APPLICATION
for Group Pure Term Life Insurance featuring QuickDecision℠

SPONSORED BY THE AMERICAN MEDICAL ASSOCIATION

Please complete all information. Applicants must be under 45 years of age. You must indicate your choices regarding questions 1, 2, 3, 4 and 5 under Coverage Options or your application cannot be processed.

Request for Group Insurance from:

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

Questions?
Call 1-800-458-5736
(8am - 5pm, CT, Mon - Fri)

WEB10NY**

Proposed Insured Information

Name _____
(First) (Middle) (Last)

Home Address _____

City _____ State _____ Zip _____

Email Address _____

Date of Birth _____ Social Security No. _____ Gender _____

Home Phone _____ Office Phone _____ *Cell Phone _____

*Please see the Telephone Consumer Protection Act consent above the signature line.

Proposed Insured is a: ☐ **Physician** ☐ **Resident** ☐ **Student** ☐ **Spouse/Domestic Partner of Physician/Student**

Name of Physician/Student whose spouse/domestic partner is applying for coverage: _____

Name and address of Applicant's Personal Physician: _____

In the next 12 months, do you intend to reside outside the U.S.? ☐ **Yes** ☐ **No** Country: _____ How Long: _____

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 or for applicants who previously transferred ownership and are requesting an increase in coverage, complete this section.

Owner's Name _____ Relationship _____ Date of Birth _____

Address _____

City _____ State _____ Zip _____

Social Security No. _____ Tax ID _____ Daytime Phone _____

Coverage Options (Refer to the plan description for more infomation on eligibility, options and coverage description.)

1. Amount of Term Life coverage desired: ☐ **$250,000** ☐ **$500,000** ☐ **$1 Million**
   Benefits from $100,000 to maximum $1 million (in increments of $1,000.) ☐ **Other** _____

2. Do you wish to elect Waiver of Premium Option? ☐ **Yes** ☐ **No** (If left unanswered, rider will automatically be "No.")

3. Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? ☐ **Yes** ☐ **No**
   If "Yes," please state when you last used tobacco or nicotine products and specify the product used.
   Product: _____ Last Used: _____/_____
   Month Year

4. Beneficiary Designation
   I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. 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.

   Primary Beneficiary(ies)
   Full Name _____ **Relationship** _____ **% of Benefits** _____
   Address _____ **City** _____ **State** _____ **Zip** _____

   Contingent Beneficiary(ies)
   Full Name _____ **Relationship** _____ **% of Benefits** _____
   Address _____ **City** _____ **State** _____ **Zip** _____

5. How do you wish to be billed? ☐ **Annually** ☐ **Semi-Annually**
   If billing choice is not made, you will automatically be billed Semi-Annually. Monthly EFT payment option offered with first bill.

Insurance Replacement Information

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 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? ☐ **Yes** ☐ **No**

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

ALL RESIDENTS: Do you have other life insurance in force? If "Yes," please indicate the total amount due, with all companies below: (If none, check "None.") ☐ **None**

Name of Company	Type of Coverage	Amount	Year Issued	Do you plan to replace this coverage? Yes/No

Authorization and Signature

I request the group insurance shown on page 1 of this application. To the best of my knowledge and belief: (a) I am eligible for such insurance; (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 also understand that the coverage afforded will be in consideration of the answers and statement set forth above, and on any supplemental forms, and that any material 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.

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 may be used 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 applicant **requests** the insurance indicated; and the applicant and any person proposed for insurance **consents** 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 **attests** to having read the IMPORTANT NOTICE (enclosed) and Fraud Notices on the following page, 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.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL.

* ***Telephone Consumer Protection Act Consent:*** By providing a Cell Phone number (on page 1), I consent to receive phone calls and/or texts to that number from the Company or its authorized representative, regarding my application for coverage, service regarding my coverage or the Company's products or services. I understand these calls may be generated using automated technology. I understand that consent is not required to make a purchase.

Signature _____ **Date** _____

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

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A blood test and urinalysis may be required in order to process your application.
A national paramedical service (such as ExamOne) will contact you directly to make arrangements.
No insurance agent or broker will call.

SEND NO MONEY NOW! We'll send you a premium notice upon approval.
Just complete, sign and mail the application to:
AMA Insurance Agency, Inc., 330 North Wabash Avenue Suite 39300, Chicago, IL 60611

Fraud Notices (PLEASE READ BEFORE SIGNING THE APPLICATION FOR INSURANCE)

FRAUD NOTICE – For Residents of all states except those listed below and NEW YORK: 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: 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 a person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bear the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 applicant.

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 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 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 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 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. 1/13 ed.