Group 10-Yr Level Term Life Insurance Application for Members of the New York State Bar Association

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

TO APPLY: Complete this form and return it to USI AFFINITY, 90 Matawan Rd., Suite 203, Matawan, NJ 07747

NYXKBAXCH

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

1. APPLICANT INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Mobile Phone Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - ____ Date of Birth: ____/____/____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*

*Eligibility of Domestic Partner/Civil Union is determined by state law.

I am applying as (please check only one):

☐ a member of the New York State Bar Association ID#: _____

☐ an employee of an New York State Bar Association member

Member/Firm Name: _____ Employment Date: _____

Are you presently insured by any other NYSBA-sponsored plan? ☐ Yes ☐ No

If yes, provide details: _____

Do you or your spouse plan to reside outside the U.S. or Canada within the next 12 months?

Applicant: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

Spouse: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. DEPENDENT INFORMATION (This section is for association members only, employees of members skip to next section):

MEMBERS ONLY: If you intend to apply for spouse or dependent child coverage, please fill out the following:

Full Name (First, MI, Last)	DOB (mm/dd/yy)	Height (ft. in.)	Weight (lbs.)	Sex
Spouse:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female
Child:				☐ Male ☐ Female

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually ☐ Charge My Credit Card (see below):

I request and authorize NYSBA Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual ☐ monthly charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan. Please note, the charge will be listed as "USI Insurance Services" on your statement.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

G-29111-0

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED.

4. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: **GROUP 10-YR. LEVEL TERM LIFE INSURANCE**

a) ☐ **Total Amount* Desired for Member Coverage:** $_____

b) ☐ **Total Amount* Desired for Spouse Coverage:** $_____

c) ☐ **Total Amount* Desired for Employee Coverage:** $_____

*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. For Member and Spouse coverage, choose an amount between $250,000 and $2,000,000 in $50,000 increments. Spouse coverage cannot exceed member coverage. For Employee Coverage, choose an amount up to $500,000 in $50,000 increments.

d) ☐ **Dependent Child Coverage**

e) **Other Insurance**: Do you have other life insurance in force? ☐ Yes ☐ No

If yes, total amount in all companies: Applicant: $ _____ Spouse: $ _____

Do you have other life insurance applications pending? ☐ Yes ☐ No If yes, indicate amount and company:

Applicant: $ _____ Company:_____

Spouse: $ _____ Company:_____

f) **Tobacco/Nicotine Use:** Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotien chewing gum and electronic cigarettes)?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

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

Member _____ _____ Spouse _____ _____
MO/YR Product MO/YR Product

g) **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.**

RESIDENTS OF NY: I have read the Important Replacement Information above. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy? Applicant: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to only the insurance requested in this application for this Group 10-yr Level Term Life Insurance Plan. 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.)

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #		Benefit %
				☐ Primary ☐ Secondary	
				☐ Primary ☐ Secondary	

6. MEDICAL HISTORY: Please indicate the best contact number for a Service Provider to contact you and/or your spouse/Domestic partner 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.)

You may be contacted by a service provider on behalf of New York Life Insurance Company to ask about your medical history.

Member:	( )	☐ Residence ☐ Business ☐ Mobile
Spouse/Domestic Partner:	( )	☐ Residence ☐ Business ☐ Mobile

Medical Requirements: Some, not all, applicants may need a physical exam, blood test, or EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly—at your convenience and without any cost to you—through our professional paramedic service. A paramedic will contact you to make an appointment.

7. AUTHORIZATIONS AND SIGNATURES:

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 above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, LLC. ("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 Insurance Company, 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 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 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. 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, the applicant **requests** the insurance indicated; and the applicant 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 our protected health information to MIB, LLC.; and **attests** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Applicant Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

Spouse Signature: _____ Date _____
(PLEASE SIGN AND DATE IN INK.)

Owner Information – Required if owner is other than applicant. (If owner is a trust, please submit a copy of the document with this application). For applicants not yet insured under this Group Policy, who wish to have initial ownership of any Certificate of Insurance resulting from this application owned by an individual or entity other than him/herself, complete this section.

Full Name (Last, First MI) | Relationship | Daytime Phone

Mailing Address | City | State | Zip Code

Tax ID | DOB | Social Security #

Owner's Signature (Necessary only if other than applicant.) | Date

Agent Signature | Date

FRAUD NOTICE – *For Residents of all states except those listed below and NY:* 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.: 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 member.

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 MD: Any person who knowingly or willfully presents a false or 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 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 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 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 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 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.

USI AFFINITY

NEW YORK LIFE

Group 10-Yr. Level Term Life Insurance

FOR NEW YORK STATE BAR ASSOCIATION MEMBERS, THEIR FAMILIES & EMPLOYEES

Why not join the millions of insureds who have chosen to help protect their families with

New York Life Insurance Company?

MEMBER NYSBA BENEFIT

Nothing can replace the loss of a loved one. But carefully chosen life insurance coverage can ease the financial stress that death brings to a family. It can help provide the resources your spouse and dependents need for a secure and comfortable future.

Eligibility

As a member of the New York State Bar Association under the age of 65, you are eligible to request this Group 10-Yr. Level Term Life coverage. You are also eligible if you are a student member under age 65, and you are 1) attending an ABA-accredited law school and 2) have a resident address in New York State. The following are also eligible for coverage:

- Your lawful spouse or domestic partner if under age 65, provided he/she is not a NYSBA member. If both you and your spouse or domestic partner are NYSBA members, you both should apply for coverage as a member. If both are insured as members, neither may insure the other as spouse/domestic partner and child coverage may be covered under only one certificate.
- Your dependent children between ages 15 days and 20 years old (through age 24, if a full-time student), unmarried and not in military service.
- Your employees provided they are under age 65, and they are not NYSBA members.

This coverage is available only for the residents of the United States (except territories).

Features

Coverage Options[1] – Your bar association membership entitles you to apply for coverage amounts from $100,000 to $2,000,000 in increments of $50,000. Coverage is also available to your:

- Spouse: You may request coverage for your eligible spouse for an amount between $100,000 and $2,000,000 in $50,000 increments. Coverage for your spouse/domestic partner cannot exceed your coverage.
- Children: You can apply for $25,000 of coverage for each of your eligible, dependent children. The annual premium cost covers all eligible dependents, regardless of the number covered.
- Employees: Your eligible FULL-TIME employees can apply for an amount up to $500,000 in $50,000 increments.

Volume Discounts – The more coverage you request, the more you can save! If you request an option of $250,000 or greater, you'll receive a discount in rates.

Accelerated Death Benefit – The Accelerated Death Benefit provides the option of requesting an advanced one-time payment of 50% of in-force coverage during the 10-year term, if you are diagnosed as terminally ill[2]. You may use the benefit payment to help pay for additional medical or personal care, household expenses, or in any other way you see fit.

To qualify you must provide proof of terminal illness and have a life expectancy of 12 months or less. This important feature is available to you at no additional cost. The death benefit will be reduced by 50%. Your premium payments will continue based on the original coverage amount.

[1] Total coverage in force through all NYSBA-endorsed life insurance underwritten by New York Life cannot exceed $2,000,000 per insured member/$500,000 per insured employee of a NYSBA member.

[2] Receipt of the accelerated death benefit may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits you should consult with the appropriate social service agency and seek the advice of tax counsel.

30-Day Free Look

Once your coverage is approved, you will be sent a Certificate of Insurance summarizing your benefits under the policy. If you are not completely satisfied with the terms of the Certificate, you may return it, without claim, within 30 days. We will refund your entire premium contribution and invalidate your coverage.

For more information, call a Customer Care Representative:

Monday - Friday, 8:30 a.m. to 4:30 p.m.
800.727.7770, Opt. 5

Summary of Terms and Conditions

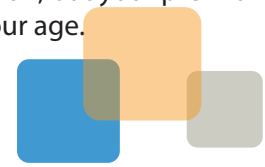
Effective Date – Coverage for the insured person becomes effective on the first day of the month following the date your application is approved, provided the initial premium is paid within 31 days after billing and any person proposed for insurance is performing the normal activities of a person in good health of like age on the approval date. **NOTE—Residents of NC:** Any reference to "performing normal activities of a person in good health of like age" is replaced by the requirement that the health status of any proposed insured person remain the same as stated in your application.

If the person proposed for insurance is not performing the normal activities of a person in good health on the effective date, coverage will become effective on the day that person is performing normal activities, provided such day is within three months of the date insurance would otherwise have taken effect. For dependent insurance, the member insurance is in force on that day; and the proposed person is still eligible to obtain the insurance on that day. Payment of a premium contribution does not mean coverage is in force.

Limitations – The covered person's death benefit will be limited to the total sum of the premiums paid if the insured person commits suicide within two years of the date coverage was issued. In addition, the validity of any amount of insurance which has been in force for two years during your lifetime will not otherwise be contested except for insurance eligibility provisions or non-payment of premium contributions.

When Insurance Ends – Coverage will remain in force until the earlier of the following: you or your spouse reach age 80; you fail to pay premiums when due for any person covered; you discontinue your NYSBA membership; the Group Policy is terminated by NYSBA; the Group Policy is modified to exclude the class of insured
in which you belong; or you elect to end coverage. Employee coverage will end when the insured is no longer employed full-time by a NYSBA member. Coverage for your spouse/domestic partner ends on the premium date which coincides with or follows the earlier of: the date your insurance ends or the end of the premium-paying period during which a) your marriage ends in divorce or annulment; b) the date your domestic partnership ends; c) your spouse/domestic partner becomes an insured member;
or d) your spouse/domestic partner turns age 80. Dependent coverage will end when the eligibility requirements are no longer being met or upon termination of the member's coverage.

Continuing Your Coverage After the Term – If you continue to meet the eligibility requirements, you can re-apply for 10-year level term coverage at the rates and undewriting guidelines in effect at the time of application. Or you may continue your existing coverage until age 80, but on a non-guaranteed rate basis. You will not be required to re-apply for coverage and submit to medical underwriting if you choose this option, but your premium will increase according to your age.



How to Apply

- Complete and sign an Application for Insurance for all parties to be insured.
- Be sure to answer all health questions and collect any documentation requested.
- Place your application and required documentation in an envelope and drop it in the mail.
- Send no payment now, we'll simply bill you upon acceptance.

Don't forget you have 30 days to review and cancel your coverage, so there's absolutely ***NO RISK*** in applying!

To file a claim, contact the Administrator for the necessary form by calling **800.727.7770, Opt. 5.**

YOUR COST ~ Current 2024 Annual Premiums per $1,000 of Coverage

The cost of this life insurance is based on the covered person's gender, amount of insurance requested, use of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Only non-tobacco/nicotine users meeting the highest underwriting standards may qualify for the Super Preferred Non-Smoker rates shown here. Other non-tobacco/nicotine users may qualify for the higher Preferred or Non-Smoker rates. (Note: tobacco/nicotine users may only qualify for Preferred Smoker or Smoker Rates.) Upon approval of your application, you will be notified of the rate classification for each approved person.

Issue Age	$100,000 - $249,000		$250,000 - $749,000		$750,000 - $2,000,000	
	Male	Female	Male	Female	Male	Female
20 - 25	$0.61	$0.46	$0.44	$0.30	$0.34	$0.23
26	$0.61	$0.47	$0.44	$0.30	$0.34	$0.24
27	$0.61	$0.47	$0.44	$0.31	$0.34	$0.24
28	$0.62	$0.48	$0.44	$0.31	$0.35	$0.25
29	$0.62	$0.48	$0.44	$0.32	$0.35	$0.25
30	$0.62	$0.50	$0.44	$0.32	$0.35	$0.26
31	$0.62	$0.51	$0.44	$0.33	$0.35	$0.28
32	$0.62	$0.51	$0.44	$0.34	$0.36	$0.28
33	$0.62	$0.52	$0.45	$0.34	$0.36	$0.29
34	$0.62	$0.52	$0.45	$0.35	$0.37	$0.29
35	$0.62	$0.53	$0.45	$0.36	$0.37	$0.30
36	$0.65	$0.55	$0.47	$0.39	$0.40	$0.32
37	$0.68	$0.57	$0.48	$0.41	$0.42	$0.34
38	$0.70	$0.59	$0.51	$0.44	$0.43	$0.37
39	$0.74	$0.62	$0.52	$0.46	$0.45	$0.40
40	$0.77	$0.64	$0.54	$0.48	$0.47	$0.42
41	$0.81	$0.68	$0.59	$0.53	$0.52	$0.46
42	$0.86	$0.73	$0.65	$0.57	$0.57	$0.51
43	$0.90	$0.78	$0.69	$0.63	$0.62	$0.55
44	$0.95	$0.83	$0.75	$0.67	$0.67	$0.59

Please see the following page for additional ages and rates.

The annual premium for all children is $50.00 for $25,000 coverage on each eligible child, regardless of the number insured.

How to Calculate the Annual Cost:

Select your coverage amount (between $100,000 and $2,000,000 in $50,000 increments):

a) _____

Divide desired amount by 1,000:

b) _____

Find your age in the chart, and multiply the amount in **b)** by the rate shown. This is the annual cost:

c) _____

How much life insurance do you need?

Everyone's situation is different, but the simplest formula for calculating how much life insurance you need is to multiply your gross annual salary by 10. However, you may find that you need more than that if you have other long-term financial goals and responsibilities. At the very least, you want to leave enough money so that your family isn't worried about how to pay the bills after your death. The more money you leave can help protect your loved ones for a longer period of time.

The premium contributions shown reflect the current rates and benefit structure.

Your initial premium is determined by your current age (nearest birthday) on the first day of December which precedes or coincides with the certificate effective date.

Rates are guaranteed to remain level for the initial 10-year term. Then, if still eligible, you may re-apply for 10-year level rates in effect for a subsequent 10-year term; rates for the subsequent term would be determined on then current age, health and tobacco/nicotine use and guaranteed for 10 years. If you're not approved for a subsequent 10-year term of guaranteed rates or do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis with increasing premium as the insured ages.

YOUR COST ~ Current 2024 Annual Premiums per $1,000 of Coverage

The cost of this life insurance is based on the covered person's gender, amount of insurance requested, use of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Only non-tobacco/nicotine users meeting the highest underwriting standards may qualify for the Super Preferred Non-Smoker rates shown here. Other non-tobacco/nicotine users may qualify for the higher Preferred or Non-Smoker rates. (Note: tobacco/nicotine users may only qualify for Preferred Smoker or Smoker Rates.) Upon approval of your application, you will be notified of the rate classification for each approved person.

Issue Age	$100,000 - $249,000		$250,000 - $749,000		$750,000 - $2,000,000	
	Male	Female	Male	Female	Male	Female
45	$0.99	$0.87	$0.80	$0.72	$0.72	$0.64
46	$1.09	$0.95	$0.89	$0.78	$0.80	$0.70
47	$1.18	$1.02	$0.98	$0.85	$0.89	$0.77
48	$1.28	$1.09	$1.08	$0.92	$0.99	$0.85
49	$1.36	$1.17	$1.17	$0.99	$1.08	$0.91
50	$1.46	$1.24	$1.25	$1.06	$1.17	$0.98
51	$1.64	$1.34	$1.42	$1.16	$1.33	$1.07
52	$1.82	$1.44	$1.58	$1.25	$1.49	$1.16
53	$2.00	$1.54	$1.75	$1.34	$1.65	$1.24
54	$2.18	$1.64	$1.91	$1.44	$1.80	$1.33
55	$2.35	$1.74	$2.08	$1.54	$1.97	$1.42
56	$2.61	$1.90	$2.31	$1.69	$2.19	$1.57
57	$2.86	$2.07	$2.55	$1.85	$2.41	$1.73
58	$3.12	$2.23	$2.78	$2.01	$2.64	$1.87
59	$3.38	$2.40	$3.03	$2.17	$2.86	$2.02
60	$3.63	$2.56	$3.26	$2.32	$3.08	$2.18
61	$3.88	$2.73	$3.49	$2.48	$3.30	$2.33
62	$4.14	$2.89	$3.73	$2.63	$3.52	$2.49
63	$4.40	$3.06	$3.96	$2.79	$3.75	$2.63
64	$4.65	$3.22	$4.20	$2.95	$3.97	$2.78

Please see the preceding page for additional ages and rates.

How to Calculate the Annual Cost:

Select your coverage amount (between $250,000 and $2,000,000 in $50,000 increments):

a) _____

Divide desired amount by 1,000:

b) _____

Find your age in the chart, and multiply the amount in **b)** by the rate shown. This is the annual cost:

c) _____

How much life insurance do you need?

Everyone's situation is different, but the simplest formula for calculating how much life insurance you need is to multiply your gross annual salary by 10. However, you may find that you need more than that if you have other long-term financial goals and responsibilities. At the very least, you want to leave enough money so that your family isn't worried about how to pay the bills after your death. The more money you leave can help protect your loved ones for a longer period of time.

The annual premium for all children is $50.00 for $25,000 coverage on each eligible child, regardless of the number insured.

The premium contributions shown reflect the current rates and benefit structure.

Your initial premium is determined by your current age (nearest birthday) on the first day of December which precedes or coincides with the certificate effective date.

Rates are guaranteed to remain level for the initial 10-year term. Then, if still eligible, you may re-apply for 10-year level rates in effect for a subsequent 10-year term; rates for the subsequent term would be determined on then current age, health and tobacco/nicotine use and guaranteed for 10 years. If you're not approved for a subsequent 10-year term of guaranteed rates or do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis with increasing premium as the insured ages.

How New York Life Obtains Information and Underwrites Your Request for Group 10-Yr. Term Life 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, 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, 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 applications 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 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 **8.12 ed**

Administered By:
USI Affinity
90 Matawan Rd., Suite 203
Matawan, NJ 07747
AR Insurance License # 325944
CA Insurance License # 0G11911

USI AFFINITY

This Insurance Is Underwritten By:
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue
New York, NY 10010
Under Group Policy G-29111-0
on Policy Form G-29111-0/GMR-FACE

NEW YORK LIFE

This Summary contains a brief description of some of the principal provisions of the proposed insurance coverage. Complete terms and conditions are set forth in the group policy issued by New York Life to the New York State Bar Association, and each insured will receive a Certificate of Insurance containing all the benefits and coverage provisions provided under Group Policy G-29111-0 on policy form GMR-FACE/G-29111-0. This group life policy is available only in the U.S.