Endorsed by American Association of Orthodontists

Insurance

Request for Group Insurance From:

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

Plan Administrator:

PEARL® INSURANCE
1200 E. Glen Ave., Peoria Heights, IL 61616
Questions: Please call 800.622.0344

Please complete the information below and return to: AAO-Endorsed Insurance Program Administrator, 1200 E. Glen Ave., Peoria Heights, IL 61616
Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

AMERICAN ASSOCIATION OF ORTHODONTISTS-ENDORSED GROUP TERM LIFE INSURANCE APPLICATION WITH CHRONIC ILLNESS RIDER

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. PLEASE COMPLETE THE INFORMATION BELOW AND RETURN TO THE PLAN ADMINISTRATOR

Name		S.S. #
Street Address		
City	State (or Province)	ZIP
Home Phone	Work Phone	Fax
Home Email		For internal use only. Email address will never be sold or shared.

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* ◯ Domestic Partner* Maiden Name: _____

Date of Birth	Height	Weight	Sex
/ /	ft. in.	lbs.	◯ M ◯ F

Upon receipt of your application, New York Life will provide a Declaration of Domestic Partnership Form that must be completed and returned — Not Applicable in Oregon.
(*Eligibility is determined by State Law.)

I am a Member of AAO. Membership # _____
(Membership is required for participation in this plan.)
Date you became a Member: _____ Annual Earned Income: $ _____
Are you a student? ◯ Yes ◯ No Orthodontic Program _____ Year Graduated _____
Are you presently insured by any AAO-Endorsed Plan? ◯ Yes ◯ No
If "Yes," indicate which plan(s) and provide details _____

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member: ◯ Yes ◯ No	Country(ies):	How Long?
Spouse: ◯ Yes ◯ No	Country(ies):	How Long?

2. DEPENDENT INFORMATION (See plan information for definition of eligible dependents)

If dependent coverage is requested, list eligible dependents (i.e., lawful spouse and unmarried, dependent children under 25). Attach separate sheet to provide additional dependent information.

Dependent Full Name (i.e., Mary J. Doe)	Social Security #	Date of Birth	Height	Weight	Sex
Spouse		/ /	ft. in.	lbs.	◯ M ◯ F
Child		/ /	ft. in.	lbs.	◯ M ◯ F
Child		/ /	ft. in.	lbs.	◯ M ◯ F
Child		/ /	ft. in.	lbs.	◯ M ◯ F

3. INSURANCE REQUESTED (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): ◯ New ◯ Addition
NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage, instead, indicate the TOTAL AMOUNT of coverage you are requesting.

GROUP LIFE INSURANCE: ◯ Term Life

a) Total Member Amount Desired: $ _____ (from $100,000 to $3,000,000 in units of $10,000)
(Please review the brochure/website or contact the plan administrator for complete details.)

b) Total Spouse Amount Desired: $ _____ (from $100,000 to $1,500,000 in units of $10,000)
NOTE: Spouse coverage cannot exceed member coverage.

G-14242-0

Be sure to complete all pages and sign page 5.
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

3. INSURANCE REQUESTED (Refer to the brochure for eligibility, options and coverage description) *(continued)*

c) Total Child Amount Desired: ◯ $5,000 each insured child ($500 from 15 days to under 6 months)
◯ $10,000 each insured child ($500 from 15 days to under 6 months)

d) Tobacco/Nicotine Use: Have you or your spouse (if applying for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? Member: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

If "Yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: (Mo/Yr)	Product
Spouse: (Mo/Yr)	Product

e) 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.

INSURANCE QUESTION: 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: ◯ Yes ◯ No Spouse: ◯ Yes ◯ No

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

ALL RESIDENTS: Do you have other life insurance in force? If "Yes," please indicate the total amount due, with all companies:

Member $ _____ Co. _____ Spouse $ _____ Co. _____

Do you have other insurance applications pending? If "Yes," indicate amount and company:

Member $ _____ Co. _____ Spouse $ _____ Co. _____

CHRONIC ILLNESS RIDER FOR GROUP TERM LIFE INSURANCE (Indicate amount of Life Insurance that will be subject to this Chronic Illness Rider). The chronic illness rider cannot be purchased as a stand-alone product.

a) Total Member Amount Desired: $ _____ (from $50,000 to $1,000,000 in units of $50,000)
(Please review the brochure/website or contact the plan administrator for complete details.)

b) Total Spouse Amount Desired: $ _____ (from $25,000 to $1,000,000 in units of $25,000)
(Spouse coverage cannot exceed member coverage.)

NOTE: The amount selected for chronic illness cannot exceed your Group Term Life face amount. The maximum amount payable for chronic illness is equal to 50% of the Group Term Life Insurance amount you indicate above. For example, if you elect $400,000 for the rider, the maximum benefit payable after the 4th installment may not exceed $200,000.

4. BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to the new insurance certificate issued on the basis of this application for Group Term Life Insurance. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) If you wish to change the beneficiary named for any other Term Life Insurance Certificate, please contact the plan administrator for the appropriate form. 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** ◯ **Secondary** **% of Benefits** _____

Beneficiary Name (Last, First, Middle Initial)

Street Address

City	State (or Province)	ZIP
S.S. #	Relationship	Date of Birth

◯ **Primary** ◯ **Secondary** **% of Benefits** _____

Beneficiary Name (Last, First, Middle Initial)

Street Address

City	State (or Province)	ZIP
S.S. #	Relationship	Date of Birth

If necessary, attach separate signed and dated sheet to provide additional beneficiary information.

G-14242-0

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5. PAYMENT OPTION SECTION (Send no money now – we'll bill you later)

OPTION 1: Electronic Funds Transfer ◯ Monthly ◯ Quarterly ◯ Semi-Annual ◯ Annual

Authorization for Electronic Funds Transfer

I request and authorize Pearl Insurance to make withdrawals based on my selected payment method above against the account specified on the attached voided check or savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. **In order to process your electronic payment, both the Account # and Bank Routing # must appear on the voided check or deposit slip.** I understand that by completing the required information regarding my enrollment I am authorizing automatic deductions/charges for the insurance premium from my account, including any increases in premium due to age.

The premium, based on the plan I selected, will be deducted from or charged to my account as indicated above unless I call the plan administrator to cancel. I understand that I must contact the plan administrator if I wish to cancel these automatic deductions/charges or if I wish to cancel my insurance coverage.

I also understand that my authorization for the deduction is not part of my certificate of insurance, nor does it modify any terms or conditions contained therein. The insurance company is not liable if the financial institution dishonors any amount deducted/charged and may terminate my insurance coverage at the end of the 31 day grace period, effective as of the Due Date if premium for my insurance is not paid. Payment of the initial premium is one of the conditions required in order for my coverage to be placed in effect. I understand that if the deduction/charge is declined for any reason, my coverage will not take effect.

X _____ _____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED / WITHDRAWALS MADE AGAINST THIS ACCOUNT | DATE

OPTION 2: Direct Bill ◯ Quarterly ◯ Semi-Annual ◯ Annual

6. STATEMENT OF HEALTH (Please initial any changes you make on this form)

To the best of your knowledge or belief, answer the following questions as they apply to you and all dependents to be insured:

1. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? ❍ YES ❍ NO
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ❍ YES ❍ NO
3. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease, or injury? ❍ YES ❍ NO
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ❍ YES ❍ NO
5. Is any person to be insured now pregnant? ❍ YES ❍ NO
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:
   a. Heart or circulatory trouble, elevated blood pressure, pain, or pressure in chest? ❍ YES ❍ NO
   b. Arthritis, back trouble, bone or joint disorder? ❍ YES ❍ NO
   c. Fainting spells, convulsions, or epilepsy? ❍ YES ❍ NO
   d. Sugar, blood, albumin, or pus in urine? ❍ YES ❍ NO
   e. Diabetes, kidney trouble, ulcers, or digestive disorder? ❍ YES ❍ NO
   f. Disorder of breast or reproductive organs or functions? ❍ YES ❍ NO
   g. Nervous or mental disorder, emotional condition, or psychiatric care? ❍ YES ❍ NO
   h. Cancer, tumor, or cyst? ❍ YES ❍ NO
   i. Varicose veins, hemorrhoids, or hernia? ❍ YES ❍ NO
   j. Disorder of eyes, ears, nose, or sinuses? ❍ YES ❍ NO
   k. Thyroid, liver, or respiratory disorder? ❍ YES ❍ NO
   l. Alcoholism or drug habit? ❍ YES ❍ NO
   m. Disorder of the blood? ❍ YES ❍ NO
   n. Other health or physical impairment including:
      (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Conditions (ARC)? ❍ YES ❍ NO
      (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years? ❍ YES ❍ NO
      (iii) Any other impairment? ❍ YES ❍ NO
7. Has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular, or mental illness? ❍ YES ❍ NO
   NOTE: Genetic Family History is not applicable to Maryland residents.
8. Within the past two years have you or your spouse participated in, or do either of you plan within the next two years to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of organized motorized racing? ❍ YES ❍ NO
9. Has your or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years? ❍ YES ❍ NO

Member Driver's License No.	State/Province in which issued:
Spouse Driver's License No.	State/Province in which issued:

10. **Except for residents of Minnesota and Connecticut,** in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ❍ YES ❍ NO
    For residents of Minnesota and Connecticut, in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? ❍ YES ❍ NO

G-14242-0

Be sure to complete all pages and sign page 5.

DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

6. STATEMENT OF HEALTH (Please initial any changes you make on this form) *(continued)*

If you have answered **"Yes"** to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

Name(s) of Proposed Insured:	Illness or Condition-Date of Onset-Duration-Treatment Operations-Degree of Recovery and Date:	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated:

Complete only if you selected the Chronic Illness Rider:

To the best of your knowledge or belief, answer the following questions as they apply to you and all dependents to be insured:

1. Do you currently need or in the past five years have you needed human assistance or supervision to perform any of the following activities?
   Bathing, dressing, eating, walking, moving in/out of a bed or chair or wheelchair, toileting, bowel or bladder control (if "Yes," please circle all that apply). . . . . ❍ YES ❍ NO
2. Within the past five years, have you been bed-ridden at your home or any other private residence for two weeks or more? . . . . . ❍ YES ❍ NO
3. Within the past five years, have you had a fall or been diagnosed or treated by a member of the medical profession for a fracture, paralysis, numbness, balance problems or skin ulcers? . . . . . ❍ YES ❍ NO
4. Within the past five years, did you lose any part of your fingers, hands, feet or limbs due to amputation, accident, disease, or deformity; or been diagnosed or treated by a member of the medical profession for any conditions causing crippling or limited motion? . . . . . ❍ YES ❍ NO
5. Are you now, or have you been in the past five years, in a wheelchair or dependent on required supportive equipment such as braces, crutches, walker, cane, back support, or splint? . . . . . ❍ YES ❍ NO
6. Within the past six months, have you had or been recommended by a member of the medical profession to have physical therapy? . . . . . ❍ YES ❍ NO
7. Within the past five years, have you been evaluated, counseled, treated by a member of the medical profession or hospitalized for any problems with memory or ability to think or reason? . . . . . ❍ YES ❍ NO
8. Within the past five years, have you been confined or has confinement been recommended by a member of the medical profession, to a hospital, nursing home, rehabilitation facility or extended care facility? . . . . . ❍ YES ❍ NO
9. Have you received Medicaid benefits or any similar federal or state financial assistance within the past five years? . . . . . ❍ YES ❍ NO
   NOTE: Medicaid is not the same as Medicare.
10. Have you received Medicare disability benefits within the past five years? . . . . . ❍ YES ❍ NO
11. In what type of dwelling do you reside?
    Private Home, Apartment, Retirement Home, Congregate Care Community, Nursing Care Facility, Mobile Home, Continuing Care/Care Community, Retirement Community, Assisted Living Unit, Personal Care Home or an Adult Care Home, Other *(Please specify)*
    Member
    Spouse
12. Within the past five years, have you been declined for issue, reinstatement or renewal of any type of long-term care insurance? . . . . . ❍ YES ❍ NO

If you have answered **"Yes"** to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

Name(s) of Proposed Insured:	Illness or Condition-Date of Onset-Duration-Treatment Operations-Degree of Recovery and Date:	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated:

DISCLOSURE: The Chronic Illness Rider is not intended to be federally tax-qualified long-term care insurance under Section 7702B of the Internal Revenue Code (IRC), as amended. Therefore, the premiums payable for the Chronic Illness Rider are not deductible from gross income for federal income tax purposes. The benefits provided by the Chronic Illness Rider are intended to be excludable from federal gross income under Section 101(g) of the IRC.

G-14242-0

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7. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY

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/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Member Signature X	Date

PLEASE SIGN AND DATE IN INK

Spouse Signature X	Date

Necessary only if Spouse Coverage is requested.

8. FRAUD NOTICES (Please read before signing the application form)

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 person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar 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 PUERTO RICO:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years. **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.

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G-14242-0

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9. IMPORTANT NOTICE

How New York Life obtains information and underwrites your request for AAO-Endorsed Group Term Life Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing, however, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator 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.

If we cannot provide the coverage you requested, 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. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

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 is determined by New York Life.

For NM Residents: PROTECTED PERSONS[1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION 2 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

[1] PROTECTED PERSONS 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.

[2] CONFIDENTIAL 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.

New York Life Insurance Company 7.15 ed.

Please complete the application and return it to:*

AAO-Endorsed Insurance Program Administrator,
PO Box 3930, Peoria, IL 61612-9806

Don't let an unanswered question delay your enrollment.

Call toll free: **1.800.622.0344** or visit **aao-insurance.com/TLCIR**

*Residents of Puerto Rico: please send your completed application to Global Insurance Agency, Inc., P.O. Box 9023918, San Juan, PR 00902-3918

G-14242-0

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