

AIChE®

GROUP TERM LIFE INSURANCE APPLICATION FORM



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)

Complete this form and return to the Plan Administrator

Group Policy No. G-11082-0 Certificate No. _____

1. MEMBER INFORMATION

Name _____ Home Phone # _____ Height _____ ft. _____ in.
 Address _____ Work Phone # _____ Weight _____ lbs.
 City _____ State _____ Zip _____ Fax # _____ Sex M F
 Home E-mail address _____ Soc. Sec. # _____ Date of Birth _____

Marital Status Married Divorced Single Widowed Civil Union* Maiden Name _____
 Domestic Partner*(Submit a completed Declaration of Domestic Partnership Form – Not Applicable in Oregon) *Eligibility is determined by State Law

I am a Member of AIChE: Membership # _____ Expiration Date _____
 (Membership is required for participation in this plan)

Date you Became a Member _____ Annual Earned Income \$ _____

Are you presently insured by any AIChE plan? Yes No

If yes, indicate which plan(s) Term Life 10 Year Level Term Life 20 Year Level Term Life
 and provide details (person(s) insured and amount) _____

Do you intend to reside outside the U.S. or Canada in the next 12 months?
 Member Yes No Spouse Yes No If yes, how long? _____ Country _____

2. BILLING OPTION SELECTION

OPTION 1: Electronic Funds Transfer

Monthly Quarterly (Feb., May, Aug., Nov.) Semi-Annual (May, Nov.) Annual (Nov.)

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 or 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 (Feb., May, Aug., Nov.) Semi-Annual (May, Nov.) Annual (Nov.)

3. DEPENDENT INFORMATION

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under 25).
 Attach separate sheet to provide additional dependent information.

Dependent Full Name (ie. Mary J. Doe)	Social Security #	Date of Birth (mo/day/yr)	Height (Ft., In.)	Weight (Lbs.)	Male or Female
Spouse's Full Name					
Child					
Child					
Child					

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4. INSURANCE REQUESTED

(Refer to the website www.aicheinsurance.com or your certificate for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Change

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.

Group Life Insurance:

a) Total Member Amount Desired: (from \$100,000 to \$1,000,000 in units of \$10,000) \$ _____

b) Total Spouse Amount Desired: (from \$100,000 to \$1,000,000 in units of \$10,000) \$ _____

NOTE: Spouse coverage cannot exceed member coverage

c) Total Child Amount Desired: \$10,000 each insured child

d) Tobacco/Nicotine Use: Have you or your spouse (if applying for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? Member: Yes No Spouse: Yes No

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

Member _____ Mo/Yr _____ Product _____ Spouse _____ Mo/Yr _____ Product _____

e) Insurance Replacement Information

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.

INSURANCE QUESTION: RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. 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 insurance or annuity?

Member Yes No Spouse Yes No

ALL RESIDENTS: Do you have other life insurance in force? If "Yes", please indicate the total amount due, with all companies. Member \$ _____ Co. _____ Spouse \$ _____ Co. _____

Do you have other insurance applications pending? If "Yes" indicate amount and company: Member \$ _____ Co. _____ Spouse \$ _____ Co. _____

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.

Primary Secondary

Beneficiary:	Last	First	Middle Initial	Relationship	Social Security #
Beneficiary Address:	Street	City	State	Zip Code	% of Benefits

Primary Secondary

Beneficiary:	Last	First	Middle Initial	Relationship	Social Security #
Beneficiary Address:	Street	City	State	Zip Code	% of Benefits

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If necessary, attached separate signed and dated sheet to provide additional beneficiary information

6. STATEMENT OF HEALTH

(Please initial any changes you make on this form.)

To the best of your knowledge or belief, answer the following questions as they apply to you and all dependents to be insured.

- | | Yes | No | | | Yes | No |
|--|--------------------------|--------------------------|--|---|--------------------------|--------------------------|
| 1. 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? | <input type="checkbox"/> | <input type="checkbox"/> | | c. Fainting spells, convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | d. Sugar, blood, albumin or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past 5 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? | <input type="checkbox"/> | <input type="checkbox"/> | | e. Diabetes, kidney trouble, ulcers or digestive disorder? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. 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? | <input type="checkbox"/> | <input type="checkbox"/> | | f. Disorder of breast or reproductive organs or functions? ... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person to be insured now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | | g. Nervous or mental disorder, emotional condition or psychiatric care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past 5 years has any person to be insured ever been medically diagnosed as having or been treated for: | | | | h. Cancer, tumor or cyst? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? | <input type="checkbox"/> | <input type="checkbox"/> | | i. Varicose veins, hemorrhoids or hernia? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arthritis, back trouble, bone or joint disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | j. Disorder of eyes, ears, nose or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | k. Thyroid, liver or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | l. Alcoholism or drug habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | m. Disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | n. Other health or physical impairment including: | | |
| | | | | (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | (iii) Any other impairment? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered "Yes" to any of the above Questions, 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:

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 the member and any person proposed for insurance **consent** 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 below 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 Signature X _____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

Spouse Signature X _____ **Date** _____
(Necessary only if Spouse Coverage is requested)

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IMPORTANT FRAUD NOTICE

Please read before signing the application

FRAUD NOTICE: 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 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 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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GMA-PR1

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 compensation disclosure information.

Please complete the application form and return 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 Term Life 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 16% 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.