

Request For Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010		Group Policy G-13776/G-13777		CERTIFICATE NO.	
MEMBER'S FULL NAME		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET-NAME & NO.		MARITAL STATUS		PLACE OF BIRTH	
CITY	STATE (OR PROVINCE)	ZIP CODE	OFFICE PHONE		
FAX NUMBER	E-MAIL ADDRESS		HOME PHONE		

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS (i.e. lawful spouse and unmarried, dependent children under age 25):

SPOUSE'S NAME		DATE OF BIRTH	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.	WEIGHT LBS.									
Child (Name)	Date of Birth	Ht.	Wt.	M/F	Child (Name)	Date of Birth	Ht.	Wt.	M/F	Child (Name)	Date of Birth	Ht.	Wt.	M/F

MEMBERSHIP AFFILIATION — OCCUPATIONAL STATUS:

a. Are you now a member of the Appraisal Institute? Yes No Membership # _____

b. What is your occupation? _____ c. Annual earned income \$ _____

BENEFICIARY DESIGNATION: (Complete this section only if applying for Life Insurance)
I hereby 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. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy.

BENEFICIARY'S NAME	BENEFICIARY'S RELATIONSHIP TO MEMBER	SOCIAL SECURITY #
BENEFICIARY'S STREET ADDRESS	CITY	STATE ZIP CODE

I HEREBY APPLY FOR THE COVERAGES CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:

Long Term Disability Income (From \$500 to \$5,000 per month in \$100 increments.) **MONTHLY AMOUNT** \$ _____

Check Plan desired below:

Plan I Benefits begin on 31st day of disability for either accident or sickness. Future Purchase Option (FPO)
(From \$500 to \$2,000 per month in \$100 units.)

Plan II Benefits begin on 91st day of disability for either accident or sickness. **FUTURE PURCHASE OPTION AMOUNT** \$ _____

Short Term Disability Income (From \$300 to \$2,000 per month in \$100 increments.) **MONTHLY AMOUNT** \$ _____

Benefits begin on 31st day of disability for either accident or sickness

10-Year Level Term Life Insurance

Member Amount (from \$100,000 to \$500,000 in \$10,000 increments) \$ _____

Spouse Amount (from \$100,000 to \$500,000 in \$10,000 increments, not to exceed member coverage.) \$ _____

Child(ren) Amount \$5,000 for each child (\$500 from 15 days old to 6 months)

\$10,000 for each child (\$500 from 15 days old to 6 months)

Please answer the following questions.
Have you smoked or used tobacco or nicotine in any form in the last 12 months? Yes No
Has your spouse smoked or used tobacco or nicotine in any form in the last 12 months? Yes No

Residents of New York: I have read the Important Replacement Information on the reverse side of this application.
Is the life insurance applied for intended to replace in whole or in part, any existing life insurance or annuity? Yes No

Residents of all other states: Is the insurance applied for intended to replace, discontinue or change (does not include increases to existing coverage) an existing policy? Yes No

For current REAGIT Group Term Life Insureds, please mark the correct box:
 I intend to cancel my in-force REAGIT Term Life insurance (Group Policy G-13776) upon approval of this application, and replace it with the 10-Year Level Term Life coverage that I am applying for on this application.
 I intend to keep my in-force REAGIT Term Life insurance (Group Policy G-13776) and add separately the new 10-Year Level Term Life coverage that I am applying for on this application.
(Note: the maximum available under all REAGIT insurance plans is \$500,000)

Professional Overhead Expense (From \$500 to \$10,000 in \$100 increments.) **MONTHLY AMOUNT** \$ _____

1. Average monthly amount of "Eligible Overhead Expenses" in preceding 6 months? \$ _____

2. Practicing as: Corporation Partnership Individual

3. Average number of employees _____

4. If corporation or partnership, for what percent of the monthly "Eligible Expenses" are you responsible? _____ %

Group Health Plans

Coverage desired for: Member Spouse Child(ren)

\$2,000 Individual Deductible HSA-Qualified PPO Plan \$4,000 Family Deductible HSA-Qualified PPO Plan

\$3,000 Individual Deductible HSA-Qualified PPO Plan \$6,000 Family Deductible HSA-Qualified PPO Plan

\$5,000 Individual Deductible HSA-Qualified PPO Plan \$10,000 Family Deductible HSA-Qualified PPO Plan

Is this coverage meant to replace any medical care insurance which was in force for at least 18 months (without a break in coverage of more than 63 days) on yourself or any other person to be insured? Yes No

If yes, please attach a copy of the certificate of creditable coverage from the prior insurance plan.

PLEASE BILL ME: Quarterly (a \$1.00 service fee will be added for quarterly billing) Semi-Annually (no service fee)

Send no money with this application. Be sure to complete and sign the reverse side.

Form GPA-AC-1 as amended by GMA-5-NYFR
G-13776/G-13777 (NC)

AGENT'S NAME _____ **AGENT'S NUMBER** _____

ANSWER THE FOLLOWING QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED:

	Yes	No		Yes	No
1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 30 or more hours per week at your usual place of business?	<input type="checkbox"/>	<input type="checkbox"/>	h. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have in force or are you applying for any other disability income insurance? If so, indicate companies, type and amounts below: Company _____ Benefit Amount _____	<input type="checkbox"/>	<input type="checkbox"/>	i. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
			j. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you or any other person to be insured receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>	k. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			l. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
4. Are you or any other person to be insured now ill, receiving or contemplating medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	m. Disorder of the blood? <i>"disorder of the blood" includes all conditions of the blood presently recognized as disorders, both primary disorders of the blood (e.g. anemia, polycythemia, leukopenia, leukocytosis, clotting disorders, platelet disorders, immune disorders whether congenital or acquired, disorders of gammaglobulin) and disorders that reflect other disease processes (e.g. infections, malignancies, sources of blood loss, biliary tract disease).</i>	<input type="checkbox"/>	<input type="checkbox"/>
			5. During the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>	(ii) Any other disorder of the immune system? <i>"disorder of the immune system" includes hyperimmune conditions, disorders of gammaglobulin synthesis (hypogammaglobulinemia), of white blood cell production and maturation, the immune-deficiency disorders, both congenital and acquired. Also included are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others.</i>	<input type="checkbox"/>	<input type="checkbox"/>
7. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years?	<input type="checkbox"/>	<input type="checkbox"/>
8. In the last five years, has any person to be insured ever had: a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>	(iv) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
			b. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
c. Fainting spells, convulsions, or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>			
d. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>			
e. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
f. Disorder of breasts or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>			
g. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>			

9. If you have answered Question 1 "No," or any of the other Questions "Yes," 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 Practitioners and Hospitals where confined or treated:
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NOTICE TO CALIFORNIA RESIDENTS: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.

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 has the right to require additional information and, if necessary, an examination by a physician, and that Disability Income and/or Professional Overhead Expense insurance may be subject to any impairment restriction(s) established by New York Life. 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 and that any mis-statements 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) medical insurance will become effective on the first of the month following 30 days after the date of receipt of the application by the REAGIT Insurance Office and (b) all other insurance will become effective on the first day of the month following the day coverage is approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age and sex on the date insurance is effective. I also understand that except for major medical coverage: (a) any person who was not performing his or her normal activities on the day insurance would otherwise become effective, will not become insured until the date he or 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, and (b) any dividend apportioned to the group policy will be paid to the Trustee of the insurance plan.

For Group Health Insurance: I also understand that in the event I cannot provide evidence that I, or if applicable, my dependent(s) had 18 months of creditable medical coverage (with no break in coverage of more than 63 days), that benefits will not be paid for up to 12 months after the effective date of coverage for losses due to a disease or condition which I or my dependent(s) now have or have had whether physical or mental, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended or received within the six months immediately preceding the effective date of this coverage.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release the information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical 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 may release information covered by this AUTHORIZATION to the plan administrator, MIB, or other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by the AUTHORIZATION to others whom I authorize in writing. 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 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. My 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 this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that if I am requesting medical coverage I or my authorized agent will receive a copy of this signed AUTHORIZATION, and that in all circumstances, I or my authorized agent will request a copy of this AUTHORIZATION.

Fraud Warning Statement NY Residents: 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Member's Signature X _____ Date _____
(Please sign in ink)

To the best of my knowledge and belief the statements made regarding my health are true and complete.

Spouse's Signature X _____ Date _____
(Necessary only if spouse coverage is requested)

Signature of Owner X _____ Date _____
(Necessary only if member previously transferred ownership of his or her group life insurance)

Form GPA-AC-1 as amended by GMA-5-NYFR
G-13776/G-13777 (NC)

03-1361

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 AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH & 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. **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 application.

For NY Residents Only — 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 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.

BEFORE YOU MAIL THIS APPLICATION, It will greatly speed action on your application if you will review it carefully. Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strike-outs, these must be initialed by the member. Once completed and dated, this should be submitted at once to the REAGIT Group Insurance Office at the address below.

REAGIT Group Insurance Office • 300 S. Wacker Drive • Suite 700 • Chicago, Illinois 60606 • Phone: 1-800-222-9958