Group Disability Income Insurance

Underwritten by New York Life Insurance Company

Benefits Guide for California Pharmacist Association Members

california pharmacists association

Questions?

888.926.CPhA

Email:

CPhA.Insurance.service@getamba.com

AMBA

"Stand-alone" OR "As A Complement"

This group coverage can be your sole, "stand-alone" disability insurance coverage. Or, if you have some type of disability coverage through an employer, this policy can be used to complement it. That's an approach some of our members take because these benefits are NOT taxable, unlike most employer insurance — and the coverage is portable, meaning it's not tied to your employment.

Eligibility

As a California Pharmacists Association member, you are eligible to request coverage under this group policy if you are:

- Under age 60
- At FULL-TIME work*
- A resident of the U.S.;** except territories

Diagnostics: 3 Key Reasons You May Need Disability Coverage

1 Your income is substantial and your lifestyle is based on the assumption of that income stream

2 Your expenses are likely significant, and may include:

- mortgage(s)
- children's college education savings to fully fund
- retirement savings to fully fund
- monthly living expenses
- healthcare costs, insurance
- student loan debt
- office rent/maintenance

3 Your livelihood demands full use of your mind and body

Common Accidents & Medical Conditions That Could Result in "Disability"

- Motor Vehicle Accident
- Sports Injury
- Fall (ex: from ladder doing work around the home)
- Arthritis
- Neuropathic Damage
- Degenerative Disc Disease
- Post-Traumatic Stress Disorder+
- Depression, Anxiety Disorder
- Visual or Auditory Impairment
- Stroke, Heart Attack, Aneurysm
- Multiple Sclerosis, Parkinson's Disease, ALS
- Cancer

* 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.

+ The policy limits benefits for Mental/Nervous disorders and Chemical Dependency. (See Exclusions & Limitations)

Advantages — How It Works

★ **Your own occupation protection for the first 60 months of disability**
As a pharmacist, your job is highly specialized. And if you are totally disabled due to a covered injury or sickness and can't perform the material duties of your regular job for the first 60 months, the coverage will pay you monthly income benefits.

★ **Your coverage is portable — you can take this insurance with you anywhere you go***
Unlike other employer-paid or sponsored insurance, your CPhA group coverage can go wherever you go, as long as you remain a CPhA member, you are under age 70, the group policy does not end or is not terminated to end coverage for your class of insureds, you continue to pay your premiums when due, you do not cease active work (except for reasons of total disability), you do not begin active-duty in the armed forces, full time, and CPhA remains a participating association. You don't have to worry about losing your disability insurance simply because you change employers, work as an independent contractor or buy a pharmacy.

★ **You pay group rates — often more favorable than those for individual coverage**
This coverage is only available to CPhA members and rates have been specifically negotiated on your behalf.

★ **Your benefit payments are TAX-FREE — you could collect 40% more each month**
Under current tax laws, if you pay your own disability premiums, your benefits are tax-free. This means you'll generally collect 40% higher benefit checks through this coverage than you'd receive from a comparable program offered through an employer. Or, you may be able to claim part of your premiums as a tax deduction if you own your own practice. Consult with your tax advisor for more details.

Example: $10,000 monthly benefit taxed vs. tax-free:
(40% paid to state and federal income taxes)

Taxable Plan	vs.	Tax-Free CPhA/County Plan
$6,000.00		$10,000.00 (you net 40% more)

TAX-FREE benefit payments assume you don't choose to take your insurance premiums as a tax deduction. Of course, always consult with your tax advisor for the best advice for your individual situation.

*Subject to policy terms and U.S. government regulations on restricted countries.

Advantages — How It Works

Group disability income insurance, underwritten by New York Life Insurance Company can help protect your income if you become totally disabled due to injury or sickness and unable to perform the material duties of your regular job. Our disability program recognizes your regular job for the first 60 months of a total disability.

Choice of Plans

You can choose either the:

Two-Year Plan — provides benefits for total disability due to a covered injury or sickness for up to two years.

Long-Term Plan — provides benefits for total disability due to a covered injury or sickness up to: Normal Retirement Age if total disability begins prior to age 60; to age 65 if total disability begins on or after age 60 but prior to age 64; or 12 months if total disability begins on or after age 64 but prior to age 70.

Choice of Benefit Amounts

If you are under age 50 on the effective date of coverage, you may apply for benefits up to $10,000 per month. If you are at least age 50, but under age 60 on the effective date of coverage, you may apply for up to $6,000 per month. The amount you choose cannot exceed 60% of your AVERAGE MONTHLY INCOME. At age 65, the benefit amount is reduced by 50% of the amount in effect on the day before you attained age 65.

Choice of Waiting Period

You determine how long a waiting period you need between the date of disability and payment of benefits. Choose either a 90- or 180-day waiting period. If you elect the two-year plan, only the 90-day waiting period is available.

Defining Features

Definition of AVERAGE MONTHLY INCOME means 1. If you're self-employed, your wages, salaries, commissions, fees and other amounts received for personal services. If your business is incorporated, the cost of fringe benefits and your share of the monthly net profit of the corporation, whether received or not received. 2. If you're not self-employed, your basic rate of compensation from your employer, including commission. AVERAGE MONTHLY INCOME is based on the immediately preceding period which produces the highest average: the preceding tax year; the preceding two tax years; or the entire period, if less than 12 months. It is computed before deduction of income or social insurance taxes and after deduction of the normal business expenses which are deductible for income tax purposes. It does not include bonuses, overtime pay or other compensation.

Definition of Total Covered Disability — You will be considered totally disabled if you are completely unable to perform the material duties of your regular job during the waiting period and the next 60 months of a total disability. Your regular job is that which you were performing on the day before total disability began. After such 60 month period, you will be considered totally disabled if you are unable to perform the material duties of any gainful job for which you are reasonably fit by training, education or experience. The total disability must be a result of a covered injury or sickness. To be considered totally disabled, you must also be under the regular care of a physician, other than yourself or a member of your immediate family, and not performing the duties of any gainful job.

Residual Disability Benefit — If you return to your regular occupation and sustain a loss of at least 25% of your predisability earned income, you may receive a residual disability benefit proportionate to your percentage of continuing income loss. For example, if you return to your work part-time and you sustain a loss of 1/3 of your monthly income, you may receive 1/3 of the monthly disability benefit.

Waiver of Premium — If you become totally disabled as defined by the group policy and receive monthly benefits for 6 continuous months, future premiums will be waived for as long as you are entitled to receive benefits. When you stop receiving monthly benefits, premiums must again be paid when due.

Monthly Benefits To Be Paid For Mental, Nervous Or Emotional Disorders, Alcoholism and Drug Addiction — Disabilities due to nervous, mental or emotional disorders, alcoholism or drug addiction are covered for up to a maximum of 24 monthly benefits while such disability continues. After that, benefits will only be paid if you are an inpatient under a doctor's care in a hospital or institution as a result of the disability, but not beyond the maximum benefit period.

Recurrent Disability — Disability due to the same or related cause, when separated by a return to active work for three or more continuous months, will be treated as a new claim subject to a new waiting period and benefit period. If less than three months has passed, it will be treated as part of the original claim. Disability due to a different cause is automatically considered as a new claim.

Optional Benefits — Long-Term Plan Only

For an extra premium cost, you can add one or more of the following benefits:
Cost-of-Living Adjustment (COLA) | **Recovery Benefit**

Cost-of-Living Adjustment (COLA)

This optional benefit offers disability coverage that, once benefits begin, can help keep pace with the rate of inflation. Monthly benefits will be adjusted annually beginning one year after the date the waiting period begins if you are Totally Disabled prior to age 65. Adjustments may be made to the monthly benefit paid in the second and each succeeding year up to a maximum of 10 adjustments. The adjustment amount will be based on the consumer price index for urban consumers (CPI-U) up to a maximum six percent increase per year and an overall maximum increase of one times the original benefit. Once you are no longer disabled and benefit payments stop, the monthly benefit returns to the original option amount.

Recovery Benefit

You can receive a lump sum recovery benefit upon your return to FULL-TIME WORK following a Covered Total Disability for which you received a Total Monthly Benefit. The benefit payable will be ¼ of the Total Monthly Benefit amount received for each full month of Total Disability to a maximum of three times the last Total Monthly Benefit. The benefit shall not be payable if Covered Residual Disability benefits have been paid.

Eligibility

All members in good standing, residing in the U.S.*, and under age 60 are eligible to apply as long as they are actively at FULL-TIME WORK (at least 30 hours per week).

Effective Date

You will become insured on the date approved by New York Life Insurance Company provided the first premium contribution is paid when due, satisfactory evidence of insurability has been submitted and you are at FULL-TIME WORK on that 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 approved by New York Life Insurance Company.

* Coverage is not available in all states at this time. Contact the Administrator about availability in your state.

Current 2024 Group Rates for Members

The insurance cost is based on the Waiting Period, Plan, Monthly Benefit, and on your attained age when coverage becomes effective and premiums increase as you age when you reach a higher age bracket. Premium contributions will vary depending upon the options and amounts chosen.

Two-Year Plan
Semiannual Premium
Per $1,000 of Monthly Benefit

Age	90-Day Waiting Period
Under AGE 30	$23.00
AGE 30 but before AGE 35	$28.00
AGE 35 but before AGE 40	$30.00
AGE 40 but before AGE 45	$43.00
AGE 45 but before AGE 50	$56.50
AGE 50 but before AGE 55	$76.00
AGE 55 but before AGE 60	$126.00
AGE 60 but before AGE 65+	$189.50
AGE 65 but before AGE 70+*	$261.00

Long-Term Plan
Semiannual Premium
Per $1,000 of Monthly Benefit

Age	90-Day Waiting Period	180-Day Waiting Period
Under AGE 30	$92.30	$72.80
AGE 30 but before AGE 35	$112.10	$88.20
AGE 35 but before AGE 40	$126.40	$99.10
AGE 40 but before AGE 45	$172.70	$134.70
AGE 45 but before AGE 50	$235.00	$185.80
AGE 50 but before AGE 55	$315.10	$247.77
AGE 55 but before AGE 60	$357.00	$280.20
AGE 60 but before AGE 65+	$405.70	$320.50
AGE 65 but before AGE 70+*	$405.70	$320.50

Consider acting NOW to request insurance protection before an accident, injury or illness makes it harder — or impossible to get!

Long-Term Plan with COLA and/or Recovery Benefit
Semiannual Premium
Per $1,000 of Monthly Benefit

Age	COLA Only (No Recovery)		Recovery Only	COLA AND Recovery	
	90-Day Waiting Period	180-Day Waiting Period	180-Day Waiting Period	90-Day Waiting Period	180-Day Waiting Period
Under AGE 30	$98.20	$77.20	$101.80	$127.20	$106.20
AGE 30 but before AGE 35	$118.80	$93.50	$121.70	$152.30	$127.00
AGE 35 but before AGE 40	$134.00	$105.00	$132.60	$167.50	$138.50
AGE 40 but before AGE 45	$183.10	$142.80	$177.30	$225.70	$185.40
AGE 45 but before AGE 50	$249.10	$196.90	$228.40	$291.70	$239.50
AGE 50 but before AGE 55	$334.00	$262.60	$313.50	$399.80	$328.40
AGE 55 but before AGE 60	$379.30	$297.00	$346.00	$445.10	$362.80
AGE 60 but before AGE 65+	$430.30	$339.70	$420.50	$530.30	$439.70
AGE 65 but before AGE 70+*	$203.00	$160.30	$260.30	$303.00	$260.30

+Renewal only. Coverage terminates at age 70.

* At age 65, benefits reduce 5% per year through age 69. 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. 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 Qualified Organization and Association Trust.

Ways to Manage Your Premium

Disability insurance to help replace lost income can be a critical part of any sound financial planning for pharmacists. The CPhA Group Disability Income Insurance Plan is flexible, giving you options so you can easily customize coverage that best meets your income replacement needs with the benefit/premium configuration that's tailored to your budget.

Strategy A

Start income benefit checks ASAP so you have an income stream quickly

Choose the 90-day waiting period

This approach is a good choice if your need for income is such that you do not want to use (or do not have) savings as a fallback at the start of your disability. Some pharmacists choose this option because they want to replace lost income starting as soon as possible.

Strategy B

Make your premium more economical by delaying the start of income checks

Choose a longer waiting period — as long as 6 months (180 days)

This approach is a good choice if you can wait for your benefit payments to begin, perhaps using your own savings in the interim. You'll see that your premium is more economical because of the longer waiting period, so you can significantly reduce your cost of coverage if you select 180 days.

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 receive a full refund, no questions asked!

Duration Of Benefits
Monthly benefits will be paid up to the maximum benefit period — see "Choice of Plans." The benefit period will end earlier if: you fail to give required proof of continuing total or residual disability; your total or residual disability ends; or you die.

When Coverage Ends
Your coverage will terminate for any one of the following reasons: when you reach age 70; you cease to be a member of the Association; you cease FULL-TIME WORK for reasons other than total disability; you fail to pay premiums when due; the group policy ends; the group policy is amended to end insurance for the group of members to whom you belong; the day you begin full-time active duty in the armed forces; or the Association ceases to be a participating Association.

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) declared or undeclared war or any act thereof; incarceration for or participation in (except as a victim) an illegal occupation/activity/insurrection/riot or the commission of a crime; pregnancy, except complications thereof; military service; 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.

The policy limits benefits for disabilities due to mental disorders to 24 months. Benefits for disabilities due to chemical dependency are limited to 24 months.

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 12 consecutive months.

Questions?

Call Toll-Free 1-888-926-CPhA • 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: CPhA.Insurance.service@getamba.com

This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms are set forth in the policy issued by New York Life Insurance Company to the California Pharmacist Association.

CA Insurance License #0I96562 • Association Member Benefits & Insurance Agency
888-926-CPhA • CPhA.Insurance.service@getamba.com • www.CPhAMemberInsurance.com

Sponsored by: california pharmacists association

Underwritten by: NEW YORK LIFE

New York Life Insurance Company
51 Madison Avenue / New York, NY 10010
Under Group Policy No. G-30856-0
on Policy Form GMR-FACE/G-30856-0
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Program Administered by: AMBA

Association Member Benefits & Insurance Agency
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California Pharmacists Association
Group Disability Income Insurance Plan

Return completed application to AMBA, P.O. Box 14555, Des Moines, IA 50306.

FOR MEMBERS OF THE CALIFORNIA PHARMACISTS ASSOCIATION 400066d

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

PART 1 Member Information

Name _____

Address 1 _____ Address 2 _____

City _____ State _____ ZIP _____

Please check one:
☐ Home Address ☐ Business Address

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

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

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

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

PART 2 Membership Affiliation — Occupational Status

A. Are you a member of the California Pharmacists Association? ☐ Yes ☐ No Membership # _____

B. What is your occupation? _____ Main Duties _____

C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed.
Are you at "FULL-TIME WORK"? ☐ Yes ☐ No

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

Commissions $ _____ Total $ _____

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

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

I hereby apply for the coverage indicated below, based upon all my statements made in this application:
☐ Long-Term Plan (Injury & Sickness to Normal Retirement Age) ☐ Two-Year Plan (Injury & Sickness for two years)

Indicate Monthly Benefit Option Desired.
Choose amount of protection from $100 to $10,000 in increments of $500, ($6,000 for ages 50–59): $ _____
You may choose any Monthly Benefit Option provided it and other disability income you may have does not exceed 60% of AVERAGE MONTHLY INCOME (as defined in the brochure).

Note: The monthly benefit amount is based on your Annual Earned Income (after business expenses.)

G-30856-0

OVER, PLEASE

53366/53367/1018/52247

GPA-DI-FMU

PART 3 Insurance Requested: Refer to the Benefits Guide for eligibility, options, rates and coverage description (con't.)

A. Waiting Period: Long Term Plan (to Normal Retirement Age): ☐ 90 days ☐ 180 days Two-Year Plan: 90 days

B. Payment Option Selected: ..... ☐ Semiannually ☐ Quarterly

C. Optional Benefits (LongTerm Plan only):

☐ Cost-of-Living Benefit ☐ Recovery Benefit

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

IF "YES," PLEASE LIST

Company	Plan	Monthly Benefit	Benefit Period

E. Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ..... ☐ Yes ☐ No

If "Yes," please indicate which coverage and the date it will be terminated: _____

PART 4 Statement of Health

To the best of your knowledge and belief, please answer the following questions as they apply to you:

	YES	NO
1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:		
a. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?	☐	☐
b. 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, chronic fatigue in the past five years?	☐	☐
(iii) Any other impairment	☐	☐
3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐	☐
4. Are you now pregnant?	☐	☐
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐	☐
6. During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	☐	☐

7. Driver's License No.: _____ State in which issued: _____

PART 4 Statement of Health (con't)

YES NO

8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations? ..... ☐ ☐

9. Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? ..... ☐ ☐

   If "Yes," please state when you last used tobacco or nicotine products and specify the product used:

   _____ Mo/Yr _____ Product

10. Except for the residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ..... ☐ ☐

    For residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years? ..... ☐ ☐

11. If you have answered any of the above Questions 1-10 "YES," give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

PART 5 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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, LLC ("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 **consents** 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, LLC; and **attest** to having read the IMPORTANT NOTICE and the Fraud Notices below, including how our 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** _____

PLEASE DO NOT SEND ANY PREMIUM UNTIL NEW YORK LIFE INSURANCE APPROVES THIS APPLICATION.
UNTIL APPROVAL IS GRANTED AND A EFFECTIVE DATE IS SPECIFIED NO COVERAGE IS IN FORCE FOR THIS COVERAGE.

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: For your protection California law requires the following to appear on this form:
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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.

IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income 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, LLC ("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, LLC 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.**