Information Request For AFA Member:

Here's the AFA Group Decreasing Term Life Insurance Plan information you requested.

Dear AFA Member,

Thank you for requesting more information about the AFA Group Decreasing Term Life Insurance Plan. We're pleased to send the enclosed information for your review today.

Many of your fellow members and their spouses have already selected this plan for their family's needs. Here's why:

- Provides higher benefit amounts when you're younger, and provides decreases in benefit amounts as you age.
- All for an affordable monthly rate that does not increase with your age.
- Offers 4 flexible plan options:
  - Select ($30/month)
  - High Option Plus ($20/month)
  - High Option ($15/month)
  - Standard ($10/month)

For example, a 49-year-old AFA Member may choose the following coverage amounts for the monthly rate listed:

Select	**High Option Plus**	**High Option**	**Standard**
$30.00 for $90,000 protection	$20.00 for $60,000 protection	$15.00 for $45,000 protection	$10.00 for $30,000 protection

- Each plan pays its highest benefit amounts when your responsibilities may be the greatest, and provides lesser benefit amounts later in life when responsibilities decline.
- Coverage is complimentary from age 95 on. AFA will pay the premiums to the underwriter on your behalf.
- Waives your premium if you become disabled.

Please see the enclosed Benefits Summary for more details about these benefits and other features of the plan.

Then to apply, please complete and return the enclosed application. Send no money now. Once your application is approved, we will then send you a bill.

We look forward to your participation in this valuable AFA life benefit.

Sincerely,

Janeé Williams
Manager, Member Relations
Air Force Association

Timothy R. Weber, Partner
Mercer Health & Benefit Administration LLC
AFA Insurance Plans Administrator
License #17526255

(Over, please)

P.S. Get valuable and competitive protection for your family's needs today through the AFA Group Decreasing Term Life Insurance Plan. Complete and return the enclosed application right away!

Please refer to the enclosures for more information on features, costs, eligibility, renewability, limitations and exclusions.

Underwritten by: New York Life Insurance Company • 51 Madison Ave. • New York, NY 10010

AFADTLL

Group Decreasing Term Life Insurance Application

11127
074030010101

Negotiated For AFA Members And Their Families

AFA-sponsored Insurance Program Administrator
12421 Meredith Drive
Urbandale, IA 50398

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

To Apply:

Complete this form and return to:
AFA-sponsored Insurance Program Administrator
P.O. Box 14464
Des Moines, IA 50306-8993

Questions? 1-800-291-8480

Send No Money Now

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.
(Please make any necessary corrections to your full name and street address)

1 MEMBER INFORMATION

Name

Address

City State ZIP **SSN#**

Home Phone ( ) **Work Phone** ( )

Email (For internal use only for important announcements, time-sensitive bulletins or member notifications. Neither AFA nor the Plan Administrator will sell or rent your email address under any circumstances.)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union†

☐ Domestic Partner† (Call administrator for Declaration of Domestic Partnership form; complete and return with application. Not applicable in OR.)

†Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Are you presently insured under any Air Force Association Group Life Insurance Plans? ☐ Yes ☐ No

If "Yes," indicate which plan(s) and provide details (person insured and amount of insurance):

☐ Term Life ☐ Decreasing Term Life ☐ 10-Year Level Term Life

Details

Do you or your spouse (if proposed for insurance) intend to reside outside the United States within the next 12 months?

Member: ☐ Yes, Country For How Long? ☐ No

Spouse: ☐ Yes, Country For How Long? ☐ No

		DATE OF BIRTH	HEIGHT	WEIGHT	SEX
MEMBER		MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
SPOUSE*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
CHILD(REN)*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F

*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.

G-30291-0

Please complete all pages and sign on page 4

2 MEMBERSHIP AFFILIATION

Are you now a member of the Air Force Association and/or AFA Veteran Benefits Association?

☐ Yes ☐ No

Membership # _____

Expiration Date _____

(Membership in AFA/AFAVBA is required for participation in the plan. Affiliate members are not eligible.)

3 PAYMENT OPTION SELECTED

☐ **Electronic Funds Transfer (EFT):** I request and authorize the Administrator, AFA Member Group Insurance Program, to make ☐ monthly ☐ quarterly ☐ semiannual ☐ annual withdrawals against the account specified on the attached check 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 under this plan. (Enclose a VOIDED check.)

X _____ _____

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

☐ **Periodic Billing: Quarterly**

4 TOBACCO/NICOTINE USE

Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum or electronic cigarettes)?

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)

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES

a. Select

High Option Plus	☐ Member Only (P0_1)	☐ Family (P0_3)
High Option	☐ Member Only (H0_1)	☐ Family (H0_3)
Standard	☐ Member Only (T0_1)	☐ Family (T0_3)

Note: Member's age determines the coverage amount.

b. Increase Member Insurance Amount from $_____ to $_____

Increase Spouse Insurance Amount from $_____ to $_____

Spouse's benefit amount is based on the benefit amount you choose.

c. Do you have other life insurance in force? If "Yes," total amount in all companies:

Member $ _____ Spouse $ _____

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

Member $ _____ Company _____

Spouse $ _____ Company _____

d. Insurance Replacement

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 be 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?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

RESIDENTS OF ALL OTHER STATES

Is the insurance applied for intended to replace, discontinue or change an existing policy? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

6 BENEFICIARY DESIGNATION

Death benefit will be paid to current beneficiary on file or if no one is designated, benefits will default to beneficiary designations as indicated in the certificate.

7 STATEMENT OF HEALTH (Please initial and date any changes you make on this form.)

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

A. 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

B. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No

C. 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

D. 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

E. Is any person to be insured now pregnant? ☐ Yes ☐ No

F. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ☐ Yes ☐ No
2. Arthritis, back trouble, bone or joint disorder? ☐ Yes ☐ No
3. Fainting spells, convulsions or epilepsy? ☐ Yes ☐ No
4. Sugar, blood, albumin or pus in urine? ☐ Yes ☐ No
5. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ Yes ☐ No
6. Disorder of the breasts or reproductive organs or functions? ☐ Yes ☐ No
7. Nervous or mental disorder, emotional condition or psychiatric care? ☐ Yes ☐ No
8. Cancer, tumor or cyst? ☐ Yes ☐ No
9. Varicose veins, hemorrhoids or hernia? ☐ Yes ☐ No
10. Disorder of eyes, ears, nose or sinuses? ☐ Yes ☐ No
11. Thyroid, liver or respiratory disorder? ☐ Yes ☐ No
12. Alcoholism or drug habit? ☐ Yes ☐ No
13. Disorder of the blood? ☐ Yes ☐ No
14. Other health or physical impairment including:
    a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
    b. Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past five years? ☐ Yes ☐ No
    c. Any other impairment? ☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS, 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 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

8 AUTHORIZATION

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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or 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 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 our protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

MEMBER'S SIGNATURE X _____ **DATE** _____

(PLEASE SIGN AND DATE IN INK.)

SPOUSE'S SIGNATURE X _____ **DATE** _____

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED. PLEASE SIGN AND DATE IN INK.)

OWNER'S SIGNATURE X _____ **DATE** _____

(NECESSARY ONLY IF MEMBER PREVIOUSLY TRANSFERRED OWNERSHIP OR HIS/HER GROUP TERM LIFE INSURANCE.)

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.

FRAUD NOTICES

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.

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 MD: Any person who knowingly or willfully presents a false and 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.

IMPORTANT NOTICE:

How New York Life Obtains Information And Underwrites Your Request For The Group Decreasing Term Life Insurance Plan

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 application 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 (TTY 866 346-3642). Information for consumers about MIB may be obtained on its Web site at www.mib.com.

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 PERSON 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 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 family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8/12 ed.**

Group Decreasing Term Life

Underwritten by New York Life Insurance Company

About this Plan

Group Decreasing Term Life insurance is a type of term coverage in which the death benefit amount decreases as you age. This is typically because there is less need for higher coverage because, for example, children become more self-sufficient and/or your mortgage may be paid off.

Eligibility

All AFA Members under age 65 may request coverage for themselves, their lawful spouse under age 65 and all unmarried dependent children ages 15 days through 21 years (23 if full time student). In order to become insured, individuals must provide satisfactory evidence of insurability and the required premium must be paid.

A dependent who is also a member is eligible for either member or dependent coverage, but not both. If both the member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

Four plans to suit your needs

Depending on your age and your family's needs, you can choose between 4 plan options: Select ($30/month), High Option Plus ($20/month), High Option ($15/month), or Standard ($10/month). Each plan pays its highest benefits when your responsibilities may be the greatest. Note: premiums remain the same when the benefit amounts begin to reduce. You benefit from this arrangement in that your overall premiums are lower so that when you grow older and are on a fixed income, you will not be paying higher and higher premiums as with many other types of life insurance.

Premiums start at just $10 a month, for the Standard Plan option, and do not increase as you grow older. Imagine, at age 20-24, for as little as $10 a month you can have as much as $200,000 in life insurance protection to help your loved ones' futures in the event of your death. Plus your premiums are level; they do not increase as you grow older.

No war clause...no extra charge for flying status personnel

Here is a valuable feature you won't find in many other life insurance policies! In the interest of Veterans and their dependents, this AFA program has no limitation or restriction on the payment of benefits should the insured be killed in a war or act of war.

Likewise, there is no restriction on benefits or extra premium charged to personnel who are on flying status. AFA's plan provides full coverage for all Veterans...all the time...at the same cost!

AFA Pays Your Premiums from Age 95

Once issued, AFA's Group Decreasing Term Life Insurance is renewable to age 95. After age 95, a death benefit of $1,000 (and $1,000 for your Spouse if you had Family coverage at age 95) will be continued at no cost to you. AFA will pay your premiums to New York Life Insurance on your behalf.

No further premiums due if you become disabled

If, prior to your attainment of age 60, you become totally disabled and the disability lasts for at least 6 months while your coverage is in force, you may apply for the Disability Waiver of Contribution Benefit. Upon approval, your coverage will remain in force without further payment of premium on your part, for as long as you continue to be totally disabled and are otherwise eligible for coverage, at the lowest level of coverage. For additional details please see the certificate of insurance.

OTHER IMPORTANT INFORMATION

Convenient payment options

Premiums may be paid quarterly, semiannually or annually. Or you may prefer to pay monthly by government allotment, or automatic debit from your checking account. Many choose the latter ways so as to eliminate additional bills and the necessity of writing and mailing checks.

30-Day Free Look

If you are not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated and you will be sent a full refund—no questions asked!

Effective Date

Insurance for you and your eligible dependents will become effective on the first of the month your application is approved by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted and you and your dependents are alive on that date. Coverage for any dependent who is confined at home, in a hospital or other medical institution, or is incapacitated so as to be unable to perform his or her normal activities on the date coverage would otherwise become effective, will not become effective until the date he or she is no longer so confined or incapacitated provided you are insured on that date and the dependent is still eligible for insurance. 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 Insurance Company.

(Over, please)

When Coverage Ends

Your insurance can remain in force for you and your insured family members as long as they remain eligible, provided: (a) you remain a member of AFA; (b) you continue to pay premium contributions when due; and (c) the group plan is not terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong. Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance.

Exclusions

For the Decreasing Term Life Insurance coverage, the only exclusion is suicide. Benefits are paid for death from any cause, at anytime, anywhere in the world except suicide within 24 months from the issue date, whether sane or insane. Accelerated Benefits will not be payable if the amount of your Life Benefits or Death Benefits is less than $10,000.

The validity of any amount of your life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and nonpayment of premium contributions.

Group Conversion Privilege

The Plan provides conversion privileges under certain circumstances of involuntary termination, as described in the Certificate of Insurance.

You Name Your Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

Renewal Payments and Claims

Once you are accepted into the Plan, you will have a 31-day grace period for your payment of renewal premium contributions. When you want to submit a claim, call or write the Administrator for claim forms.

This brochure explains the general purpose of the insurance described, but in no way changes of affects the policy as actually issued. In the event of any discrepancy between this brochure and the contract, the terms of the contract will apply. Details are found in the certificate of insurance issued to each insured individual. Coverage may not be available in all states contract the administrator for details.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your Application may be used as the basis for rescinding your insurance.

The Group Decreasing Term Life Insurance Plan is medically underwritten based on the information provided by you on the Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the Plan.

1. Truthfully complete and sign the application. Be sure to indicate whether you are requesting coverage for your dependents.

2. Do not send any money until New York Life Insurance Company has approved your application and notifies you of the premium contribution due, based on the information you have provided.

Certificate of Insurance

This information is only a brief description of the principal provisions and features of the Plan. The complete terms and conditions are set forth in the group policy issued by New York Life to the Air Force Association Life Insurance Plan. When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Plan.

The Group Decreasing Term Life Insurance Plan is underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30291-0
on Policy Form GMR

The Group Decreasing Term Life Insurance Plan is administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
AFA Group Insurance Program
P.O. Box 14464
Des Moines, IA 50306-8993

Questions?
Phone: 1-800-291-8480

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

CURRENT 2019 RATE TABLE OF BENEFITS AND PREMIUMS

Four plans to choose from…there's one to fit your needs.
Remember, premiums do not increase as you grow older!

The four plans are offered below at the monthly rate shown. Your premiums do not increase as you grow older. Your current age will determine your coverage amount. As you move into a new age bracket, coverage amounts decrease in accordance to age brackets below.

Plan:	**Select**	**High Option Plus**	**High Option**	**Standard**	**Family Coverage: This optional family coverage may be added to any of the 4 plans for just $2.50 per month**	
Premium:	**$30/month**	**$20/month**	**$15/month**	**$10/month**		
Member's Attained Age	**Coverage**	**Coverage**	**Coverage**	**Coverage**	**Coverage For Spouse**	**Coverage For Each Child**
20-24	n/a	$400,000	$300,000	$200,000	$50,000	$5,000
25-29	n/a	350,000	262,500	175,000	50,000	5,000
30-34	n/a	250,000	187,500	125,000	40,000	5,000
35-39	n/a	180,000	135,000	90,000	30,000	5,000
40-44	$150,000	100,000	75,000	50,000	20,000	5,000
45-49	90,000	60,000	45,000	30,000	10,000	5,000
50-54	60,000	40,000	30,000	20,000	7,500	5,000
55-59	42,000	28,000	21,000	14,000	5,000	5,000
60-64	27,000	18,000	13,500	9,000	3,000	5,000
RENEWAL ONLY						
65-69	12,000	8,000	6,000	4,000	2,000	5,000
70-74	7,500	5,000	3,750	2,500	1,000	5,000
75-79	6,000	4,000	3,000	2,000	1,000	5,000
80-84	4,500	3,000	2,250	1,500	1,000	5,000
85-89	3,750	2,500	1,825	1,250	1,000	5,000
90-94	3,000	2,000	1,500	1,000	1,000	5,000
*95+	1,000	1,000	1,000	1,000	1,000	5,000

Between the ages of 6 months and 21 years, each dependent unmarried child is provided $5,000 coverage. Children under 6 months are provided with $250 coverage once they are 15 days old and discharged from the hospital.

*Coverage is complimentary from age 95 on. AFA will pay the premiums to the underwriter on your behalf.

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date (but not more than once in any 12-month period) and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insurance under this group policy. For example, a class of insureds is a group of people all with the same issue age. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Air Force Association.

AFADTB