County Medical Associations & Societies Group Disability Income Insurance Plan

NEW YORK LIFE The Company You Keep®

FOR MEMBERS OF THE COUNTY MEDICAL ASSOCIATIONS & SOCIETIES/CMA 1-455

★ **REQUEST FOR GROUP INSURANCE FROM NEW YORK LIFE INSURANCE COMPANY, 51 MADISON AVENUE, NEW YORK, NEW YORK, 10010.**
PLEASE PRINT IN INK OR TYPE ALL ANSWERS. DO NOT USE FLUID OR GEL PENS. INITIAL ANY CHANGES YOU MAKE.

PART 1 Member Information

Name _____

Address 1 _____ Address 2 _____

Please check one:

City _____ State ____ ZIP _____ ☐ Home Address ☐ Business Address

Home Phone # (____) _____ Work Phone # (____) _____ Email Address _____

Date of Birth _____ Sex: ☐ Male ☐ Female Height _____ ft. _____ in. Weight _____ lbs.

Do you intend to reside outside the U.S. or Canada in the next 12 months? ..... ☐ Yes ☐ No

If "Yes," countries _____ For how long? _____

PART 2 Membership Affiliation — Occupational Status

A. Are you a member of your County Medical Association/Society? ..... ☐ Yes ☐ No
County: _____ Membership # _____

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 are normally performed.
Are you at "FULL-TIME WORK"? ..... ☐ Yes ☐ No

D. Gross Annual Income from: Salary $ _____ Self-Employment $ _____ Self-Employment Start Date ___ /___ /___

Bonus $ _____ Commissions $ _____ Total $ _____

PART 3 Insurance Requested: Refer to the Benefits Guide for eligibility, options, rates and coverage description.

I hereby apply for the following coverage: ..... ☐ New ☐ Additional

I hereby apply for the coverage indicated below, based upon all my statements made in this application: ..... ☐ Long-Term Disability Income

Indicate Monthly Benefit Option Desired.
Choose amount of protection from $500 to $10,000 in increments of $500, ($6,000 if age 50 or over): $ _____

You may choose any Monthly Benefit Option provided it and other disability income you may have does not exceed 66⅔% of AVERAGE MONTHLY INCOME (as defined in the brochure).

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PART 3 Insurance Requested: Refer to the Benefits Guide for eligibility, options, rates and coverage description.

A. Waiting Period: ☐ 90 days ☐ 120 days ☐ 180 days

B. Payment Option Selected:

Option 1: PERIODIC BILLING: ..... ☐ Semiannually ☐ Quarterly

Option 2: ELECTRONIC FUNDS TRANSFER (EFT): I request and authorize the Administrator, Mercer Health & Benefits Insurance Services LLC, to make withdrawals against the account specified on the attached voided 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 _____ Date _____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED AGAINST THIS ACCOUNT

C. Optional Benefits:

☐ Cost-of-Living Benefit ☐ Catastrophic Benefit: ☐ $1,000 ☐ $2,500 ☐ $5,000 / ☐ 90 days ☐ 180 days

☐ Automatic Increase Benefit ☐ Recovery Benefit

D. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? ..... ☐ Yes ☐ No

IF "YES," PLEASE LIST

Company	Plan	Monthly Benefit	Benefit Period

E. 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: _____

PART 4 Statement of Health

This part of the application consists of meeting with a paramedic to take a simple exam, provide clinical specimens and give your statement of health. This data will be used for underwriting purposes by New York Life Insurance Company. Send no money at this time. If you are approved for coverage, we will advise you of your rate classification, effective date of coverage and enclose an invoice with your premium amount due.

What is the best time to contact you to arrange for a paramedic visit to complete your application, PARA-MED statement of health?

☐ A.M. ☐ P.M. ☐ Email ☐ Phone

Phone Number (____) _____ Email _____

Medical Requirements: Some, not all applicants, may need a physical exam, blood test or EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly, at your convenience and without any cost to you through our professional paramedic service. A paramedic will contact you to make an appointment.

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PART 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 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.

FOR 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 or 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 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.

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PART 6 Authorization and Signature

I understand that New York Life Insurance Company 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 licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company, 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this 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, 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 in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated on the previous page, including how my 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** _____

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