Group Business Overhead Expense Insurance

Underwritten by New York Life Insurance Company

Benefits Guide for County Medical Association & Society/CMA Members

CMA
California Medical Association

Butte-Glenn Medical Society
Fresno-Madera Medical Society
Humboldt-Del Norte County Medical Society
Imperial County Medical Society
Inyo-Mono County Medical Society
Kern County Medical Society
Kings County Medical Society
Lassen-Plumas-Modoc-Sierra County Medical Society
Los Angeles County Medical Association
Marin Medical Society
Mendocino-Lake County Medical Society
Merced-Mariposa County Medical Society
Napa County Medical Society/Solano County Medical Society
North Valley Medical Association
Orange County Medical Association
Placer-Nevada County Medical Society
Riverside County Medical Association
Sierra Sacramento Valley Medical Society
San Benito County Medical Society
San Bernardino County Medical Society
San Francisco Medical Society
San Joaquin Medical Society
San Luis Obispo County Medical Association
San Mateo County Medical Association
Santa Barbara County Medical Society
Santa Clara County Medical Association/Monterey County Medical Society
Santa Cruz County Medical Society
Siskiyou County Medical Society
Solano County Medical Society
Sonoma County Medical Association
Stanislaus Medical Society
Tehama County Medical Society
Tulare County Medical Society
Tuolomne County Medical Society
Ventura County Medical Association
Yuba-Sutter-Colusa Medical Society

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Questions? **800.842.3761**
Email: **CMACounty.Insurance.service@mercer.com**

Helps you maintain your practice while you are disabled

Business office expenses need to be met, even if you aren't around to pay them. The CMA/County Medical Association and Society sponsored Group Business Overhead Expense Insurance Plan can help you keep your practice running by providing financial coverage for your normal operating expenses while you are recovering from a disability. You will be able to take the time needed to recuperate while finding comfort in knowing that your office and staff will be ready and waiting for your return.

Eligibility

As a member, you are eligible to request coverage under this group plan if you are:

- Under age 65
- At FULL-TIME WORK*
- A resident of the U.S. and Puerto Rico;** except territories

Eligible Overhead Expenses

This Plan is designed to provide coverage for the normal operating expenses of your current practice which are incurred while you are Totally Disabled (as defined on page 2.) Eligible Overhead Expenses include, but are not limited to:

- Office rent
- Interest payments on existing business equipment or furniture loans
- Utilities (heat, water, telephone, electricity, etc.)
- Employees' salaries and payroll taxes
- Rental, lease or depreciation of office equipment
- Monthly average of taxes on the premises
- Insurance premiums
- Accounting fees, to the extent that such expenses are normal and customary in the conduct and operations of the business
- Professional membership and/or subscription dues
- Such other fixed expenses as are normal and customary in the conduct and operation of your office

If you're incorporated, a partner or joint tenant, Eligible Overhead Expenses include only your share of overhead expenses.

Eligible Overhead Expenses do not include: the salary, fees, drawing accounts, profits, or any compensation for you, your partner or any member of your profession employed by or working for you; any individual hired after the date your disability begins; income taxes; personal expenses; charitable contributions; the cost of purchase of office equipment, goods or merchandise; or the payment of principal on any indebtedness.

* 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 performed.

** Not available in all states at this time. Contact the Administrator for current information.

How The Plan Works

★ The Plan is designed to pay Monthly Benefits when you are Totally Disabled. Totally Disabled means an incapacity from an injury or sickness that completely and continuously prevents you from performing with reasonable continuity the material and substantial duties of your regular medical specialty.

★ **Monthly Benefit**
You may apply for a Monthly Benefit of $1,000 to $10,000 per month in ($1,000 units). However, the actual monthly benefit payable will not exceed the lesser of the covered Expenses incurred for each month of Total Disability, the monthly benefit in force on the date the Total Disability began or of the average of monthly Eligible Expenses incurred during the six month period immediately preceding your Total Disability. To find the amount that's appropriate, check your records for your actual expenses and calculate your average monthly expenses for the past twelve months.

For some benefit amounts requested, a financial questionnaire may be required as evidence of insurability.

★ **Waiting Period**
A waiting period is the number of consecutive days you must be Totally Disabled before benefits can begin. You have a 60 day waiting period.

★ **Benefit Period**
A Benefit Period is the duration of how long monthly benefits are payable after you have satisfied your waiting period for a Total Disability. This plan offers a maximum benefit period of 12 months.

★ **How To Determine Your Cost for Other Monthly Benefits**
If you wish to request a Monthly Benefit (in $1,000 units) for an amount not shown, please contact the Plan Administrator for assistance.

Plan Features

Waiver of Premium Contributions
If you have been Totally Disabled for six consecutive months, premium contributions due thereafter will be waived for as long as benefits are payable for that Total Disability, provided the disability began before age 70.

Benefits for Recurring Disability
Successive periods of disability which are due to the same or related causes and are not separated by return to FULL-TIME WORK for at least 180 consecutive days will be considered as one period of disability, as will unrelated disabilities that are not separated by return to FULL-TIME WORK. Disabilities which meet these separation requirements will be treated as a new disability, subject to a new benefit and waiting period.

Tax-Deductible Premium Contribution
The IRS currently recognizes "Group Business Overhead Expense Insurance" as a legitimate business expense and allows deductions of its premium contributions as a business expense under Rev. Rul. 55-264, 1955-IC.B11. This aspect should be discussed with your financial advisor.

Current 2014 Group Rates for Members

Quarterly Premium — per $1,000 of Monthly Benefit

Cost is based on the Monthly Benefit and your age when coverage becomes effective. Cost increases on the premium due date on January 1 after you reach a higher age bracket.

Age	60-Day
Under AGE 30	$11.00
AGE 30 but before AGE 35	$16.44
AGE 35 but before AGE 40	$16.44
AGE 40 but before AGE 45	$29.00
AGE 45 but before AGE 50	$29.00
AGE 50 but before AGE 55	$61.30
AGE 55 but before AGE 60	$89.15
AGE 60 but before AGE 65*	$122.00
AGE 65 but before AGE 70*	$152.45

SEND NO MONEY NOW 30-Day Free Look

As a member in good standing, you are NOT required to send any premium payment with your application. All applications will be processed promptly and coverage issued for every eligible member whose evidence of insurability is found to be satisfactory.

We want you to be 100% satisfied with your coverage before you pay. As soon as your request for coverage is approved, you'll be sent a Certificate of Insurance with more information about your group coverage benefits. Review it for a full 30 days.

If you are not satisfied for any reason: Return your Certificate marked "Cancel" and your coverage will be invalidated, no questions asked, provided there have been no claims. You'll owe nothing.

* Renewal only. Coverage terminates at age 70.

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any anniversary date and any date on which benefits are changed and on January 1 when you attain a new age bracket. However, your rates may change only if they are changed for all others in the same class of insureds. For example, a class of insureds is a group of people 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 Trustees of the Association and Society Group Insurance Trust.

When Coverage Starts (Effective Date)
You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution is paid when due, satisfactory evidence of insurability has been submitted and you have been at FULL-TIME WORK for a period of six consecutive months on the Certificate effective date.

If you are not at FULL-TIME WORK as required, coverage will not become effective until the day you are at FULL-TIME WORK provided such date is within six months of the date insurance would have been effective and you are still eligible for insurance.

Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date specified by New York Life Insurance Company.

Exclusions & Limitations

The plan does not provide benefits for any disability that occurs during or is due or related to: intentionally self-inflicted injury while sane or insane, (Missouri Residents: This exclusion is not applicable to injury caused by an intentionally self-inflicted injury while insane) engagement in war or any act thereof, or incarceration or participation in (except as a victim) an illegal occupation/activity or the commission of a crime, flying in any aircraft, except as a fare-paying passenger on a licensed commercial carrier: PRE-EXISTING CONDITION (except as noted below) or any impairment or disease specifically excluded from your coverage.

No benefits are payable for any disability for which you are not under the regular care of a licensed physician or surgeon other than yourself, your business associate, or member of your immediate family or household.

A PRE-EXISTING CONDITION is an injury or illness for which you consulted a physician, took medication, or received medical services or supplies during the immediate 12-month period prior to becoming insured under this plan. Benefits are not payable for a disability due to a PRE-EXISTING CONDITION until the end of the earlier of: 12 consecutive months during which you have not consulted a physician, take medication, or received medical services or supplies; or 24 months.

When Coverage Ends
Insurance can remain in force until you reach age 70 provided: Your Association/Society membership is maintained, you continue to incur covered expenses for the business, premium contributions are paid when due, you do not end the insurance, you do not enter full-time active duty in the armed forces (except for training purposes of two months or less), the group policy is not terminated or modified by the policyholder or New York Life Insurance Company to exclude coverage for the group of individuals to which you belong or the Association/Society ceases to be a participating organization.

Medical Requirements
New York Life reserves the right to request medical information needed to determine an applicant's eligibility for coverage. Based upon the age of the person proposed for insurance and the amount of coverage requested, a physical exam, EKG, blood test or other medical information may be required.

Not all applicants will have to supply additional information. However, if required, 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.

Request for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

Questions?

Call Toll-Free 1-800-842-3761 • 8:00 AM - 5:00 PM Monday-Friday

If you have any questions about your eligibility, what the plan covers, rates, or how to complete the application, please do not hesitate to call. A Client Advisor will be able to immediately provide you with the information you need. Or you can email us: CMACounty.Insurance.service@mercer.com

This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are set forth in the policy issued by New York Life Insurance Company to the County Medical Associations & Societies/CMA.

About Our Role and Compensation

The County Medical Associations and Societies/NORCAP/CMA have selected New York Life Insurance Company for this insurance program. Alternative insurance products may be available in the insurance marketplace. Mercer Health & Benefits Insurance Services LLC is providing this single insurer option on behalf of the County Medical Associations and Societies/ NORCAP/CMA. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability, or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E4525185 or call us at 1-888-206-5088 for specific details.

CA Ins. Lic. #0G39709 • Mercer Health & Benefits Insurance Services LLC

800-842-3761 • CMACounty.Insurance.servcie@mercer.com • www.CountyCMAMemberInsurance.com

Sponsored by:

CMA
California Medical Association
and 30 County Medical Associations and Societies

Underwritten by:

NEW YORK LIFE The Company You Keep®

New York Life Insurance Company
51 Madison Avenue / New York, NY 10010
Under Group Policy No. G-29323-0
on Policy Form GMR-FACE/G-29323-0

MERCER

777 S. Figueroa Street
Los Angeles, CA 90017

Important Notice:

How New York Life Obtains Information and Underwrites Your Request For Business Overhead Expense Insurance

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, 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 applications 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). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website 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 person 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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **8.12ed.**

Underwritten by New York Life Insurance Company, 51 Madison Ave., New York NY 10010
Under Group Policy No. G-29323-0 • On Policy Form GMR-FACE/29323-0

County Medical Associations & Societies Group Business Overhead Expense Insurance Plan

NEW YORK LIFE The Company You Keep®

FOR MEMBERS OF THE COUNTY MEDICAL ASSOCIATION & SOCIETIES/CMA 1-456

★ **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 _____ 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 now a member of your County Medical Association/Society? ..... ☐ Yes ☐ No
County: _____ Membership # _____

B. Average monthly amount of "Covered Overhead Expenses" in preceding 6 months: $_____

C. Practicing as: ☐ Corporation ☐ Partnership ☐ Individual ☐ LLC

D. If corporation or partnership, for what amount of monthly "Covered Expenses" are you responsible? $_____

E. Average number of employees: _____

F. What is your occupation? _____
Main Duties: _____

G: FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours each week at the place such duties are normally performed.
Are you now at FULL-TIME WORK? ..... ☐ Yes ☐ No

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: ..... ☐ Business Overhead Expense

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

A. **Waiting Period:** 60 days **Benefit Period:** 12 months

B. **Monthly Benefit** (Choose amount of protection from $1,000 to $10,000 in $1,000 increments): $_____

C. **Payment Option:**

Option 1: PERIODIC BILLING: ☐ Quarterly

Option 2: ELECTRONIC FUNDS TRANSFER (EFT): I request and authorize the Administrator, Mercer Health & Benefits Insurance Services LLC, to make monthly 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

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.

OVER, PLEASE

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.

OVER, PLEASE

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.