited into fiduciary accounts in accordance with applicable insurance laws until they are due to be paid to the insurance company or Client. Subject to such laws and the applicable insurance company's consent, where required, Affinity will retain the interest or investment income earned while such funds are on deposit in such accounts.

Aon Corporation, our ultimate parent company, and its affiliates have from time to time sponsored and invested in insurance and reinsurance companies. While we generally undertake such activities with a view to creating an orderly flow of capacity for our clients, we also seek an appropriate return on our investment. These investments, for which Aon is generally at-risk for potential price loss, typically are small and range from fixed-income to common stock transactions. In such case, the gains or losses we make through our investments could potentially be linked, in part, to the results of treaties or policies transacted with you. Please visit the Aon website at **http://www.aon.com/market_relationships** for a current listing of insurance and reinsurance carriers in which Aon Corporation and its affiliates hold any ownership interests.

Contracts and Agreements

Aon Corporation's operating affiliates are parties to numerous agreements with many insurance and reinsurance companies, including companies from which our clients have purchased insurance or reinsurance. Please visit **http://www.aon.com/market_relationships** for more detail on these agreements.

The AIChE Insurance Program is brokered and administered by Aon Affinity, a division of Affinity Insurance Services, Inc.; in CA, MN & OK, a division of AIS Affinity Insurance Agency, Inc.; and in NY a division of AIS Affinity Insurance Agency. CA License #0795465. AR License #244489.

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