

GROUP TERM LIFE WITH LIVING BENEFITS INSURANCE APPLICATION

FOR MEMBERS OF THE IEEE



To Apply:

Complete This Form And Return To:

ADMINISTRATOR

IEEE GROUP INSURANCE PROGRAM

P.O. Box 10374 • Des Moines, IA 50306-8812

For Puerto Rico Residents, the address is:

Global Insurance Agency, Inc.

P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS?

1-800-493-IEEE(4333)

ieee.service@mercer.com

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

Social Security #: _____

Home Phone: (____) _____

Add 1: _____

Work Phone: (____) _____

Add 2: _____

Fax: (____) _____

City, St., Zip: _____

Email Address: _____

Merger 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 IEEE Group Life Insurance Plans? Yes No

If "yes," indicate which Plan(s) and provide details (person insured and amount of insurance): Term Life

Level Term Life to Age 65 Universal Life Permanent Whole Life 10-Year Level Term Life 20-Year Level Term Life

Details: _____

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. or Canada 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:
	MO. DAY YR.			
Member: _____	____/____/____	____ft. ____in.	____lbs.	<input type="checkbox"/> M <input type="checkbox"/> F
Spouse*: _____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	____lbs.	<input type="checkbox"/> M <input type="checkbox"/> F

* See Plan Information/Plan Details for definition of eligible dependents.

2. Membership Affiliation:

Are you now a member of The Institute of Electrical and Electronics Engineers, Incorporated? Yes No

Membership # _____ Exp. Date _____

(Membership in IEEE is required for participation in this plan. Affiliate members are not eligible.)

3. Payment Option:

(Choose only one)

Total Premium Contribution Enclosed: \$ _____

OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT): I request and authorize the IEEE Group Insurance Program, Inc. to make monthly semiannual semiannual withdrawals against the account specified on the attached voided check and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Term Life With Living Benefits Insurance Plan. (Enclose a VOIDED check.)

X _____
SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

OPTION 2: PERIODIC BILLING: Semiannual (March 1 and September 1)

G-8100-2

4. Insurance Requested:

(Refer to the Plan Information/Plan Details for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a. Initial Member Insurance Amount: \$50,000 \$100,000

Initial Spouse* Insurance Amount: \$50,000 \$100,000

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

b. Increase Member Insurance Amount from \$50,000 to \$100,000

Increase Spouse* Insurance Amount from \$50,000 to \$100,000

*Spouse coverage cannot exceed 100% of member's coverage.

c. **TOBACCO/NICOTINE USE:** Have you 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," _____ When did you last use tobacco or nicotine products? ____/____/____
TYPE OF PRODUCT MM/YYYY

Spouse: Yes No If "Yes," _____ When did you last use tobacco or nicotine products? ____/____/____
TYPE OF PRODUCT MM/YYYY

Current Insurance Coverage:

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 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 all insurance on my life under this Group Term Life With Living Benefits Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, 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 %: _____

Primary Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Social Security #: _____

Street Address: _____

Street Address: _____

City _____ State _____ Zip Code _____

City _____ State _____ Zip Code _____

6. Statement of Health: (Please initial and date any changes you make on this form.)

Based upon age and amount requirements, you may be contacted by a service provider on behalf of New York Life to ask about your medical history.

When would be best to contact you Monday through Friday?

Time (Mon - Thu 7 AM - 11 PM CST and Friday 7 AM - 9 PM CST) _____ Telephone Number (_____) _____

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse, if proposed for insurance:

- | | Member | | Spouse | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO |
| a. Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. During the past five years has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During the past five years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. During the past five years has any person proposed for insurance suffered from incontinence or required assistance in bathing, toileting, dressing, eating, cooking or transferring (e.g. difficulty rising from a chair or getting out of bed)? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Has any person 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?..... | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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 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.

AUTHORIZATION: (continued)

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 on the following page 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) (PLEASE SIGN AND DATE IN INK)

Owner's Signature X _____ Date _____
(NECESSARY ONLY IF MEMBER PREVIOUSLY TRANSFERRED OWNERSHIP OF HIS/HER GROUP TERM LIFE WITH LIVING BENEFITS 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.

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 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 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 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 With Living Benefits 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.

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 Web site at www.mib.com.

For NM Residents: PROTECTED PERSONS¹ have a right of access to certain CONFIDENTIAL ABUSE INFORMATION² 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.

¹PROTECTED 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.

²CONFIDENTIAL 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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Group Term Life with Living Benefits (LWLB) Insurance Plan

Underwritten by New York Life Insurance Company

For IEEE Members and Their Spouses

A LIFE INSURANCE PLAN WITH CRITICAL ILLNESS BENEFITS!

Whether you have life insurance or not, you may find this new Group Term Life With Living Benefits Plan an important choice for your insurance portfolio. The Plan is structured to allow benefit payments for qualifying critical health conditions, in addition to the standard accelerated death benefit in the event of a terminal illness diagnosis, and a death benefit. While planning revenue source for your survivors with life insurance benefits is most likely an integral part of your estate planning, consider the significant financial burden that a critical illness can impose on you and your family. With this Plan, there is the possibility of accelerating benefit payments for qualifying critical illnesses, permanent critical conditions or terminal illness, while maintaining a portion of your benefit as death benefit proceeds.

You've probably seen the devastating effects a critical illness can have on a family. The Plan provides benefits payable to you (or whomever is the certificate owner of record) to be used as you decide.

WHO IS ELIGIBLE?

IEEE members under age 65 are eligible to apply for coverage for themselves, and for their lawful spouses under age 65. In order to become insured, satisfactory evidence of insurability must be provided and the required premium contribution must be paid.

A spouse who is also a member is eligible for either member or spouse coverage, but not both. If both member and spouse are covered as members, neither may insure the other as spouse.

Non-Dependent Family Members: Any eligible "non-dependent" family members may also apply for coverage as long as they join IEEE as an Associate Member. For membership information, please call IEEE directly at 1-800-678-IEEE (4333).

This coverage is available only for residents of the United States (excluding CA, CT, FL, MA, MT, NJ, NY, OR, SD, UT, WA and territories), Puerto Rico and Canada (except Quebec).

WHAT YOU CAN CHOOSE

FOR MEMBER \$50,000 or \$100,000

FOR SPOUSE \$50,000 or \$100,000 (may not exceed 100% of member coverage)

The total amount of coverage an individual may have under all group life insurance plans underwritten by New York Life Insurance Company may not exceed \$2,000,000. However, coverage under this plan is not subject to this maximum and can be in addition to the \$2,000,000 aggregate maximum.

In addition, the total amount of coverage an individual may have under all group policies issued by New York Life Insurance Company to the Trustee of the IEEE Life Insurance Plan may not exceed the maximum benefit option for any insured person.

PLAN FEATURES

Schedule of Benefits:

Member or Spouse Benefit

\$50,000	\$100,000
Benefit Amount Payable+	

Death Benefit

\$50,000	\$100,000
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The Death Benefit will be reduced by the amount of any Accelerated Benefits paid for the insured person.

Accelerated Benefits

For Qualifying Event:

Terminal Illness*	\$25,000	\$50,000
Critical Illness**	\$12,500	\$25,000
Permanent Critical Condition***	\$12,500	\$25,000

*Terminal Illness is a condition for which the patient has a life expectancy of 12 months or less.

Receipt of these benefits may affect eligibility for public assistance programs and may be taxable. Before applying for these benefits consult with the appropriate social service agency and a qualified tax advisor. **The Accelerated Death Benefit is not currently available for residents of CA, CT, FL, MA, MT, NJ, NY, OR, SD, UT or WA.**

**Critical Illness means any one of these conditions, as defined below: Major Stroke, Major Heart Attack, Malignant Cancer, Major Organ Transplant, Paralysis or Renal Failure.

***Permanent Critical Condition means a medical condition that usually requires continuous confinement in a Convalescent Care Facility, Hospice, Nursing Home or at home, if the insured is expected to remain confined for the rest of his or her life.

+Maximum Benefit Payable: An insured may receive only one Critical Illness Benefit or Terminal Illness Benefit or Permanent Critical Condition Benefit, but would be eligible for benefits under any combination of these three qualifying events, subject to a maximum under all three types of accelerated benefits of 75% of the insurance amount in force. The minimum Death Benefit payable is 25% of the benefit in force and no more than 75% of that benefit amount is payable for Qualifying Events on each insured person. (In order to preserve the 25% payable minimum death benefit, the amount payable for any Qualifying Event may be reduced so that, when combined with any Accelerated Benefit already paid, no more than 75% of the insured's benefit is paid.) If the Death Benefit is reduced by payment of an accelerated benefit, premiums due are based on the reduced level of death benefit.

Qualifying Events Defined

For any benefit to be paid, New York Life must receive a written request and written satisfactory medical proof of the Qualifying Event.

Terminal Illness: a condition where the patient has a life expectancy of 12 months or less.

Critical Illness:

Major Stroke: a cerebrovascular incident or accident which produces: (a) neurological sequel that lasts more than 24 hours; and (b) evidence of permanent neurological defect. Included in the definition of a stroke are infarction of brain tissue, hemorrhage and embolism from an extracranial source, but Transient Ischemic Attacks (TIAs) and attacks of Vertebrobasilar Ischemia are not included.

Major Heart Attack: death of a portion of the heart muscle as a result of a myocardial infarction; evidence of the following must be present: electrocardiographic evidence of a myocardial infarction occurring prior to the effective date of this insurance; and elevated levels of cardiac enzymes consistent with myocardial infarction. Your Certificate of Insurance will provide details on the measurement of certain cardiac enzyme levels.)

Malignant Cancer: a disease manifested by the presence of malignant tumors characterized by the uncontrolled growth and spread of malignant cells and invasion of tissue. Included in the definition of Cancer are leukemia, Hodgkin's disease, Kaposi's sarcoma and malignant melanomas. It does not include Carcinoma in Situ or Skin Cancer/Pre-Malignant Conditions. Your Certificate provides more detail on the definitions of "in situ" cancers and pre-malignant conditions.

Major Organ Transplant: undergoing as a recipient the transplant of a heart, lung, liver, pancreas, kidney or bone marrow. Transplantation means the replacement of malfunctioning organs(s) or tissue with the organ(s) or tissue of a donor suitable under generally accepted medical procedures.

Paralysis: the complete and permanent loss of functional use of two or more limbs, as a result of medically documented physical paralysis. Loss of functional use resulting from psychosomatic causes is not included in the definition. New York Life must receive satisfactory written medical proof of a continuous period of at least 90 days of paralysis.

Renal Failure: end stage renal disease due to chronic irreversible failure of both kidneys to function, requiring regular peritoneal dialysis, hemodialysis or renal transplantation. New York Life must receive satisfactory written medical proof of a continuous period of at least 90 days of persistent renal failure.

Permanent Critical Condition: a medical condition that usually requires continuous confinement in a Convalescent Care Facility, Hospice, Nursing Home or at home, if the insured is expected to remain confined for the rest of his or her life. New York Life will consider an insured to have suffered a Permanent Critical Condition if he or she cannot perform any two of these Activities of Daily Living for a continuous period of 180 days: bathing, dressing, toileting, transferring, eating or continence.

- *Convalescent Care Facility* means a licensed institution which provides post-hospital care or rehabilitation services; room and board, 24-hour-a-day nursing service by registered professional nurses (on duty or call with at least one full-time nurse) and a doctor on duty or call. It does not include a rest home, a place for care of the aged, alcoholics, mentally ill or drug addicts and/or a place for custodial care.
- *Hospice* means a facility providing a coordinated program of home and inpatient care for terminally ill patients, meeting the standards of the National Hospice Organization and any State licensing requirements.
- *Nursing Home* means an institution or a distinct part of a hospital, that is primarily engaged in providing skilled nursing services for sick or injured inpatients and has continuous nursing services under the supervision of a doctor, with the services of a doctor and clinical records available, and is certified as a skilled nursing facility.

No Exclusions

Benefits will be paid in the event of death, anywhere in the world regardless of cause. The validity of any amount of your insurance which has been in force for two years during your lifetime will not be contested except for insurance eligibility provisions or nonpayment of premium contributions.

Your Choice of Beneficiary – Benefit Payment

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

When Coverage Ends

Insurance can remain in force to age 75, provided: (a) you continue to pay premium contributions when due (Note: The Office of Foreign Assets Control (OFAC), an agency of the U.S. Department of Treasury, ensures economic and trade sanctions based on the U.S. foreign policy against targeted foreign countries and specially designated individuals and organizations. New York Life may not be able to accept premium originating from an OFAC-targeted country or provide insurance services to an individual who is located in a targeted country); (b) you remain a member of IEEEE; (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; and, for an insured spouse, provided member coverage remains in force and he/she remains the lawful married spouse to the member. Insurance will not terminate if you change employment or retire. Upon your death, coverage for your insured spouse may continue as described in the Certificate of Insurance.

Group Conversion Privilege

The Plan provides conversion privileges under certain circumstances of involuntary termination as described in the Certificate of Insurance.

EFFECTIVE DATE

Note: Residents of NC: Any reference to "performing the normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application. You and your spouse will become insured on the date specified by New York Life Insurance Company provided the initial premium contribution received within 31 days after you are billed, satisfactory evidence of insurability has been submitted, and you and your spouse are performing the normal activities of a person in good health of like age. For any proposed insured who is not performing such normal activities on the date insurance would otherwise have taken effect, insurance will not take effect until the day he/she is performing such normal activities, provided such as is within three months of the date insurance would otherwise have taken effect and the person is still eligible. Spouse coverage will not take effect prior to member 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.

CERTIFICATE OF INSURANCE

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustee of the Institute of Electrical & Electronics Engineers Life Insurance Plan.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Plan.

Incontestability: Except for non-payment of any premiums due and provision related to eligibility, your coverage is incontestable after it has been in force for 24 months following its effective date.

30-DAY FREE LOOK

If you're 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!

RENEWAL PAYMENTS AND CLAIMS

Once you are accepted into the Plan, you will have a 31-day grace period for your payment of renewal premium contribution. When you want to submit a claim, call or write the Administrator for claim forms.

HOW TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing with IEEEE. Please wait until your application for membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact IEEEE directly.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your application may be used as the basis for invalidating your insurance.

It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the Plan.

Apply in Three Easy Steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application. Be sure to indicate if you are requesting coverage for your spouse.
2. Complete, sign and date the Application.

**DO NOT SEND MONEY NOW.
YOU'LL BE BILLED LATER.**

If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form or go to www.ieeeeinsurance.com to download the form.

IMPORTANT NOTICE TO RESIDENTS OF MANITOBA AND ONTARIO, CANADA:

Manitoba and Ontario, Canada have enacted laws requiring taxation (Manitoba 7% and Ontario 8%) of all group insurance purchased by individuals. This tax will be added to the amount of any premium contributions due (in U.S. dollars), which is then reported and remitted to the province.

3. Mail the completed application to:
Administrator
IEEE Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

Residents of Puerto Rico:

Please send your completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

If you have questions about your eligibility or the features of this Plan, call a Customer Service Representative toll-free at 1-800-493-IEEE (4333).

This Group Term Life With Living Benefits Insurance Plan Is Administered By:



Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
IEEE Group Insurance Program
PO Box 10374
Des Moines, IA 50306-8812
1-800-493-IEEE (4333)
www.ieeeinsurance.com

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

This coverage is available to residents of Canada (except Quebec). Mercer (Canada) Limited, represented by its employees Nicole Swift and Suzanne Dominico, acts as broker with respect to residents of Canada.

This Group Term Life With Living Benefits Insurance Plan Is Underwritten By:



New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-8100-2
on Policy Form GMR-FACE/G-8100-2

This is a life insurance benefit that also gives you the option to accelerate some of the death benefit in the event that you are certified with a critical illness or permanent critical condition as described in the certificate.

IMPORTANT NOTICE: This coverage is not intended to be a federally tax-qualified long-term care insurance contract under Internal Revenue Code (IRC) Section 7702B. Therefore, the premiums payable do not qualify as long-term care insurance premiums and are not deductible from gross income for federal income tax purposes. A Critical Illness or Permanent Critical Condition acceleration is subject to the federal per diem limits set forth in IRC Section 7702B. Under this acceleration, New York Life will not pay claimants more than the federal per diem limits. Assuming the amount you receive in the aggregate from all applicable policies does not exceed the federal per diem limits set forth in IRC Section 7702B, the benefits provided by the Critical Illness or Permanent Critical condition acceleration are intended to be excludable from federal gross income under Section 101 (g) of the IRC.

Receipt of an accelerated death benefit may affect eligibility for Medicaid or other government benefits or entitlements and may have income tax consequences. Accelerating benefits before applying for these programs, or while you are receiving government benefits, may affect your initial or continued eligibility. Clients can contact the appropriate social service agency (e.g., the Medicaid Unit of your local Department of Public Welfare or the Social Security Administration Office) for more information.

IEEE is compensated in connection with this sponsored group plan to provide and maintain this valuable membership benefit.

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Current 2020 Monthly Premium Contributions

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

Manitoba and Ontario, Canada Residents: Please see tax notice under HOW TO APPLY section.

IEEE Group Term Life with Living Benefits Insurance Plan Current 2019 Rates*

Member \$100,000 Option			Spouse \$100,000 Option		
Age	Nonsmoker	Smoker	Age	Nonsmoker	Smoker
Under 35	\$7.68	\$11.36	Under 35	\$7.12	\$11.36
35-39	10.32	16.64	35-39	10.80	18.08
40-44	17.76	29.12	40-44	17.28	30.48
45-49	28.72	46.56	45-49	27.28	47.68
50-54	47.20	77.36	50-54	50.40	85.76
55-59	76.16	125.20	55-59	76.48	130.00
60-64**	150.40	235.52	60-64**	117.52	195.12
Member \$50,000 Option			Spouse \$50,000 Option		
Age	Nonsmoker	Smoker	Age	Nonsmoker	Smoker
Under 35	\$3.84	\$5.68	Under 35	\$3.56	\$5.68
35-39	5.16	8.32	35-39	5.40	9.04
40-44	8.88	14.56	40-44	8.64	15.24
45-49	14.36	23.28	45-49	13.64	23.84
50-54	23.60	38.68	50-54	25.20	42.88
55-59	38.08	62.60	55-59	38.24	65.00
60-64**	75.20	117.76	60-64**	58.76	97.56

*Rates are shown monthly for easier comparison to other plans, but you will be billed twice a year (March 1 and September 1) for renewal payments. Multiply by 6 to determine the semiannual rate. If you select the convenient monthly Electronic Funds Transfer (EFT) option, your monthly cost will be the premium contribution shown above.

**Contact the Administrator for renewal rates at age 65-74. Coverage terminates when the insured attains age 75. See "Group Conversion Privilege".

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 Trustee of the IEEE Life Insurance Plan.

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