



**Appraisal
Institute®**

*Professionals Providing
Real Estate Solutions*



Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

Residents of Puerto Rico,
please return application to:
Global Insurance Agency
P.O. Box 9023918
San Juan, Puerto Rico 00902-3918

To Apply: Please complete this form and return to:

REAGIT Group Insurance Program Administrator, 1200 E Glen Ave, Peoria Heights, IL 61616-5348

Questions: Please call 1.800.222.9958

REAGIT GROUP INSURANCE PROGRAM
GROUP DISABILITY INCOME APPLICATION

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

1. Member Information:

Full Name _____
Last First Middle Initial

Street Address _____

City _____ State (or Province) _____ Zip Code [][][][][][]-[][][][][]

Please check one: Home Address Business Address Social Security #: [][][][]-[][][]-[][][][][]

Home Phone (_____) _____ Work Phone (_____) _____

Fax (_____) _____ Email _____
For internal use only. Email address will never be sold or shared.

Marital Status: Married Divorced Single Widowed

Birth Date: ____/____/____ Height: ____ Ft. In. Weight: ____ LBS Sex: M F
MO./ DAY / YR.

In the next 12 months do you intend to reside outside the U.S. or Canada?
 Yes No Country(ies) _____ If "Yes," for how long? _____

2. Membership Affiliation—Occupational Status:

a. Are you now a member of the Appraisal Institute? Yes No (Association Membership is required for participation in this plan.)
Appraisal Institute Membership # _____ Exp. Date: _____

b. What is your occupation? _____ Main Duties _____

c. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties normally are performed, or other location to which travel is required. Are you at "FULL-TIME WORK"? Yes No

d. Gross Annual Income from:
Salary \$ _____ Self-Employment \$ _____ (Self-Employment Start Date ____/____/____)
Bonus \$ _____ Commissions \$ _____ **Total \$** _____

Your gross annual earned income must be at least \$20,000 for you to be eligible for this coverage.

3. Insurance Requested—Insurance Status: Refer to brochure for eligibility, options, and coverage description.

I hereby apply for the coverage: **New** **Additional** (Group Disability Plan is not available to residents of TN, VT, or WA.)

Note: If you are increasing or altering present coverage in any way, do NOT indicate in "Item A" below only the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

Long-Term Disability: You may choose any Monthly Benefit Option from \$500 to \$5,000 (in \$100 units) provided it and other disability income coverage you may have does not exceed 60% of your MONTHLY GROSS EARNED INCOME (as defined in the brochure).

Short-Term Disability: You may choose any Monthly Benefit Option from \$300 to \$2,000 (in \$100 units) provided it and other disability income coverage you may have does not exceed 70% of your MONTHLY GROSS EARNED INCOME (as defined in the brochure).

I hereby apply for the coverage indicated below, based upon all my statements made in this Application:

- A. Member Monthly Benefit Option:** \$ _____
- B. Member Disability Plan:** Long-Term (30-day waiting period) Long-Term (90-day waiting period) Short-Term
- C. Future Purchase Option (Available only if Long-Term Plan is selected and you are under age 50):**
Amount Desired \$ _____ Not to exceed monthly Disability Benefit Amount

Do you now have or are you applying for other insurance which provides benefits if you are unable to work because of disability?

Yes No If "Yes," please list:

Company:	Plan:	Monthly Benefit:	Benefit Period:

Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? Yes No (If "Yes," please indicate which coverage and the date it will be terminated: _____)

4. Payment Option Selection: Choose only one.

- Option 1: Direct Billing** (Choose one): Annually (January 1) Semiannually (January 1 and July 1)
 Quarterly (January 1, April 1, July 1, and October 1)
- Option 2: Electronic Funds Transfer:** I request and authorize the REAGIT Group Insurance Program to make monthly quarterly semiannual annual withdrawals against the account specified on the attached voided check, statement 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 Group Disability Income Plan (Enclose a VOIDED check or deposit slip, as applicable).

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

- Option 3: Credit Card:** I authorize premium contributions to be charged to my credit card monthly quarterly semiannually annually: Credit Card # _____ Exp. Date _____
 MasterCard Visa Discover American Express

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

5. Statement of Health: Please initial any changes you make on this form.

To the best of your knowledge and belief, please answer the following questions as they apply to you (if proposed for insurance):
[California residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.]

- | | | |
|--|--------------------------|--------------------------|
| | YES | NO |
| 1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for: | | |
| a) Heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury? | <input type="checkbox"/> | <input type="checkbox"/> |

continued...

5. Statement of Health continued: Please initial any changes you make on this form.

- | | |
|--|---|
| | YES NO |
| b) Other health or physical impairment including: | |
| (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> <input type="checkbox"/> |
| (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? | <input type="checkbox"/> <input type="checkbox"/> |
| (iii) Any other impairment? | <input type="checkbox"/> <input type="checkbox"/> |
| 3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? | <input type="checkbox"/> <input type="checkbox"/> |
| 4. Are you now pregnant? | <input type="checkbox"/> <input type="checkbox"/> |
| 5. Are you now disabled, or have you applied or are you applying for, or receiving any disability or Workers' Compensation benefits, or on waiver of premium for life or health insurance? | <input type="checkbox"/> <input type="checkbox"/> |
| 6. During the past two years, have you participated in, or plan to participate in: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing? | <input type="checkbox"/> <input type="checkbox"/> |
| 7. Driver's License No: _____ State Issued: _____ | |
| 8. During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations? | <input type="checkbox"/> <input type="checkbox"/> |
| 9. Except for Residents of Minnesota and Connecticut , has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending? | <input type="checkbox"/> <input type="checkbox"/> |
| 10. For residents of Minnesota and Connecticut only , has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years? | <input type="checkbox"/> <input type="checkbox"/> |

11. If you have answered any of the above Questions 1–10 "Yes," give complete details below. (If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various," or "miscellaneous.")

Question Letter/No.	Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and Address of Physicians or other Practitioners and Hospitals where confined or treated:

6. Fraud Notices

FRAUD NOTICE – For Residents of all states except those listed below: 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 AR/LA/MD/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.

FOR 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 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 NY: any person who knowingly and with intent to defraud any insurance company or any 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

7. Authorization and Signature

I understand that New York Life 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 authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. 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 subsidiaries, or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings and treatment but excluding psychotherapy notes.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of the AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, I request the insurance indicated, consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how 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.

Member's Signature **X** _____ Date **X** _____
(PLEASE SIGN AND DATE IN INK)

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

PART IV Your Signature(s)

G-13776-2

Be Sure To Complete All Pages and Sign Last Page

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GPA-DI-FMU

*Do Not Send Payment: Upon approval,
you will be notified of the premium due.*

10/09 ed. 10/09

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