



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 HOSPITAL INDEMNITY 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 _____ SS # [][]-[][]-[][][][]
First Middle Initial Last

Street Address _____

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

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

Fax (_____) _____ Email _____

For internal use only. Email address will never be sold or shared.

Marital Status: Married Divorced Single Widowed

Date of Birth: _____ Sex: _____
MO./ DAY / YR.S

Member: _____ / / M F

Spouse*: _____ / / M F
Name if proposed for insurance (First/MI/Last)

Child*: _____ / / M F
Name if proposed for insurance (First/MI/Last)

Child*: _____ / / M F
Name if proposed for insurance (First/MI/Last)

*See Plan Information/Plan Details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please **sign and date** the additional sheet.

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) _____

Spouse: Yes No Country(ies) _____

2. Membership Affiliation:

Membership in Appraisal Institute is required for participation in this plan. Appraisal Institute Membership #: _____

3. Payment Option Selection: Choose only one.

Option 1: Direct Billing: Following your initial billing, you will be billed twice a year on April 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 Hospital Indemnity 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. Da _____
 MasterCard
 Visa Discover
 American Express

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

4. Insurance Requested: Refer to plan information for eligibility, options, and coverage description.

I HEREBY APPLY FOR THE FOLLOWING COVERAGES: New Additional 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.

The daily benefit selected is:

For Myself: _____ (\$10-\$100 in units of \$10)

For Dependent Children: _____ (\$10-\$100 in units of \$10)

For Spouse*: _____ (\$10-\$100 in units of \$10)

*Spouse amount cannot exceed member amount.

(coverage section continues on next page)

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Be Sure To Complete All Pages and Sign Last Page

PART I Personal Info

PART II Your Coverage

4. Insurance Requested continued: Refer to plan information for eligibility, options, and coverage description.

Other Coverage:

- a) Are you presently insured by any other Hospital Indemnity Plan? Member: [] Yes [] No Spouse: [] Yes [] No
b) If "Yes," do you intend to discontinue or change this other Plan? Member: [] Yes [] No Spouse: [] Yes [] No

If "Yes," complete below:

Member: Insurance Company Name, Policy #, & Benefit Amount: _____
Coverage Status: [] to be discontinued [] to be changed; please indicate New Daily Benefit Amount: \$ _____

Spouse: Insurance Company Name, Policy #, & Benefit Amount: _____
Coverage Status: [] to be discontinued [] to be changed; please indicate New Daily Benefit Amount: \$ _____

Coordination of Benefits (COB) applies to this plan when a covered person has hospital indemnity benefits under another plan which exceed \$100 per day. COB limits the total benefits payable by all plans to the amount of the allowable expense actually incurred during each day of Hospital Confinement.

5. 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.

6. 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)

Spouse's Signature X _____ Date X _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

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Be Sure To Complete All Pages and Sign This Page

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

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.