Chronic Illness Rider Application

IEEE

Negotiated For IEEE Members And Their Spouses

IEEE-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 application form and return to:
IEEE-sponsored Insurance Program Administrator
P.O. Box 10374
Des Moines, IA 50306-8812

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

Questions? 1-800-493-IEEE (4333)

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.

1 MEMBER INFORMATION

Name _____ (Last Name / First / Initial)

Address _____

City _____ State (Province) _____ ZIP (Postal Code) _____

Please check one:
☐ Home address
☐ Business address

Preferred Phone ( )

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

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

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

Are you presently insured under the IEEE Member Group Term Life Insurance Plan? ☐ Yes ☐ No

Details _____

Does any person proposed for insurance intend to reside outside the United States and Canada within the next 12 months?

Member: ☐ Yes, Countries _____ For How Long? _____ ☐ No

Spouse: ☐ Yes, Countries _____ 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

2 MEMBERSHIP INFORMATION

Are you now a member of The Institute of Electrical and Electronics Engineers Incorporated?

☐ Yes ☐ No

Membership # _____

Expiration Date _____

(Membership in IEEE 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, IEEE Member Group Insurance Program, to make ☐ monthly ☐ semiannual 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:** Semiannual (March 1 and September 1)

4 INSURANCE REQUESTED

I **HEREBY APPLY FOR THE CHRONIC CARE RIDER UNDER GROUP TERM LIFE INSURANCE POLICY (8100-1) BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION**

A. MEMBER ☐ Chronic Care Rider (under age 65)

Benefit Amount: $ _____ *($100,000-$1,000,000 in $10,000 increments)*

SPOUSE ☐ Chronic Care Rider (under age 65)

Benefit Amount: $ _____ *($100,000-$1,000,000 in $10,000 increments)*

NOTE: The amount of life insurance subject to the rider may not exceed $1,000,000

Tobacco/Nicotine Use: Have you or your spouse (if applying for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine shewing gum and 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 STATEMENT OF HEALTH (Please initial and date any changes you make on this form.)

Complete only if you selected the Chronic Illness Rider:
To the best of your knowlidge and belief, answer the following questions as they apply to you and all depemdents to be insured:

	Member	Spouse
A. Do you currently need or in the past five years have you needed human assistance or supervision to perform any of the following activities? Bathing, dressing, eating, walking, moving in/out of a bed or chair or wheelchair, toileting, bowel, or bladder control. (If "Yes", please indicate all that apply per applicant).....	☐ Yes ☐ No	☐ Yes ☐ No
B. Within the past five years, have you been bed-ridden at your home or any other private residence for two weeks or more?.....	☐ Yes ☐ No	☐ Yes ☐ No
C. Within the past five years, have you had a fall or been diagnosed or treated by a member of the medical profession for a fracture, paralysis, numbness, balance problems, or skin ulcers?.....	☐ Yes ☐ No	☐ Yes ☐ No
D. Within the past five years did you lose any part of your fingers, hands, feet, or limbs due to amputation, accident, disease, or deformity; or been diagnosed or treated by a member of the medical profession for any conditions causing crippling or limited motion?.....	☐ Yes ☐ No	☐ Yes ☐ No
E. Are you now, or have you been in the past 5 years, in a wheelchair or dependent on or required supportive equipment such as braces, crutches, walker, cane, back support, or splint?.....	☐ Yes ☐ No	☐ Yes ☐ No
F. Within the past six months, have you had or been recommended by a member of the medical profession to have physical therapy?.....	☐ Yes ☐ No	☐ Yes ☐ No
G. Within the past five years, have you been evaluated, counseled, treated by a member of the medical profession or hospitalized for any problems with memory or ability to think or reason?.....	☐ Yes ☐ No	☐ Yes ☐ No
H. Within the past five years, have you been confined or has confinement been recommended by a member of the medical profession, to a hospital, nursing home, rehabilitation facility or extended care facility?.....	☐ Yes ☐ No	☐ Yes ☐ No
I. Have you received Medicaid benefits or any similar federal or state financial assistance within the past five years? (Note: Medicaid is not the same as Medicare).....	☐ Yes ☐ No	☐ Yes ☐ No
J. Have you received Medicare disability benefits within the past five years?.....	☐ Yes ☐ No	☐ Yes ☐ No

K. In what type of dwelling do you reside?

Private Home, Apartment, Retirement Home, Congregate Care Community, Nursing Care Facility, Mobile Home, Continuing Care/Care Community, Retirement Community, Assisted Living Unit, Personal Care Home, Adult Care Home, or Other (Please specify)

Member _____

Spouse _____

L. Within the past five years, have you been declined for issue, reinstatement, or renewal of any type of long-term care insurance?.....	☐ Yes ☐ No	☐ 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-Treatmnet-Operation-Degree of Recovery and Date	Name and Address of Physicians or Other Practitioners nad Hospitals Where Confined or Treated

6 AUTHORIZATION AND SIGNATURE

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, 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 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 OF HIS/HER GROUP TERM LIFE INSURANCE.)

For purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada.

G-8100-1

1/19 ed.

amended by, GMA-CHR

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 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.

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. Information for consumers about MIB may be obtained on its Web site at www.mib.com. **For Canadian residents the address is:** MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590.

***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.**