Information Request For AFA Member:

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

Dear AFA Member,

Thank you for requesting more information about the AFA Group 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:

- Offers flexible benefit amounts up to $500,000, depending on your needs, budget and age.
- Features competitive group rates that may be lower than those you could find on your own.

  For example, a 49-year-old nonsmoking AFA Member may be eligible for the following monthly rates:

  $14.40
for $100,000[1]
protection

  $28.80
for $200,000[1]
protection

- Includes two plan options: Member only coverage or Family coverage, which covers you, your spouse and dependent children for one rate.
- Pays up to an 80% "Living Benefit Payout" if you are diagnosed as terminally ill.
- 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 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.

[1] At age 65, your coverage reduces to 50% of your benefit amount or $50,000, whichever is less.

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

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AFATLL

Group Term Life Insurance Application

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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

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.

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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 ☐ Member Only (N/S_ _1) ☐ Family Plan (N/S_ _3)

a. Initial Member Insurance Amount $____________________

(use $25,000 increments)

Initial Spouse Insurance Amount $____________________

Spouse coverage is 50% of member's coverage.

Initial Child Insurance Amount ☐ $5,000 each eligible child

Note: Member coverage must be in force to request child coverage.

b. Increase Member Insurance Amount from $______________ **to $**______________

Increase Spouse Insurance Amount from $______________ **to $**______________

Spouse's benefit amount is 50% of 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

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Please complete all pages and sign on page 4

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

G-30290-0

Please complete all pages and sign on page 4

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 <u>except</u> those listed below <u>and</u> 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 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.**

AFA Group Term Life Insurance Plan
Benefits Summary

AFA used its buying power of more than 115,000 members to secure valuable benefits for you and your family. These high-caliber benefits are automatically included in your AFA Group Term Life Insurance Plan.

Benefit Amounts up to $500,000

AFA members under age 65 who reside in the U.S. are eligible to apply for up to $500,000 in benefits (in increments of $25,000). Your spouse under age 65 and dependent children are also eligible for coverage. Eligible children include your natural child, adopted child (including a child from the date of placement with the adopting parents until the legal adoption) or stepchild who is: at least 15 days old, under age 19, unmarried and supported by you; or under age 25 and who is a full-time student at an accredited school, college or university that is licensed in the jurisdiction where it is located; unmarried; supported by you; and not employed on a full-time basis.

Choice of Two Plan Options

AFA members can choose the member only option for coverage on themselves or the family coverage option. Under the Family Plan, you, your spouse and dependent children can all be covered for one competitive rate. Your spouse's benefit amount is 50% of the benefit amount you choose. Each dependent child age 6 months to under age 19 (25 if full-time student) qualify for a $5,000 benefit: each dependent child 15 days to 6 months qualify for a $250 benefit.

Protection 24/7

You are protected 24 hours a day, 365 days a year—no matter where you are or what you're doing. It even covers you if you're flying in a military aircraft. The only thing that isn't covered is suicide within the first two years of coverage. If you commit suicide within two years from the date Life Insurance for you takes effect, we will not pay such insurance and our liability will be limited to any premium paid by you and will be returned to the beneficiary.

80% "Living Benefit Payout"

You can collect up to 80% of your benefit as an "Accelerated Benefit Option" if you're diagnosed with a terminal illness with less than 12 months to live. The request must be made at least 12 months prior to the insured person's scheduled coverage termination age and the amount of insurance payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.) If a scheduled reduction in coverage will occur within one year of the date the Accelerated Death Benefit will be paid, the benefit payable will be 50% of the reduced coverage amount.

This allows you access to funds that could help you and your family during a difficult time. You can use this money however you choose, with no restrictions. The maximum benefit available for member-only coverage is $400,000; for spouse, $200,000. Receipt of accelerated benefits may be taxable, so consult your personal tax advisor. For additional details and limitations, please see the Certificate of Insurance.

For additional details and limitations, please see the certificate of insurance.

Waives Your Premium if Disabled

Your protection will continue at no cost to you if you become continuously Totally Disabled, as defined in the Certificate, for at least 6 consecutive months and if your Total Disability starts before age 60. Your premium will be waived by New York Life Insurance Company for as long as you continue to be Totally Disabled, and benefits are payable, up to age 85.

Keep Your Coverage for the Long Haul

You can keep your coverage up to age 85—no matter what your health—as long as you remain an AFA member, pay your premiums on time and the Master Policy stays in force.

Note: At age 65, benefits reduce to 50% or $50,000, whichever is less. Premiums do not reduce.

Easy to Apply Today

Everything you need to apply for coverage is included here. Complete and return the application enclosed. Send no money now. Once you're approved for coverage, you'll be sent a Certificate of Insurance.

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!

(Over, please)

Current 2019 Competitive Group Rates

Thanks to the AFA group buying power, you pay a competitive rate for this coverage. In fact, these rates may be lower than rates you could find on your own in the individual market.

The initial cost of insurance for a member is based on the member's attained age when insurance becomes effective, the amount of insurance selected and the member's tobacco/nicotine use. The cost increases as the member grows older. Premium contributions will vary depending upon the options chosen.

MONTHLY RATES

$25,000 Life Benefit				
	Member Only Plan		Family Plan	
Age	Nonsmoker	Smoker	Nonsmoker	Smoker
20–29	$1.04	$1.26	$1.54	$1.76
30–39	1.66	2.04	2.29	2.67
40–49	3.60	4.42	4.85	5.67
50–54	9.00	11.06	12.33	14.39
55–59	12.90	15.86	17.90	20.86
60–64	19.94	24.52	28.27	32.85
$12,500 Life Benefit – For Renewal Only (At age 65 benefits reduce to 50% of your benefit amount or $50,000, whichever is less.)				
65-69*	22.50	27.67	28.75	33.92
70-74*	36.00	44.28	48.50	56.78
75-79*	45.00	55.35	57.50	67.85
80-84*	61.58	75.74	74.08	88.24

$100,000 Life Benefit				
	Member Only Plan		Family Plan	
Age	Nonsmoker	Smoker	Nonsmoker	Smoker
20–29	$4.16	$5.04	$6.16	$7.04
30–39	6.64	8.16	9.16	10.68
40–49	14.40	17.68	19.40	22.68
50–54	36.00	44.24	49.32	57.56
55–59	51.60	63.44	71.60	83.44
60–64	79.76	98.08	113.08	131.40
$50,000 Life Benefit – For Renewal Only (At age 65, benefits reduce to 50% of Benefit amount or $50,000, whichever is less.)				
65-69*	90.00	110.68	115.00	135.68
70-74*	144.00	177.12	194.00	227.12
75-79*	180.00	221.40	230.00	271.40
80-84*	246.32	302.96	296.32	352.96

$200,000 Life Benefit				
	Member Only Plan		Family Plan	
Age	Nonsmoker	Smoker	Nonsmoker	Smoker
20–29	$8.32	$10.08	$12.32	$14.08
30–39	13.28	16.32	18.32	21.36
40–49	28.80	35.36	38.80	45.36
50–54	72.00	88.48	98.64	115.12
55–59	103.20	126.88	143.20	166.88
60–64	159.52	196.16	226.16	262.80
$50,000 Life Benefit – For Renewal Only (At age 65, benefits reduce to 50% of Benefit amount or $50,000, whichever is less.)				
65-69*	90.00	110.68	115.00	135.68
70-74*	144.00	177.12	194.00	227.12
75-79*	180.00	221.40	230.00	271.40
80-84*	246.32	302.96	296.32	352.96

$300,000 Life Benefit				
	Member Only Plan		Family Plan	
Age	Nonsmoker	Smoker	Nonsmoker	Smoker
20–29	$12.48	$15.12	$18.48	$21.12
30–39	19.92	24.48	27.48	32.04
40–49	43.20	53.04	58.20	68.04
50–54	108.00	132.72	147.96	172.68
55–59	154.80	190.32	214.80	250.32
60–64	239.28	294.24	339.24	394.20
$50,000 Life Benefit – For Renewal Only (At age 65, benefits reduce to 50% of Benefit amount or $50,000, whichever is less.)				
65-69*	90.00	110.68	115.00	135.68
70-74*	144.00	177.12	194.00	227.12
75-79*	180.00	221.40	230.00	271.40
80-84*	246.32	302.96	296.32	352.96

*For Renewal Only. Members under age 65 are eligible to apply for coverage. Once approved, coverage is renewable to age 85. At age 65, your coverage reduces to 50% of your benefit amount or $50,000, whichever is less.

You will be billed on a quarterly basis.

NOTE: Higher benefit amounts for members only are available up to $500,000 (in $25,000 increments). For a complete rate schedule, please contact the Plan Administrator at 1-800-291-8480.

Your premium will be determined based on your age as of the 1st of the month in which each premium payment is due. For example, if you turn 40 during March and pay monthly, your premium will increase April 1st. Whereas, if you pay annually each January 1st, your premium will not increase until January 1st of the following year.

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, and tobacco/nicotine use. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Air Force Association.

Effective Date: Insurance for you and your eligible dependents will become effective on the first of the month after 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.

When coverage ends: Your insurance will remain in force until you reach age 85, 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.

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.

This brochure explains the general purpose of the insurance described, but in no way changes or 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; contact the administrator for details.

QUESTIONS?
Call: 1-800-291-8480
E-Mail: afa.service@mercer.com

Administered by:

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

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

Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
on Policy Form GMR-FACE/G-30290-0
Under Group Policy No. G-30290-0

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