AMERICAN ACADEMY OF FAMILY PHYSICIANS

Level Term Life Insurance Application

NEW YORK LIFE

(Policy G30240 and/or G30241)

Request for association-group insurance from: New York Life Insurance Company • 51 Madison Avenue • New York, NY 10010

PLEASE COMPLETE THIS FORM AND RETURN IT TO THE PLAN ADMINISTRATOR:

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

Questions? Call (866) 537-1039 Web: www.aafpins.com Email: nsurance@aafpins.com

1020-21-1

AAFP Member Information

Full Name: _____ Soc. Sec. #: _____ Date of Birth: _____ (MM/DD/YYYY)

Address: _____ Sex: M ☐ F ☐ Membership #: _____

State _____ Zip Code _____ Height: _____ Weight: _____ Email: _____

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

Do you intend to reside outside the U.S. in the next 12 months? Yes ☐ No ☐ Country: _____ For how long? _____

MEDICAL UNDERWRITING REQUIRED **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.**

(Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

Member: Contact Number : _____ Residence ☐ Business ☐ Mobile ☐

CONTACT INFORMATION - Indicate where you'd like to receive the following:

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

HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

BUSINESS ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Spouse/Domestic Partner Enrollment (DP) (Complete only if Spouse/DP coverage is desired.)

Spouse/DP's Full Name

_____

First M.I. Last

Soc. Sec. #: _____ Date of Birth: _____ (MM/DD/YYYY)

Sex: M ☐ F ☐ Membership # (if applicable): _____

Height: _____ Weight: _____

Do you intend to reside outside the U.S. in the next 12 months? Yes ☐ No ☐ Country: _____ For how long? _____

MEDICAL UNDERWRITING REQUIRED **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.**

(Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

Spouse/Domestic Partner: Contact Number: _____ Residence ☐ Business ☐ Mobile ☐ Email Address _____

CONTACT INFORMATION - Indicate where you'd like to receive the following:

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

HOME ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

BUSINESS ADDRESS: _____ CITY: _____ ST: _____ ZIP: _____

Insurance Requested (Refer to the brochure for eligibility, options & coverage description)

I hereby apply for the following association-group 10-Year and/or 20-Year Level Term Life Insurance:

Notes: The maximum available through New York Life Insurance Company for any individual is $2,000,000 whether coverage is in one or divided among several group policies. **Amounts available from $100,000 to $2,000,000 in $10,000 increments.**

Insurance Benefit Amount Requested: 10-Year Level Term Life: Member $ _____ Spouse/DP $ _____

20-Year Level Term Life: Member $ _____ Spouse/DP $ _____

Do you have other life insurance in force? If yes, list the total amount in all companies:

	Member	Spouse/DP
Dollar Amount:	_____	_____
Company:	_____	_____

Do you have other insurance applications pending? If yes amount and company:

Member $: _____ Company: _____

Spouse/DP $: _____ Company: _____

I hereby apply for Dependent child(ren) insurance. ☐

If more children are proposed for insurance, list them on a signed and dated separate sheet and endorse with this application.

Child's Name (First MI Last) _____ **Date of Birth** _____ (MM/DD/YYYY) **Sex** M ☐ F ☐

Child's Name (First MI Last) _____ **Date of Birth** _____ (MM/DD/YYYY) **Sex** M ☐ F ☐

FOR ADMINISTRATIVE USE ONLY:

Payment Options

If you do not want to be billed **annually** on June 1st please select one of these optional modes at no additional charge.
Optional billing modes available: **Semi-annually** (June & December) ☐ **Quarterly** (March, June, September & December) ☐

Insurance Replacement

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 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 New York: I have read the Important Replacement Information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Member No ☐ Yes ☐ Spouse/DP No ☐ Yes ☐

Residents of Other States: Is the insurance applied for intended to replace, discontinue or change any existing policy? Member No ☐ Yes ☐ Spouse/DP No ☐ Yes ☐

Beneficiary Designation

I make the following beneficiary designation with respect to new insurance issued on the basis of this application for association-group 10-year and/or 20-year Level Term Life Insurance (policy G30240 and/or G30241). If naming a trust, please indicate the full name and date of the trust. Attach a separate sheet, signed and dated, if you need more space.

Note: If you currently have AAFP life insurance and wish to change your beneficiary, call the Plan Administrator for the proper form.

Beneficiary of AAFP Member Insurance

Name: _____
(First MI Last) Relationship Social Security # Date of Birth: (MM/DD/YYYY)

Full Address: _____
(Street, City, State, Zip) Phone

Beneficiary of Spouse/DP's Insurance AAFP Member ☐ Other ☐

Name: _____
(First MI Last) Relationship Social Security # Date of Birth: (MM/DD/YYYY)

Full Address: _____
(Street, City, State, Zip) Phone

I understand the beneficiary for dependent child(ren) coverage shall be the insured AAFP member as provided in the association-group policy.

Read, Sign and Date

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, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life 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, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from 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, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; 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.

AAFP Member's Signature **X**_____ Date _____
(Please sign and date in ink.)

Spouses/DP Signature **X**_____ Date _____
(Necessary only if Spouse/DP coverage is requested. Please sign and date in ink.)

Agent Signature **X**_____ Date _____
(For applicants who reside in CA, MI, MN, MS VA, WA. Please sign and date in ink.)

GMA-AC-IR **ENCLOSE NO MONEY AT THIS TIME. YOU WILL BE BILLED ONCE YOUR APPLICATION HAS BEEN APPROVED.** G30240 G30241

FOR ADMINISTRATIVE USE ONLY: