AIChE MEMBER INSURANCE SOLUTIONS
Plan for What Matters Most

Group Insurance Application Form

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

Complete this form and return to the AIChE Insurance Program Plan Administrator:
Affinity Insurance Services, Inc.
159 East County Line Road
Hatboro, PA 19040-1218

MEMBER INFORMATION

Please print in ink or type all answers – initial and date any changes you make

MEMBER'S FULL NAME			**GROUP POLICY**: G-29343-0 (AD&D) G-11082-0 (TL) G-29138-0 (10YT) G-29251-0 (20YT) G-29342-0 (DI)	CERTIFICATE #	
ADDRESS			SOCIAL SECURITY NO.		
CITY	STATE	ZIP CODE	DATE OF BIRTH MM / DD / YYYY	❒ MALE ❒ FEMALE	HEIGHT FT. IN. / WEIGHT LBS.
HOME PHONE #	WORK PHONE #		FAX #		
E-MAIL ADDRESS			CELL PHONE #		

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Maiden Name_____
☐ Civil Union* ☐ Domestic Partnership *Eligibility determined by State Law)

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No If yes, Country _____ How Long?_____

MEMBERSHIP AFFILIATION (Membership is required to participate in this plan)

Are you a member in good standing of the American Institute of Chemical Engineers (AIChE)? ☐ Yes ☐ No

Are you presently insured by any AIChE plan? ☐ Yes ☐ No If yes, indicate which plan(s) and provide details (person(s) insured and amount)_____

_____

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

lawful Spouse and unmarried, dependent children less than age 25 *If necessary attach a separate signed and dated sheet to provide additional dependent information*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	❒ MALE ❒ FEMALE	HEIGHT ft. in.	WEIGHT lbs.

Child (Name)	Date of Birth	❒ MALE ❒ FEMALE	Child (Name)	Date of Birth	❒ MALE ❒ FEMALE
1.	/ /		3.	/ /	
Child (Name)	Date of Birth	❒ MALE ❒ FEMALE	Child (Name)	Date of Birth	❒ MALE ❒ FEMALE
2.	/ /		4.	/ /	

BILLING OPTION SELECTION

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 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.

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

Please attach voided check or savings account deposit slip

OPTION 2 - Periodic Billing: ☐ Quarterly ☐ Semi-Annual ☐ Annual

Application continued – see following page

I HEREBY APPLY FOR THE COVERAGE(S) CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:

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

NOTE (1): If you are increasing or altering present coverage in any way, only indicate the additional amount of coverage you are applying for. Exclude the amount you may already have under the plan.

NOTE (2): The maximum amount available to any one person under all life insurance plans combined may not exceed $2,000,000. Children may only be covered under one plan.

☐ Term Life Insurance

The amount of coverage available to member/spouse is per unit, determined by AGE and will decrease as you grow older.

Members/Spouses coverage amounts available are:

Under Age 60 - up to $1,000,000 in units of $10,000

Age 60 but under age 65 – up to $750,000 in units of $7,500

Age 65 but under age 70 – up to $375,000 in units of $3,750

Member Amount Desired…… $ _____

Spouse Amount Desired (spouse coverage amount may not exceed member amount)…….. $ _____

Child(ren) Unmarried dependent children, 14 days but under age 25 (check box if applying)…… ☐ $10,000 each

☐ 10-Year Level Term Life Insurance

Member/Spouse under age 65 coverage amounts available are from $100,000 to $2,000,000 in $10,000 increments

Member Amount Desired…… $ _____

Spouse Amount Desired (spouse coverage amount may not exceed member amount)…….. $ _____

Child(ren) Unmarried dependent children, 14 days but under age 25 (check box if applying)…… ☐ $10,000 each

☐ 20-Year Level Group Term Life Insurance

Member/Spouse under age 55 coverage amounts available are from $100,000 to $2,000,000 in $10,000 increments

Member Amount Desired…… $ _____

Spouse Amount Desired (spouse coverage amount may not exceed member amount)…….. $ _____

Child(ren) Unmarried dependent children, 14 days but under age 25 (check box if applying)…… ☐ $10,000 each

☐ Disability Income Insurance

Member under age 65 may select a Monthly Benefit Option, provided it and other disability income coverage you have does not exceed 60% of your AVERAGE MONTHLY INCOME (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).

a. **Member** Principal Monthly Benefit ($110 to $7,700 in $110 Units) …… $ _____

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

c. Waiting Period (WP)…… ☐ 30-day ☐ 60-day ☐ 90-day ☐ 180-day ☐ 365-day

d. Catastrophic Disability Monthly Benefit (in $110 units – ONLY available with 90 & 180 day Waiting Period) ☐ None $ _____
[not to exceed the lesser of: a) Principal Monthly Benefit shown above; b) 40% of your AVERAGE MONTHLY INCOME; and c) together with any other Disability income insurance you may have (including existing and requested Principal coverage under this Plan) 100% of your AVERAGE MONTHLY INCOME.]

e. Do you have in force or are you applying for any other disability income insurance? ☐ Yes ☐ No
If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above? ☐ Yes ☐ No If yes, indicate which, and date it will be terminated_____

☐ Accidental Death & Dismemberment Insurance

Member under age 70 may select coverage amounts from $50,000 to $500,000 in $50,000 increments. Dependent Coverage is a percentage of Member's principal sum.

Select Desired Plan**:** ☐ Member Only Plan ☐ Family Plan **Member** Principal Sum Desired: $ _____

Application continued – see following page

OCCUPATIONAL STATUS Must be completed if applying for Disability Insurance

What is your occupation?_____ Main Duties_____

FULL-TIME WORK means actively performing the regular deities of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ☐ Yes ☐ No

Gross Annual Income from: Salary $ _____ Bonus $ _____ Commissions $ _____

Self Employment $_____ (Self Employment Start Date _____) **Total** $_____

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

LIFE INSURANCE QUESTIONS Must Be Completed if applying for Life Insurance

Do you have other life insurance in force? ..... **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

If "Yes," total amount in all companies: Member: $_____ Spouse: $_____

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

Member: ☐ Yes ☐ No Amount $_____ Company_____

Spouse: ☐ Yes ☐ No Amount $_____ Company_____

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance

Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? ..... **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

Residents of New York: I have read the Important Replacement Information below. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? …… **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK 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.

BENEFICIARY DESIGNATION (necessary if applying for Life or Accidental Death & Dismemberment Insurance)

(*If necessary, attach separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect total insurance on my life under the Group Term Life and/or AD&D Insurance Plan(s)and if I am already covered I hereby revoke any prior beneficiary designation. For Group 10-Year and 20-Year Level Term Life Insurance, the designation below only applies to the insurance issued as a result of this application. 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, or change the beneficiary for insurance under any other 10- or 20-Year Term Life Insurance Certificate, contact the AIChE Plan Administrator at the number provided).*

NOTE: 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, please indicate the full name and date of the trust.

☐ Primary ☐ Secondary Percent of Proceeds _____%

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

☐ Primary ☐ Secondary Percent of Proceeds _____%

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

Application continued – see following page

MEDICAL HISTORY Please indicate the best contact number for a Service Provider to contact you and/or your spouse, if applying, on behalf of New York Life Insurance Company for Medical History. (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls)			
Member	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile	**Spouse**	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile

I request the group insurance shown on page 2 of 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 on any supplemental forms, 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 the first of the month on or following the date approved by New York Life if I am alive on that date and the initial contribution is paid within 31 days after the date I am billed and (b) I and any approved dependents must be actively performing the activities of a person in good health of like age and sex on the date coverage is effective. I also understand that I must be actively working 30 or more hours per week on the date Disability Income Insurance is effective. *(Residents of NC: Any reference to "performing normal activities" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application)*.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company or MIB, Inc. ("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, 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.

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, including making a brief report of my/our protected health information to MIB; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated on the attached; including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature_____ Date_____

Spouse's Signature _____ Date_____
(Necessary only if Spouse coverage is requested)

Application continued – see following page

BEFORE YOU MAIL THIS APPLICATION it will greatly speed action on your application if you review it carefully.
Have all questions been answered? Have you provided contact information for the Service Provider to contact you for Medical History?
Any corrections or strikeouts must be initialed by the member.

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

Fraud Notices

Please read before signing the application form

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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 ALAR/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: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR 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 and 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 NY (applicable to AD&D and Disability Insurance only)**:** 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 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.

Please see next page for compensation disclosure information

Please complete the application form and return it to:*

AIChE Insurance Program Administrator
Affinity Insurance Services Inc.
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

Affinity Insurance Services Inc. is an insurance producer licensed in your state. Insurance producers are authorized by their license to confer with insurance purchasers about the benefits, terms and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction involves one or more of these activities. Compensation will be paid to the producer, based on the insurance contract the producer sells. Depending on the insurer(s) and insurance contract(s) the purchaser selects, compensation will be paid by the insurer(s) selling the insurance contract or by another third party. Such compensation may vary depending on a number of factors, including the insurance contract(s) and the insurer(s) the purchaser selects. In addition, Affinity may charge a fee for administrative services. 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. The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by contacting member services at (800) 982-4243.

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.

In placing, renewing, consulting on or servicing your insurance coverages Affinity and its affiliates may participate in contingent commission arrangements with insurance companies that provide for additional contingent compensation, if, for example, certain underwriting, profitability, volume or retention goals are achieved. Such goals are typically based on the total amount of certain insurance coverages placed by Aon with the insurance company or the overall performance of the policies placed with that insurance company, not on an individual policy basis. As a result, Aon may be considered to have an incentive to place your insurance coverages with a particular insurance company.

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 your 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 Corporate and its affiliates hold any ownership interest.

The AIChE Insurance Program is brokered and administered by Aon Affinity, a division of Affinity Insurance Services, Inc.(AR 244489); in CA, MN & OK, AIS Affinity Insurance Agency, Inc. (CA 0795465); in CA, Aon Affinity Insurance Services, Inc. (0G94493), Aon Direct Insurance Administrators and Berkely Insurance Agency and in NY and NH, AIS Affinity Insurance Agency.

CA Insurance License # 0795465

IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request for AIChE endorsed Group 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 a 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, of the 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 life and health 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 7.15ed