AMERICAN ACADEMY OF FAMILY PHYSICIANS
INSURANCE PROGRAM
for your financial health

Introducing Quick Start Life:
A Simpler Life Insurance Option for AAFP Members

With AAFP Quick Start Life, you can quickly and easily apply for up to $250,000 in term life insurance without the need for a physical exam or medical tests. And as a member of the Academy, you are eligible for affordable rates, which means your rates may be significantly lower than other individual plans available to you.

- Up to $250,000 in term life insurance
- Streamlined application process
- AAFP membership assures your eligibility
- No physical exam, medical tests or lab work required
- Group rates – exclusive to AAFP members
- Your protection is portable

APPLYING FOR COVERAGE IS EASY

To apply for $250,000 in Quick Start Life benefits, follow these simple steps:

1. Download and complete the attached form.

2. Return application to:

- AAFP Insurance Services Inc., Suite #430, 11400 Tomahawk Creek Parkway, Leawood, KS 66211
- You can also fax to **(800) 223-7463** or email your application to insurance@aafp.org

Here's what happens next ...

- We'll call to ask you a few questions.
- You'll be notified of a coverage decision by mail.
- Your Certificate of Insurance will be issued.
- It's that easy! There is no risk and no obligation.

Your Guarantee of Satisfaction:

Once you receive your Certificate of Insurance, you will have 30 days to review it. If you are not fully satisfied, **return it without claim for a full refund**.

$250,000 Benefits

Current Quarterly Rates — Non-Smoker

Age	Female	Male
< 25	$12.94	$23.63
25-29	16.88	25.88
30-34	19.69	28.13
35-39	32.63	41.06
40-44	52.31	64.69
45	88.88	103.50

The rates shown reflect the current (2016) benefit structure and QUARTERLY rate. Your initial premium is based on your age at issue. Rates increase as you enter each new five-year age band. The premium shown is the amount you pay and is based on your gender, current age, health status and tobacco/nicotine use. Amounts available range from $100,000 to $2,000,000 in $10,000 increments and volume discounts commence at $250,000 and $500,000 levels. Male rates apply to all coverage issued to Montana residents, regardless of a person's sex.

Highest Financial Strength Ratings

This exclusive coverage is underwritten by New York Life Insurance Company. An industry leader for over 170 years, New York Life has the highest financial strength ratings currently awarded to any life insurer from all four leading independent rating agencies:

A++ Highest Rating from A.M. Best	**AAA** Highest Rating from Fitch
AA+ Second-Highest Rating from Standard & Poor's	**Aaa** Highest Rating from Moody's Investors Service

(ratings as of 8/11/15)

Answers to Your Questions
About AAFP Quick Start Life

NEVER BEFORE OFFERED

Q. What makes applying so easy?

A. With our simple application process, you can apply for up to $250,000 in benefits by mail – without a physical exam, medical tests or lab work. All you do is complete and return a simple application. We'll call to ask a few questions ... and mail your coverage decision. It's as simple as that.

Q. How long may I keep this life insurance?

A. Once insured, you can remain insured until you turn age 75, as long as your premiums are paid on time and the group master policy remains in force. Only the Academy can terminate this policy. It cannot be cancelled by New York Life.

Q. Can purchasing insurance through AAFP save me money?

A. Yes. As an AAFP member, you are eligible for affordable rates. These rates, specifically negotiated on your behalf, have the group buying power of more than 120,900 Academy members behind them. As a result, rates may be significantly lower than those available to you as an individual.

Q. Who can apply for this coverage?

A. If you are an AAFP member age 45 or under, you may apply for this coverage.

Q. Is there any way I may increase my coverage amount, once I'm insured?

A. Yes. You'll be guaranteed the right to add another $50,000 in benefits at ages 31, 34, 37, 40, 43 and 46, provided you are working full time. That means that if eligible, over time, and depending on your age, you could more than double your protection — guaranteed, without any proof of insurability. Of course, you may apply at any time for additional coverage, subject to proof of insurability.

Q. Does this coverage come with any exclusions?

A. There are no exclusions. This group policy will pay benefits for death from any cause. The validity of any amount of insurance that has been in force for two years or more will not be contested except for insurance eligibility provisions or non-payment of premium contributions.

Q. Why is AAFP making this coverage available to members?

A. AAFP has long recognized that busy physicians often don't have time to search for the protection they need to help preserve and improve their financial health. With that in mind, AAFP Insurance Services was founded more than 60 years ago. This wholly-owned subsidiary of the AAFP Foundation is dedicated to helping physicians protect what they've worked so hard to achieve.

Have a Question?
Need Help Applying?
Call (800) 325-8166

Underwritten by

NEW YORK LIFE

AMERICAN ACADEMY OF FAMILY PHYSICIANS
INSURANCE PROGRAM
for your financial health

facebook.com/aafpinsurance twitter.com/aafpinsurance linkedin.com/company/aafp-insurance-services

AAFP Association Group Term Life Insurance Plan
11400 Tomahawk Creek Parkway, #430 • Leawood, KS 66211-2672 • www.aafpins.com

AP-06-16-ART
LT-QS-0616

AMERICAN ACADEMY OF FAMILY PHYSICIANS

Association Group Term Life Insurance Application

NEW YORK LIFE

(Policy G7200)

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: aafpins.com Email: insurance@aafp.org WEB

AAFP MEMBER INFORMATION

Name: _____ Soc. Sec. #: _____ – ___ – _____ Date of Birth: _____
(First MI Last) (MM/DD/YYYY)

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

CITY: _____ ST: _____ ZIP: _____ Height: _____ Weight: _____ Email: _____

Marital Status: Single ☐ Married ☐ on __/__/__ Widowed ☐ Divorced ☐ Civil Union (eligibility of DP/Civil Union is determined by State Law) ☐
Domestic Partner ☐

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

INSURANCE REQUESTED (Refer to the factsheet for eligibility, options & coverage description)

I hereby apply for $250,000 of association-group Traditional Term Life Insurance.

CONTACT INFORMATION

Best place for a service provider to contact you on behalf of New York Life for medical history:

Contact Number : (_____)_____–_____ Residence ☐ Business ☐ Cell ☐

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: _____

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) ☐

BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to new insurance issued on the basis of this application for association-group Traditional Term Life Insurance (policy G7200). 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 # DOB

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

FOR ADMINISTRATIVE USE ONLY:

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 ☐

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

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/our] protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated below, 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.)

GMA-ACEN ENCLOSE NO MONEY AT THIS TIME. YOU WILL BE BILLED ONCE YOUR APPLICATION HAS BEEN APPROVED. G7200

FOR ADMINISTRATIVE USE ONLY: