

Statement of health: Note: To evaluate your insurability, New York Life Insurance Co. may ask you to supply further medical information, which could include an examination and/or laboratory studies.

ANSWER THESE QUESTIONS AS THEY APPLY TO YOU.

Please initial any changes you make on this form.

- | | | |
|---|--------------------------|--------------------------|
| | Yes | No |
| A. Are you now receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Are you now ill, receiving or contemplating any medical attention or surgical treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| C. During the past five years have you consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| D. Are you under any kind of medication or, so far as you know, in impaired physical or mental health?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| E. Are you now pregnant?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| F. Have you ever had: | | |
| 1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Arthritis, back trouble, bone or joint disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fainting spells, convulsions or epilepsy?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sugar, blood, albumin or pus in urine?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Diabetes, kidney trouble, ulcers or digestive disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Disorder of breasts or reproductive organs or functions?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Nervous or mental disorder, emotional condition or psychiatric care?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cancer, tumor or cyst?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Varicose veins, hemorrhoids or hernia?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Disorder of eyes, ears, nose or sinuses?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Thyroid, liver or respiratory disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Alcoholism or drug habit?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Disorder of the blood?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other health or physical impairment including: | | |
| (a) Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Condition (ARC)?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Any other disorder of the immune system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past five years?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (d) Any other impairment?..... | <input type="checkbox"/> | <input type="checkbox"/> |

G. If you have answered any of the above questions "Yes", give complete details below.

(Attach a separate sheet with your signature and date if you need additional space.)

| question number and/or letter | illness or condition, date of onset, duration, treatment, operations, degree of recovery and date | name and address of physicians or other practitioners and hospitals where confined or treated |
|-------------------------------|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

I request the group insurance shown on the reverse side. 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 that any 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 on the date approved by New York Life provided the initial contribution is paid within 31 days after the date I am billed and I am at FULL-TIME WORK (as defined on reverse side) on the later of the date of approval and the date the contribution is paid; (b) if I am not at FULL-TIME WORK as required, I will not become insured until the day I return to FULL-TIME WORK, provided such date is within three months of the date insurance would have been effective and I am still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the AAFP. I understand that benefits will not be payable for up to two years for losses due to a disease or condition which I now have or have had in the past and which is not disclosed fully on this form. I authorize disclosure of the types of information detailed in the AUTHORIZATION in this pamphlet, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE in this pamphlet which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau).

(Note: The following Fraud Warning is included in the AAFP Group Disability Income Policy Application in compliance with New York State statutes.) **Fraud Warning Statement:** 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation.

Member's signature X _____ Date _____

Residents of AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH, OR and PA: 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 is a crime and subjects such person to criminal and civil penalties. **For 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. **For residents of DC, the following also applies:** An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.



Protection for your most important asset – your ability to earn an income

AAFP Group Disability Insurance Plan

Semi-Annual Premium Contribution per \$100 Unit of Monthly Benefits

Accident & Sickness Benefits to Age 65

The initial cost is based upon your age when insurance becomes effective and increases as you grow older and enter a higher age bracket.

Select one of the waiting periods across the top, then find the row corresponding to your age group to determine your premium. If you want to include the Inflation Protection Option, add the additional charge. Then multiply this amount by the number of \$100 units selected.

Example: A 37 year-old who selected a 90-day waiting period and a \$3,000 Monthly Benefit Option would have a semi-annual premium contribution of \$221.40. [Calculation: 30 x \$7.38] The semi-annual premium contribution *with* Inflation Protection is \$325.80. [Calculation: 30 x \$10.86 (\$7.38 + \$3.48)]

Semi-Annual Premium Contribution per \$100 Unit of Monthly Benefits

Accident & Sickness Benefits to Age 65

| Age | Waiting Period | | | Inflation Protection Option |
|----------|----------------|---------|---------|-----------------------------|
| | 60-day | 90-day | 180-day | |
| Under 30 | \$ 6.12 | \$ 4.98 | \$ 4.14 | \$1.74 |
| 30 - 34 | 6.96 | 5.82 | 4.86 | 2.52 |
| 35 - 39 | 8.88 | 7.38 | 6.12 | 3.48 |
| 40 - 44 | 12.00 | 10.02 | 8.52 | 5.28 |
| 45 - 49 | 16.92 | 14.10 | 12.12 | 7.02 |
| 50 - 54 | 23.70 | 19.92 | 17.46 | 6.24 |
| 55 - 59 | 38.88 | 32.94 | 29.64 | 4.50 |
| 60 - 64* | 47.28 | 40.74 | 36.66 | 1.98 |
| 65 - 69* | 30.12 | 25.98 | 23.40 | n/a |

*Renewal only

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life on any premium due date and any date on which benefits are changed. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life and the AAFP.

If you rely upon an earned income to support yourself and your family... apply today



AAFP GROUP DISABILITY INCOME INSURANCE APPLICATION

For members of the American Academy of Family Physicians

HOW TO APPLY

1. Please read this application and give complete answers to all questions. Failure to provide complete and truthful information may invalidate coverage.
2. Detach the application at the perforation. Save this section for your records. Use the enclosed postage-free envelope to mail your signed application to: **AAFP Insurance Services, Inc.**
3. **Enclose no money at this time.**
Upon approval of your application, we will bill you.

Medical Requirements

The AAFP Group Disability Income Policy is medically underwritten based on the information you provide on the application and possible additional medical information as indicated below. It is important that you complete the application truthfully and completely. • Your application is subject to New York Life Insurance Company approval. Occasionally, an application must be declined due to past health history. Do not cancel any existing insurance until you receive your Certificate Of Insurance and you have had a chance to review it. • New York Life may request further medical information. Based on the age of the person proposed for insurance and the amount of coverage requested, a physical examination, EKG, blood test or other information may be required. • Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to perform a simple exam with blood tests at your convenience and at our expense. If you prefer to use your own physician, you may do so at your own expense with prenotification to New York Life of your intention. If that exam provides the information needed to underwrite your application for insurance, you will be reimbursed for the charge normally incurred by New York Life for an exam conducted by a professional paramedic.

Important Notice – “How New York Life Underwrites Your Request For Disability Income Insurance”

Information regarding insurability will be treated as confidential. In considering whether you qualify for coverage, we will rely on the medical information you provide and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may make a brief report to MIB; however, we will not disclose our underwriting decision. Information in our files may be seen by New York Life and the Plan Administrator (AAFP Insurance Services, Inc.) 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. • MIB is a nonprofit organization of life insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or nonmedical information may be given to the Bureau, which may then be furnished to member companies. • Upon written request to New York Life or MIB, you will be provided with nonmedical information; medical information, however, will only be given to a physician you designate. (Note: In certain jurisdictions, you may choose to receive

QUESTIONS?

Contact your Plan Administrator: AAFP Insurance Services, Inc.

Call toll-free: 800-325-8166 AAFP Headquarters, Suite 430
 Fax toll-free: 800-223-7463 11400 Tomahawk Creek Parkway
 E-mail: insurance@aafp.org Leawood, KS 66211

Underwritten by:



New York Life Insurance Company (on Policy Form GMR)
 51 Madison Avenue
 New York, NY 10010

medical information directly.) If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. • **For NM residents:** *In addition, PROTECTED PERSONS¹ have a right of access to certain CONFIDENTIAL ABUSE INFORMATION² 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.*

¹PROTECTED 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.

²CONFIDENTIAL 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.

- If we cannot provide the coverage you request, 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.
- If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean there is any insurance in force before the effective date as determined by New York Life.

New York Life Insurance Company 7/99 ed.

Authorization

I authorize any physician, medical practitioner, hospital, medical or medically-related facility, insurance company or MIB to release information to New York Life Insurance Company, its subsidiaries or the Plan Administrator about my physical and mental health, including significant history, findings, diagnosis and treatment. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with nonmedical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). New York Life and its subsidiaries may release to the Plan Administrator, MIB, other insurance companies and to others whom I authorize in writing, information covered by this AUTHORIZATION. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 30 months from the date the application was signed. A photocopy of this request form shall be as valid as the original. I know that I may request a copy of this AUTHORIZATION.

Detach at perforation and save.

AAFP GROUP DISABILITY INCOME INSURANCE APPLICATION

For members of the American Academy of Family Physicians

Request for Group Disability Income Insurance from New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

Administered by AAFP Insurance Services, Inc., AAFP Headquarters, Suite 430, 11400 Tomahawk Creek Parkway, Leawood, KS 66211

Attention FL, MN, NC and VA residents: Do not use this form. Call AAFP Insurance Services for a special form.

Questions? Call 800-325-8166 Fax: 800-223-7463

Full answers to all questions are required. Please print in ink or type all answers. Thank you.

AAFP member information:

Full name: last, first, middle _____ Social Security # _____

Date of birth _____ Place of birth (City, State) _____

Sex: male female Height _____ ft. _____ in. Weight _____ lbs. E-mail: _____

Home address (street, city, state, zip) _____

Business name _____ Business type: Corp. Partnership Proprietorship

Business address (street, city, state, zip) _____

Home phone _____ Business phone and fax _____

Your confidentiality is important to us. Please indicate the address where you want to receive:

Medical underwriting information: Home Business Policy information and premium notices: Home Business

Membership affiliation-occupational status:

Are you now a member of the American Academy of Family Physicians? Yes No AAFP membership # _____

(if available)

What is your occupation? _____ Main duties? _____

“FULL-TIME WORK” means the active performance of the regular duties of your normal occupation for pay or profit at the place such duties are normally performed. Do you presently meet this definition of FULL-TIME WORK? Yes No

Disability income benefit calculator:

Refer to brochure and/or your Certificate Of Insurance for eligibility, options and coverage description.

I hereby apply for the coverage indicated below based upon all my statements made in this application.

Please enter on line A your “monthly earnings” from your medical practice. A. \$ _____

(Monthly earnings shall mean 1/12th of your medical practice income as reported to the IRS.

Include salary, self-employment earnings, bonus, commissions, etc.

The amount stated is subject to verification in determining your monthly benefit.)

Multiply line A by 60% B. \$ _____

Multiply line A by 75% C. \$ _____

Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? Yes No If yes, please list. If more space is needed, attach separate sheet with your signature & date.

| Insurance company | Plan name | Length of benefit period (i.e. to age 65) | Monthly benefit amount |
|-------------------|-----------|---|------------------------|
| _____ | _____ | _____ | 1. \$ _____ |
| _____ | _____ | _____ | 2. \$ _____ |
| _____ | _____ | _____ | 3. \$ _____ |

Add lines 1 through 3. D. \$ _____

Subtract line D from line C. E. \$ _____

Enter the Monthly Benefit Option you wish to apply for not to exceed the lesser of line B or line E. \$ _____

(in multiples of \$100 only, to a maximum of \$8,000)

Do you want the Inflation Protection Option? Yes No

Select your disability waiting period: 60-days 90-days 180-days

If you do not want to be billed semi-annually (Mar & Sep), please select an optional billing mode:

Payment option: Annually (Sept) Quarterly (Mar, June, Sept, Dec)