

Dependent Child(ren) Term Life coverage: (Complete this section only if Dependent Child coverage is desired.)

Name _____ Sex M F Name _____ Sex M F
Name _____ Sex M F Name _____ Sex M F
Name _____ Sex M F Name _____ Sex M F

If more children are proposed for insurance, please list them on a separate sheet with your signature and date.

Payment option: If you do not want to be billed semi-annually (Jun and Dec), please select an optional billing mode:

Annually (June) Quarterly (Mar, Jun, Sep, and Dec)

BENEFICIARY DESIGNATION:

I hereby make the following beneficiary designation with respect to my insurance under this Group Life Insurance Policy, and if I am already covered under the Policy, I hereby revoke any prior beneficiary designation. I understand the beneficiary for Dependent Child(ren) coverage shall be the insured AAFP Member as provided in the Group Policy:

Beneficiary of AAFP MEMBER'S Insurance Social Security Number Relationship Full Address

Beneficiary of SPOUSE'S Insurance AAFP Member Other

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 will require additional medical 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 all supplements to it, while considering my request. I also understand that the coverage afforded will be in consideration of the answers and statements on this form and all supplements to it 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 first of the month on or immediately after the date approved by New York Life provided the initial contribution is paid within 31 days after the date I am billed, and I and any approved spouse and/or child(ren) are actively performing the normal activities of a person in good health of like age on the date of approval, or, if later, the date the contribution is paid; (**For NC residents: I and any approved spouse and/or child(ren) are actively performing the normal activities of a person of like age on the date of approval, or, if later, the date the contribution is paid;**) (b) spouse and/or child(ren) insurance will not take effect unless my insurance is in effect on a paying basis; and (c) 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 for insurance. I understand that any dividend apportioned to the group policy will be paid to the American Academy of Family Physicians. **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).

Please sign in ink and date.

AAFP Member's signature

X _____ Date _____

Please sign in ink and date.

(Necessary only if AAFP Member previously transferred ownership of his/her AAFP Group Term Life Insurance.)

Owner's signature X _____ Date _____

Please sign in ink and date.

(Spouse's signature necessary only if spouse coverage is applied for.)

To the best of my knowledge and belief, the statement made regarding my smoking status is true and complete.

Spouse'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.

Residents of FL: Any person 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. **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.

AAFP Term Life Insurance

Your semi-annual premium contributions for member and spouse coverage

The initial cost of this term life insurance is based on the individual's sex, usage of tobacco/nicotine products, the amount of insurance requested, and current age. The cost will increase as the individual reaches the next age bracket.

Below are the current semi-annual contributions for primary coverage.

They reflect volume discounts at \$250,000 and \$500,000 of death benefit protection. *Example:* If you are male (non-smoker, age 34) requesting \$600,000 of coverage, your semi-annual premium contribution is \$233. A female (non-smoker, age 34) requesting \$600,000 of coverage would pay \$199 semi-annually.

Male (non-smoker)*		reflects volume discount					includes additional volume discount					
Age	Benefit †	\$100,000	\$200,000	\$250,000	\$300,000	\$400,000	\$500,000	\$600,000	\$700,000	\$800,000	\$900,000	\$1,000,000
<25	Premium †	\$29	\$58	\$65	\$78	\$104	\$117	\$141	\$164	\$188	\$211	\$235
25-29		30	60	68	81	108	122	146	170	194	219	243
30-34		48	96	108	130	173	194	233	272	311	350	389
35-39		71	142	160	192	256	288	345	403	460	518	575
40-44		104	208	234	281	374	421	505	590	674	758	842
45-49		157	314	353	424	565	636	763	890	1,017	1,145	1,272
50-54		270	540	608	729	972	1,094	1,312	1,531	1,750	1,968	2,187
55-59		431	862	970	1,164	1,552	1,746	2,095	2,444	2,793	3,142	3,491
60-64**		805	1,610	1,811	2,174	2,898	3,260	3,912	4,564	5,216	5,868	6,521
Female (non-smoker)*												
Age	Benefit †	\$100,000	\$200,000	\$250,000	\$300,000	\$400,000	\$500,000	\$600,000	\$700,000	\$800,000	\$900,000	\$1,000,000
<25	Premium †	\$17	\$34	\$38	\$46	\$61	\$69	\$83	\$96	\$110	\$124	\$138
25-29		23	46	52	62	83	93	112	130	149	168	186
30-34		41	82	92	111	148	166	199	232	266	299	332
35-39		64	128	144	173	230	259	311	363	415	467	518
40-44		94	188	212	254	338	381	457	533	609	685	761
45-49		141	282	317	381	508	571	685	799	914	1,028	1,142
50-54		230	460	518	621	828	932	1,118	1,304	1,490	1,677	1,863
55-59		345	690	776	932	1,242	1,397	1,677	1,956	2,236	2,515	2,795
60-64**		523	1,046	1,177	1,412	1,883	2,118	2,542	2,965	3,389	3,813	4,236

* Smoker rates are approximately 20% higher. **For renewal rates at ages 65-74, contact AAFP Insurance Services, Inc. at 1-800-325-8166.

Accidental Death & Dismemberment Insurance

Your semi-annual premium contribution

Principal Sum †	\$100,000	\$200,000	\$300,000	\$400,000	\$500,000
Cost †	\$21.60	\$43.20	\$64.80	\$86.40	\$108.00

The maximum AD&D benefit is \$500,000 but not to exceed your term life insurance benefit.

†Regardless of your age or sex, the rate is \$2.16 semi-annually per \$10,000 of coverage. AD&D benefits and premium contributions reduce automatically at age 65 (to 75%) and at age 70 (to 50%). The benefit terminates at age 75.

Dependent Child(ren) Term Life Insurance

Your semi-annual premium contribution is \$16 regardless of the number of children in your family

Child's attained age	Amount of insurance
Between 14 days and 6 months	\$1,000
6 months to age 25	\$10,000

All premium contributions shown are the current rates based upon the current benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date and on any date on which benefits are changed. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Co., (51 Madison Ave., NY, NY, 10010 on Policy Form GMR) and the American Academy of Family Physicians. If you have questions, contact the plan administrator: AAFP Insurance Services, Inc., 11400 Tomahawk Creek Pkwy., Ste. 430, Leawood, KS 66211

**It's fast
and easy
to apply!**

*Your application
form is inside...*

HOW TO APPLY

1. Please indicate the amount of coverage you are requesting for yourself and your eligible dependents by completing "Part I: Request For AAFP Group Insurance".
2. Detach the Application at the perforation. Save this section for your records. Use the enclosed postage-free envelope to mail your signed Application Form - Part I to:
AAFP Insurance Services, Inc. Enclose no money at this time.
3. Part II of your Application consists of meeting with a Paramedic to take a simple exam, provide clinical specimens and give your statement of health. This information will be forwarded to New York Life Insurance Company for underwriting review.
4. Upon approval of your Application (Parts I and II), we will bill you.

Medical Requirements

Requests for insurance under the AAFP Term Life Insurance Policy are medically underwritten based on the information you provide and possible additional medical information as indicated below.

- A professional Paramedic will be engaged by the AAFP Insurance Program to take your statement of health and perform a physical examination. Based on the age of the person proposed for insurance and the amount of coverage requested, the exam will include an EKG, physical measurements, and blood and urine specimens. The exam will be performed at a time and place specified by you and at the Program's expense.
- It is important that you provide full and accurate answers to all questions on the Application (Parts I and II). Failure to provide complete and truthful information may invalidate coverage.
- Your Application is subject to New York Life Insurance Company approval. Occasionally, an Application must be declined due to past health history.

Important Notice – "How New York Life Underwrites Your Request For Life Insurance"

Information regarding insurability will be treated as confidential.

In considering whether the persons in your request for insurance 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 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 07/99 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 the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment. I also authorize New York Life to obtain the motor vehicle records of any persons proposed for insurance. 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 (**For MN residents: 26 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.

- **For VA residents:** *I know that I or my authorized representative may request a copy of this AUTHORIZATION.*

- **For MN residents:** *This AUTHORIZATION excludes the release of information about HIV (AIDS Virus) tests which were administered (1) to a criminal offender or crime victim as a result of a crime that was reported to the police; (2) to a patient who received the services of emergency medical services personnel at a hospital or medical care facility; (3) to emergency medical personnel who were tested as a result of performing emergency medical services. The term "emergency medical personnel" includes individuals employed to provide pre-hospital emergency services: licensed police officers, firefighters, paramedics, emergency medical technicians, licensed nurses, rescue squad personnel, or other individuals who serve as volunteers of an ambulance service who provide emergency medical services; crime lab personnel, correctional guards, including security guards at the Minnesota security hospital, who experience a significant exposure to an inmate who is transported to a facility for emergency medical care; and other persons who render emergency care or assistance at the scene of an emergency, or while an injured person is being transported to receive medical care and who would qualify for immunity under the good samaritan law.*

- **For NY residents: 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 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 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.

Detach at perforation and save.

Application Form - Part I: Request for AAFP Group Term Life Insurance

from New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

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

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

True and complete answers to all questions contained in Part I and II of the Application for insurance 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 M F

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

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

What is the best time to call to arrange for a Paramedic visit to complete your **Application Part II, PARA-MED** statement of health?

_____ a.m. _____ p.m. daytime phone _____

_____ a.m. _____ p.m. home phone _____

Daytime fax _____

E-mail _____

Are you a member of the American Academy of Family Physicians?

Yes No AAFP Membership # (if available) _____

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

Non-smoker discount

Do you wish to apply for nonsmoker rates? Yes No

During the past 12 months, have you used tobacco or nicotine in any form? Yes No

Do you understand that the answer to this question may result in a reduced premium contribution and that, if the answer is not true, coverage may be invalidated? Yes No

I hereby apply for the coverages indicated below,

based upon all my statements made in the Application - Parts I and II:

Answer the following questions as they apply to you and all dependents to be insured.

For AAFP Members who are NOT currently insured under this policy

Please select your Term Life Insurance benefit:

\$100,000 \$200,000 \$250,000 \$300,000 \$400,000

\$500,000 \$600,000 \$700,000 \$800,000 \$900,000 \$1,000,000

If you did not select a benefit amount above, enter your desired benefit here:

\$ _____ (in multiples of \$10,000 only)

Please select your Accidental Death & Dismemberment benefit:

(Your AD&D benefit cannot exceed your Term Life benefit, or a maximum of \$500,000.)

\$100,000 \$200,000 \$250,000 \$300,000 \$400,000 \$500,000 Other:

\$ _____ (in multiples of \$10,000 only)

For AAFP Members who ARE currently insured under this policy

I wish to INCREASE my Term Life Insurance

from \$ _____ to \$ _____.

I wish to INCREASE my Accidental Death & Dismemberment benefit

from \$ _____ to \$ _____.

For AAFP Members requesting insurance for their SPOUSE

(Note: Spouse coverage cannot exceed 100% of AAFP Member's coverage.)

My Spouse is NOT currently insured under this policy

\$100,000 \$200,000 \$250,000 \$300,000 \$400,000

\$500,000 \$600,000 \$700,000 \$800,000 \$900,000 \$1,000,000

If you did not select a benefit amount above; enter your desired benefit here:

\$ _____ (in multiples of \$10,000 only)

My Spouse IS currently insured under this policy

I wish to INCREASE spouse coverage from \$ _____ to \$ _____.

Spouse name _____
First Middle/Maiden Last

Social Security # _____ Sex M F Date of birth _____

Do you wish to apply for the non-smoker discount? Yes No

During the past 12 months, has your spouse used tobacco or nicotine in any form? Yes No

Do you understand that the answer to this question may result in a reduced premium contribution and that, if the answer is not true, coverage may be invalidated? Yes No

Insurance replacement-status of other coverage

New York residents: answer this question *I have read the "Important Replacement Information" that accompanied this application.*

Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Yes No

All others: answer this question Is the insurance applied for intended to replace, discontinue or change an existing policy? Yes No