# Alumni Group Term Life and Common Carrier Accident Insurance

## Underwritten by New York Life Insurance Company

### Up to $1 million in Alumni Group Term Life Insurance available

### Up to $1 million of common carrier coverage

### Volume Discounts for coverage amounts over $100,000 ... the more life insurance you buy, the more you save!

### Important Program Feature

**Common Carrier Coverage Benefit for Alumni and Spouses**

When you are insured in the Alumni Group Term Life Insurance you are also covered for accidental death or injuries on a "Common Carrier."

The Coverage Amount provided is equal to 3 times the amount of your Group Term Life Coverage, up to a maximum of $1,000,000.

The Benefits Payments listed below are payable if you have a loss within 365 days of a covered accident which occurs while traveling as a passenger on a licensed common carrier (an airplane, train, bus, taxi, etc.).

| Loss of ... | Benefit Payment (Percentage of Coverage Amount) |
|---|---|
| Life | 100% |
| Both Hands or Both Feet | 100% |
| Entire Sight of Both Eyes | 100% |
| Either Hand or Foot | 50% |
| Entire Sight of One Eye | 50% |
| Speech | 50% |
| Hearing in Both Ears | 50% |
| Thumb and Index Finger of Same Hand | 25% |

The loss must be the result of an injury incurred while coverage is in force.

Loss of hand or foot means severance at or above the wrist or ankle joint. Loss of thumb and index finger means severance at the base of the thumb and finger.

Loss of sight, speech, or hearing means its total and irreversible loss. The total benefit payable for all losses due to the same accident will not exceed the full coverage amount.

Should two or more insureds under this Group Policy be injured on the same aircraft as a result of the same accident the total benefits payable will not exceed $10,000,000.

### You can apply for your choice of up to $1 million of coverage in $50,000 units.

**Life Insurance Helps Provide Security For Families**

The last thing you want your family worrying about is where to turn for financial security in the event of your death. Alumni Group Term Life and Common Carrier Accident Insurance can provide way to help maintain your family's standard of living.

**Who is Eligible?**

All alumni and their spouses, under age 65 and a resident of the United States (except FL, NC, NY, OR, SD, VT and WA), may request coverage for themselves and their lawful spouses and domestic partners. Unmarried dependent children ages 14 days to 6 months are eligible for $1,000 of coverage, and dependent children ages 6 months to 23 years are eligible for $10,000 of coverage.

Note: if both parents are applying for coverage only one may request children coverage.

**You Select Your Beneficiary**

You may name anyone as your beneficiary. And changing your beneficiary is quick and easy. Just give the Alumni Insurance Administrator a call to request a beneficiary change form.

**You Can't Be Singled Out for Cancellation Due to a Change in Your Health**

Once you're insured under this program, New York Life guarantees that your coverage can never be cancelled just because of a change in your health – See "When Coverage Ends" for renewal terms.

**When Coverage Begins**

Insurance will take effect on the first of the month on or after approval of your application by New York Life Insurance Company, provided the initial contribution is paid within 31 days after the date you are billed (send no money now) and any person to be insured is performing the normal activities of a person in good health of like age on the date of approval.

Any person who is not performing his/her normal daily activities as required will not become insured until the day 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.

**Volume Discount**
With Volume Discount Rates for coverage amounts over $100,000, the more life insurance coverage you purchase, the more you save! An additional discount is available for amounts of $500,000 and more.

**Coverage Amounts at Ages 65 and Over**
Coverage Amounts for insured alumni and spouses reduce 50% at their attainment of age 65 and an additional 50% at their attainment age of 70.

**When Coverage Ends**
Coverage for an insured alumni or spouse may be continued until age 80 so long as he/she continues to pay premium contributions when due; he/she doesn't request to end such coverage; and the group program is not terminated or modified by the policyholder or New York Life Insurance Company to end insurance for the group of insureds to which he/she belongs. Insurance will not terminate if you change employment or retire. Dependent coverage ends when the alumni's coverage ends.

Please note that AD&D coverage will end on the day before the day the insured begins active duty in the armed forces.

Coverage for children may be continued to age 23 as long as alumnus/a or spouse coverage is in force, premiums are paid and they remain otherwise eligible.

**Incontestability**
The validity of any amount of your insurance which has been in force for two years during the insured's lifetime will not be contested, except for insurance eligibility provisions or non-payment of premium contributions.

**Accelerated Death Benefit**
This benefit is available to help terminally ill insureds during a difficult and often financially challenging time. Under this provision, the insured may request one advance payment equal to 50% of his or her (or an insured child's) in-force life insurance, to be paid while he or she is still alive. If the scheduled reduction will occur within one year of the date payment will be made, the payment will be 50% of the reduced coverage amount. (Your premiums will continue to be payable in full and the amount of insurance payable after the insured's death will be reduced by any payment made under this benefit.)

This money can be used to help cover high prescription drug costs ... medical bills ... outstanding debts ... to help pay for experimental treatments ... the cost of modifications to your home.

To qualify, a terminally ill insured must be under age 79 and provide the insurance company with proof of terminal illness no later than 12 month's before the insured person's termination age and anticipated life expectancy (12 months or less), as well as any other medically necessary information requested. For additional details and limitations, please see the Certificate of Insurance.

Please note that the receipt of accelerated death benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult the appropriate social services agency and seek the advice of tax counsel.

**Conversion Privilege**
Can allow you to convert your term coverage to an individual New York Life Policy without taking a medical exam, under certain circumstances of involuntary termination as described in the Certificate of Insurance. See Certificate of Insurance for full details.

**Exclusions & Limitations**

- **Term Life**
  Coverage is provided for death from any cause, except death from suicide, for the first two years coverage is in effect, whether sane or insane.
- **Common Carrier Accidental Death & Dismemberment (AD&D) Coverage**
  No benefits are payable for loss due to: Suicide or intentionally self-inflicted injury, whether sane or insane; war or act of war, whether declared or undeclared; service in the armed forces: injury sustained while riding on any aircraft (except while riding as a passenger on a civil or public aircraft or military transport aircraft); or loss resulting from sickness or disease, or medical or surgical treatment of a sickness or disease.

**How to Apply**
1. Complete, date and sign the enclosed application.
2. Determine the amount of coverage you wish to apply for and check the child coverage box if you wish to insure your dependent children. Children may be insured under either the Alumni or Spouse application but not both.
3. Return your application to:
   Alumni Insurance
   P.O. Box 14533
   Des Moines, IA 50306
   888-560 ALUM (2586)

**Send no money now ... you'll be billed later.**

Acceptance into this program is subject to medical evidence of insurability as determined by New York Life. Depending on your age, the amount of coverage you request, and your answers on the application, a medical examination, medical test(s), or other evidence of good health may be required. Any exams/tests requested by the company will be conducted at your convenience and at no expense to you.

## 30-DAY FREE LOOK

If you are not completely satisfied with the terms of your Certificate of Insurance, you may return it without claim within 30 days. Your coverage will be invalidated, and you will be sent a full refund, no-questions asked!

**Alumni Insurance Services of AMBA**

What qualities do you look for in your insurance representative? Chances are, you hope to find a company that is honest and professional and that will give you solid life insurance at a competitive price.

Your Alumni Association has found someone even better. The Alumni Insurance Services of AMBA has been in the business of insurance administration for over 50 years and is one of the largest administrators of alumni insurance programs in the country, serving over one million Alumni.

Your account information is right at the fingertips of each Alumni Insurance Services Customer Service Representative - individuals who will be providing you with quick and accurate answers to all of your questions.

## **Current** 2026-2027 Premiums
## Payable by Automatic Check Withdrawal
## Monthly Premiums for each $50,000 unit
## (Includes Alum/Spouse Common Carrier Accident Coverage)

| | Volume Discounted Rates | | | | | |
|---|---|---|---|---|---|---|
| | For Coverage of $100,000 or Less | | For Coverage of $101,000-$499,000 | | For Coverage of $500,000+ | |
| **Applicant's Age** | **Non-Smoker Rates** | **Smoker Rates** | **Non-Smoker Rates** | **Smoker Rates** | **Non-Smoker Rates** | **Smoker Rates** |
| Under 25 | $4.58 | $6.88 | $3.58 | $5.29 | $3.13 | $4.63 |
| 25–29 | 5.00 | 7.50 | 3.88 | 5.69 | 3.42 | 4.96 |
| 32–34 | 5.50 | 8.33 | 4.29 | 6.17 | 3.75 | 5.42 |
| 35–39 | 7.92 | 11.88 | 5.92 | 8.46 | 5.17 | 7.40 |
| 42–44 | 13.08 | 19.67 | 9.21 | 13.42 | 8.08 | 11.75 |
| 45–49 | 17.58 | 26.42 | 12.25 | 18.04 | 10.75 | 15.79 |
| 50–54 | 27.79 | 41.75 | 19.21 | 28.46 | 16.79 | 24.92 |
| 55–59 | 42.67 | 64.04 | 29.50 | 43.88 | 25.83 | 38.38 |
| 60–64* | 71.96 | 108.00 | 52.25 | 78.00 | 45.75 | 68.25 |

**Contact the Administrator for rates at ages 65-79. Coverage terminates at age 80.*

**Children's Coverage: $1.25 a month covers each child for a $10,000 benefit amount as explained in the "Who Is Eligible" section in this brochure.**

Premiums are payable semiannually or annually. If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To avoid the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

The premium contributions shown reflect the current rate and benefit structure. Premium rates are based upon the members/spouses' smoking status and attained age at issue. Rates increase on the renewal date coinciding with or next following our attainment of a new age class (e.g., 25, 30, 35, etc.). Premium contributions may be changed by New York Life Insurance Company on any premium due date (but not more than once in any 12-month period) and any date on which benefits are changed. However, your rates may be changed only if they are changed for all others in the same class of insureds under this group policy. For examples, a class of insureds is a group of people all with the same issue age and tobacco/nicotine usage. Premium contribution will vary with the amount of benefit. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Alumni Group Insurance Trust.

The amount of life insurance for you and your spouse decreases to $50,000 at age 65 and to $25,000 at age 70.

Coverage under this program is provided by New York Life Insurance Company under Group Policy No. G-29121-1 and G-29121-8 on Policy Form GMR issued to the Trustee of the Alumni Group Insurance Trust (ALGIT).

This information is only a brief description of the principal provisions and features of the program. The complete terms and conditions are set forth in the group policy issued by New York Life. When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the program.

ALGIT incurs costs in providing oversight of this program and your Alumni Association incurs administrative costs in connection with its sponsorship. To provide and maintain this valuable membership benefit both ALGIT and your Alumni Association may be reimbursed for these costs.

**Administered by:**

Association Member Benefits Advisors, LLC (AMBA)

Alumni Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

1-888-560-2586
www.alumniplans.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member
Benefits & Insurance Agency

**Underwritten by:**

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New York Life Insurance Company
51 Madison Ave.
New York, NY 10010
under Group Policy G-29121-1/8
on Policy Form GMR-FACE/G-29121-1/8

ALUMP-G29121
10/25 ed.

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# Application for the Group Term Life Insurance and Common Carrier Accidental Death & Dismemberment (AD&D) Plan

**To Apply:**
Complete this form and return to:
**ADMINISTRATOR**
GROUP INSURANCE PROGRAM
P.O. BOX 14533
Des Moines, IA 50306

**QUESTIONS?**
1-888-560-2586
customerservice.service@getamba.com

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

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

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**Alum:**

Association
Alumni Association: Boise State University Alumni Association

Sex: ❑ M ❑ F Height _____Ft. _____In. Weight _____Lbs.

Date of Birth: _____

Social Security Number: _____

Daytime Phone Number: _____

E-Mail Address: _____
AMBA will not share your email information

Fax Number: _____

**Spouse (Only if Applying):**

Spouse Name: _____

Sex: ❑ M ❑ F Height _____Ft. _____In. Weight _____Lbs.

Date of Birth: _____

Social Security Number: _____

Daytime Phone Number: _____

E-Mail Address: _____
AMBA will not share your email information

Fax Number: _____

**Marital Status:** ❑ Married ❑ Divorced ❑ Single Maiden Name_____
❑ Civil Union* ❑ Domestic Partner* **Eligibility determined by State Law.*

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Do you or your spouse (if applying for insurance) intend to reside outside the U.S. within the next 12 months?
Alum: ❑ Yes, Country(ies)_____ ❑ No If "Yes," for how long? _____
Spouse: ❑ Yes, Country(ies)_____ ❑ No If "Yes," for how long? _____

## Dependent Information

If dependent coverage is requested, list eligible dependent children (i.e. unmarried, dependent children from age 14 days to age 23)

| Full Name First | Last | Middle Initial | Date of Birth | Male/Female |
|---|---|---|---|---|
| Child | | | | |
| Child | | | | |
| Child | | | | |

(If more than 3 children, please list on a separate sheet.) See brochure for definition of eligible dependents.

## Insurance Requested: (refer to enclosed materials for eligibility options and coverage description)

| | Alum | Spouse |
|---|---|---|
| **I hereby apply for the following amount of coverage*:** | ❑ $_____ | ❑ $_____ |

(*Note; if you are increasing your current coverage do not indicate the additional amount of coverage you are requesting. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.)

## Insurance Requested: (continued)

**A. Tobacco/Nicotine Use**

Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Member: ❑ Yes ❑ No If "Yes," _____ (Type of Product) Spouse: ❑ Yes ❑ No If "Yes," _____ (Type of Product)

When did you last use tobacco or nicotine products? _____/_____ (Month/Year) When did you last use tobacco or nicotine products? _____/_____ (Month/Year)

| | Alum | Spouse |
|---|---|---|
| **B. Payment Option** (Please check Semi Annual or Annual) | | |
| You will be billed upon approval of your application. Premiums are payable Semi Annually or Annually. A $2.00 billing fee will be added to all Semi Annual Premium bills. To avoid this fee opt for Annual Premium Payments | ❑ Semi Annual or ❑ Annual | ❑ Semi Annual or ❑ Annual |
| **C. Insurance Replacement** | | |
| Is the insurance applied for intended to replace, discontinue or change an existing policy? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| **D. Other Coverage** | | |
| Do you have other life insurance in force? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| If "Yes," total amount in all companies Alum $_____ Spouse $_____ | | |
| Do you have other insurance applications pending? | ❑ Yes ❑ No | ❑ Yes ❑ No |
| If "Yes," indicate amount and company: Member $_____ Company _____ Spouse $_____ Company _____ | | |

## Alum Beneficiary Designation: *(Insert name, relationship and address.)*

I make the following beneficiary designation with respect to all of my insurance under this Group Insurance Plan, and if I am already covered under this Plan, I hereby revoke any prior beneficiary designation. 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.)

❑ Primary ❑ Secondary %: _____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security #

Street Address City State ZIP

❑ Primary ❑ Secondary %: _____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security #

Street Address City State ZIP

## Spouse Beneficiary Designation: *(Insert name, relationship and address.)*

I make the following beneficiary designation with respect to all of my insurance under this Group Insurance Plan, and if I am already covered under this Plan, I hereby revoke any prior beneficiary designation. 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.)

❑ Primary ❑ Secondary %: _____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security #

Street Address City State ZIP

❑ Primary ❑ Secondary %: _____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security #

Street Address City State ZIP

**Statement of Health:** (Please initial and date any changes you make)

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse (if also applying for coverage).

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

If you have answered Question 1 "No" or any other Questions "Yes" give complete details below.
(Attach a separate sheet if necessary, then sign and date it.)

| Question Letter/No and 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: |
|---|---|---|
| | | |
| | | |
| | | |

## Authorization

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 the 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.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, pharmacy, medical or medically related facility, laboratory, insurance company or MIB LLC 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 for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months for the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

By signing and dating this application, I **request** the insurance indicated; and I **consent** to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices enclosed, 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.

SIGN HERE **Alum's Signature** _____ **Date** _____

By signing and dating this application, I **request** the insurance indicated; and I **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 and Fraud Notices enclosed, 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.

SIGN HERE **Spouse Signature** _____ **Date** _____

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

**FRAUD NOTICE -** ***For Residents of all states <u>except</u> 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 AL/AR/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:** For your protection, California law requires the following to appear on this form: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

**FOR RESIDENTS OF D.C.,** <u>WARNING</u>: 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:** <u>WARNING</u>: 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:** <u>WARNING</u>: 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 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.

**IMPORTANT NOTICE:**

**How New York Life Obtains Information and Underwrites Your Request For The Group Term Life Insurance Plan**

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, LLC ("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 an 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 application for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this 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, LLC 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site 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 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 family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

**New York Life Insurance Company** **7/15 ed.**