GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF ORGANIZATIONS PARTICIPATING IN THE ENGINEERING ASSOCIATIONS INSURANCE TRUST

To Apply:
Complete this form and return to:
ADMINISTRATOR
ASSE GROUP INSURANCE PROGRAM
P.O. BOX 10374 • Des Moines, IA 50306-8812

For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS?
Call: 1-800-424-9883
customerservice.service@mercer.com

AMERICAN SOCIETY OF SAFETY PROFESSIONALS

NEW YORK LIFE

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

(Please make any necessary corrections to your full name and street address if shown below.)

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: ☐☐☐ – ☐☐ – ☐☐☐☐

Home Phone: (____)_____

Work Phone: (____)_____

Fax: (____)_____

Email Address: _____
Mercer Consumer will not share your email information

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)
❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any Engineering Associations Insurance Trust (of which ASSE is a participant) Group Life Insurance Plans? ❑ Yes ❑ No

If "yes," indicate which Plan(s) and provide details (person(s) insured and amount of insurance):
❑ Term Life ❑ 10-Year Level Term Life Details:_____

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?
Member: ❑ Yes, Country_____ For how long? _____ ❑ No
Spouse: ❑ Yes, Country_____ For how long? _____ ❑ No

		DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:	_____	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Spouse*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Child(ren)*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F

*See Plan Information/Insurance Brochure 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.

2. Membership Affiliation:

Are you now a member of American Society of Safety Engineers? ❑ Yes ❑ No

Membership # _____ Exp. Date _____
(Membership in the ASSE is required for participation in this Plan.)

3. Payment Option: (Choose only one)

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT)**: I request and authorize the ASSE Group Insurance Program, Inc. to make ❑ monthly ❑ semiannual 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 due under this Group 10-Year Level Term Life Insurance Plan. (Enclose a VOIDED check.)

X _____

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

❑ **OPTION 2: PERIODIC BILLING:** Semiannually (April 1 and October 1)

4. Insurance Requested: (Refer to the Plan Information/Insurance Brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a. Total* Member Insurance Amount Requested: $ _____

b. Total* Spouse Insurance Amount Requested: $** _____

c. Total Child Insurance Amount Requested: ❑ $10,000 each eligible child ❑ None

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

***Increased coverage requested in this application, if approved, will be issued in a separate, new Certificate of Insurance.**
****Spouse coverage cannot exceed 100% of Member's coverage.**

d. 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 _____

e. TOBACCO/NICOTINE USE: Have you and/or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Member: ❑ Yes ❑ No If "Yes," _____ Spouse: ❑ Yes ❑ No If "Yes," _____
TYPE OF PRODUCT TYPE OF PRODUCT

When did you last use tobacco or nicotine product? _____/_____ When did you last use tobacco or nicotine products? _____/_____
MONTH/YEAR MONTH/YEAR

f. 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 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

5. Beneficiary Designation: (Insert name, relationship and address)

I make the following beneficiary designation with respect to only the insurance requested in this application for Group 10-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member - or owner of the coverage, if other than the member - as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other ASSE Group 10-Year Term Life Insurance Certificate, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

6. 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:

	YES	NO
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?	❑	❑
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❑	❑
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?	❑	❑
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?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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:

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

g. Have you or your spouse (if proposed for insurance) had a parent, brother or sister who, prior to age 60, had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? [Note: This question is <u>not</u> applicable to MD residents.] ❑ ❑

h. Within the past two years have you or your spouse (if proposed for insurance) participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; hang gliding; parasailing; bungee jumping; organized motorcycle racing, or any type of organized motorized racing? ❑ ❑

i. Driver's License No.: Member _____ Spouse _____

State in which issued: Member _____ Spouse _____

Have you or your spouse (if proposed for insurance) had a driver's license suspended or revoked, or had any moving violations, within the last five years? ❑ ❑

6. Statement of Health: continued...

YES NO

j. ***Except for residents of CT and MN,*** in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending?. . . . . ❑ ❑

For residents of CT and MN only, in the last seven years have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?. . . . . ❑ ❑

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" 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-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

I understand that New York Life has the right to require additional information and, if necessary, an examination by 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 hereby 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, representative 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 indicated below and Fraud Notices indicated below, 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)

Owner Information is required if owner is other than Applicant
(If Owner is a Trust, please submit a copy of the document with this application.)

Full Name: Last | First | Middle Initial | Relationship to Proposed Insured | Daytime Phone

Mailing Address: Street | City | State | Zip Code

Tax ID# | Date of Birth (/ /) | Social Security Number (☐☐☐ – ☐☐ – ☐☐☐☐)

Owner's Signature X _____ **Date** _____

(NECESSARY ONLY IF OTHER THAN MEMBER)

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 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 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 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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IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group 10-Year Level Term Life 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.

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 **7/15 ed.**

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