Texas Society of CPA Certified Public Accountants

Please complete this form and return to:
TSCPA Group Insurance Program Administrator,
1200 East Glen Avenue, Peoria Heights, IL 61616-5348
Questions: Please call 800.845.8941

NEW YORK LIFE

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

TSCPA GROUP TERM LIFE APPLICATION

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

PART I Personal Info

1. Member Information

Full Name _____ S.S.#: ☐☐☐-☐☐-☐☐☐☐
Last First Middle Initial

Street Address: _____

City: _____ State: _____ Zip Code: ☐☐-☐☐☐ ☐☐☐☐

Home Phone: (_____) _____ Work Phone: (_____) _____

Fax: (_____) _____ Email: _____
For internal use only. Email address will never be sold or shared.

Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single ☐ Civil Union (Eligibility of Civil Union partners is determined by State Law)

		Date of Birth: MO DAY YR	Height:	Weight:	Sex:
Member/Employee:	_____	___/___/___	ft.___ in.___ LBS.	_____	☐ M ☐ F
Spouse**:	_____ Name if proposed for insurance	___/___/___	ft.___ in.___ LBS.	_____	☐ M ☐ F
Child*:	_____ Name if proposed for insurance	___/___/___	ft.___ in.___ LBS.	_____	☐ M ☐ F
Child*:	_____ Name if proposed for insurance	___/___/___	ft.___ in.___ LBS.	_____	☐ M ☐ F

See Plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please **sign and date the additional sheet.

In the next 12 months does any person proposed for insurance intend to reside outside the U.S.?

Member/Employee: ☐ Yes ☐ No Country(ies)_____ How Long? _____
Spouse: ☐ Yes ☐ No Country(ies)_____ How Long? _____

2. Membership Affiliation:

To participate in this plan you must be a TSCPA member or full-time employee of a member. TSCPA Membership? _____

PART II Your Coverage

3. Insurance Requested: Refer to plan information for eligibility, options, and coverage description.

I HEREBY APPLY FOR THE FOLLOWING GROUP TERM LIFE INSURANCE COVERAGE:

A. Member: ☐ **Initial Insurance Amt.** (up to $750,000): $_____ ☐ Add'l Insurance Amt. requested from: $_____ to $_____
Employee:* ☐ **Initial Insurance Amt.** (up to $250,000): $_____ ☐ Add'l Insurance Amt. requested from: $_____ to $_____
Spouse:* ☐ **Initial Insurance Amt.** (not to exceed members): $_____ ☐ Add'l Insurance Amt. requested from: $_____ to $_____
Child:** ☐ **$2,000** for all eligible dependent children.

*Spouse coverage cannot exceed 100% of member's coverage. **Member coverage must be in force to request child coverage.

B. CURRENT COVERAGE:

Member/Employee:
Do you have other life insurance in force? If "Yes," total amount in all companies: ☐ Yes ☐ No Amount: $_____ Company
Do you have other insurance applications pending? If "Yes," indicate amount and company: ☐ Yes ☐ No Amount: $_____ _____

Spouse:
Do you have other life insurance in force? If "Yes," total amount in all companies: ☐ Yes ☐ No Amount: $_____ Company
Do you have other insurance applications pending? If "Yes," indicate amount and company: ☐ Yes ☐ No Amount: $_____ _____

C. INSURANCE REPLACEMENT: IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK
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/Employee: ☐ 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/Employee: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

3. Premium Billing:

Following your initial billing, you will be billed twice a year on January 1 and July 1. You can also access a secure website where you can register to have your premium withdrawn from your bank account or charged to your credit card.

Be Sure To Complete All Pages and Sign Last Page
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

G-14046-1

PART III Your Health

4. Beneficiary Designation: Insert name, relationship, and address.

I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member or employee as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.)

Beneficiary Name:_____ Address:_____ Phone:(____)_____

Beneficiary's relationship to Member/Employee and Social Security #: _____

5. Member/Employee Statement of Health: Please initial any changes you make on this form an

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	MEMBER/ EMPLOYEE		DEPENDENT	
	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?	☐	☐	☐	☐
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, pus, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	☐	☐	☐	☐
c. During the past five years has any person proposed for insurance been counseled, treated, or hospitalized for the use of alcohol or drugs?	☐	☐	☐	☐

Details (please fill out if answered "YES" to a, b, or c): _____

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.

What time and telephone number would be best to contact you? _____

6. 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.
FOR RESIDENTS OF CA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **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 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.

7. 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, 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 in the IMPORTANT NOTICE, including mailing a brief report of my protected health information to MIB, Inc, and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

PART IV Your Signature

Member/Employee Signature **X**_____ Date: _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature **X**_____ Date: _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

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

Full Name: _____ Relationship to proposed insured: _____
LAST FIRST MIDDLE INITIAL

Home Phone: (_____) _____ Work Phone: (_____) _____

Mailing Address: _____
STREET CITY STATE ZIP CODE

Tax ID#:_____ Date of Birth:___/___/___ Social Security #:_____ - ___ - _____

Owner's Signature **X** _____ Date: _____
(NECESSARY ONLY IF OTHER THAN MEMBER/EMPLOYEE)

Be Sure To Complete All Pages and Sign Last Page
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

G-14046-1