

GROUP 10-YEAR LEVEL TERM LIFE APPLICATION

For AAP Members, Spouses and Children

Request for Group Insurance from:

New York Life Insurance Co.
51 Madison Ave.
New York, NY 10010



To apply:
 Complete Form
 Mail To:
 Pediatrics Insurance Consultants, Inc.
 300 S. Wacker Dr.
 Suite 2000
 Chicago, IL 60606-6736



Any Questions?
 Call
 1-800-257-3220
 or
 312-419-9700



(Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.)

1. Member Information

Last	First	Middle	
Billing Street Address	City	State	ZIP
Home Street Address	City	State	ZIP
()	()		
Home Phone	Business Phone		
Fax	Email Address		
Member Social Security Number	Spouse Social Security Number (if applying)		

Are you currently insured under the AAP program? Yes No

If yes, provide details (person insured and amount of insurance):

Person Insured	Amount of Insurance

2. Insurance Requested

Refer to product information for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

Group 10-Year Level Term Life Insurance

A. Total Member Amount Desired:

- \$2,000,000
 \$1,500,000
 \$1,000,000
 \$750,000
 \$500,000
 \$250,000
 Other:* \$ _____

Total Spouse Amount Desired:

- \$2,000,000
 \$1,500,000
 \$1,000,000
 \$750,000
 \$500,000
 \$250,000
 Other:* \$ _____

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

*Coverage is available from \$100,000 to \$2,000,000 in \$10,000 increments.

California and Nevada residents: If applicable, contact the Administrator for Declaration of Domestic Partnership form.

I also request coverage for my eligible children: \$15,000 per child (Check if desired)

B. Payment Option: I request the following periodic billing method: Semi-Annual Annual

C. **Tobacco/Nicotine Use:** Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?

Member: Yes No Spouse: Yes No

If "Yes," when did you last use tobacco or nicotine products?

Member: Month _____ Year _____ Spouse: Month _____ Year _____

2. Insurance Requested (CONTINUED)

D. Insurance Replacement:

RESIDENTS OF NEW YORK: I have read the Important Replacement Information below. 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

NEW YORK RESIDENTS – 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 ALL OTHER STATES:

Is the Life Insurance applied for intended to replace, discontinue or change an existing policy?

Member: Yes No Spouse: Yes No

ALL RESIDENTS:

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_____

Does any person proposed for insurance intend to reside outside the U.S. or Canada in the next 12 months?

Member Yes No Country _____ Spouse Yes No Country _____

If yes, for how long? _____

Proposed for Insurance Member must be insured to insure Spouse or Children	Date of Birth			Height ft./in.	Weight Lbs.	Sex
	Mo.	Day	Yr.			
Member: (First, Middle Initial, Last)						
Spouse*: (First, Middle Initial, Last)						
Child(ren)*: (Name if proposed for insurance)						
Child(ren)*: (Name if proposed for insurance)						

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

3. Membership Affiliation

Are you now an AAP member? Yes, Member ID: _____ No

4. Beneficiary Designation for Member Coverage

I make the following beneficiary designation(s) with respect to all insurance on my life under this Group 10-Year Term Life Insurance plan. The beneficiary for the 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.)

Beneficiary Name	Address	Social Security #	Relationship to Insured	Percent

Statement of Health Please initial any changes you make on this form

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

- | | Yes | No |
|--|--------------------------|--------------------------|
| a. Are you or any other person to be insured disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Is any person to be insured now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. During the past 5 years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for: | | |
| 1. Heart or circulatory trouble, high blood pressure, pain or pressure in the chest? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Arthritis, back trouble, bone or joint disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Fainting spells, convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Sugar, blood, albumin or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Diabetes, kidney trouble, ulcers or digestive disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Disorder of the breast or reproductive organs or functions? | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Nervous or mental disorder, emotional condition or psychiatric care? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Cancer, tumor or cyst? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Varicose veins, hemorrhoids or hernia? | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. Disorder of eyes, ears, nose or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. Thyroid, liver or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. Alcoholism or drug habit? | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. Disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. Other health or physical impairment including: | | |
| (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Any other impairment? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Except for residents of Maryland, has any person to be insured 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"/> |
| h. Within the past two years have you or your spouse participated in, or do either of you plan within the next 2 years to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing or any type of organized motorized racing? | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Driver's License No.: Member _____ Spouse _____
State in which issued: Member _____ Spouse _____
Has your or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years? | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Except for the residents of Minnesota and Connecticut , in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending? | <input type="checkbox"/> | <input type="checkbox"/> |
| For the residents of Minnesota and Connecticut only , in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? | <input type="checkbox"/> | <input type="checkbox"/> |

If you have answered any of the above questions "Yes," give complete details below. (Attach a separate sheet, if necessary, sign and date.) Please avoid the use of such terms as "etc.," "various," or "miscellaneous."

Question Letter/No.	Name(s) 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

FRAUD NOTICES

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 there-to 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 AR/LA/MD: 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 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.

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 authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. 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 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.

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 may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

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; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how their information is exchanged with MIB, and that to the best of their knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature * _____ Date _____ (Please sign and date in ink)

Spouse's Signature * _____ Date _____ (Necessary only if spouse coverage is requested)

Owner Information-Required if owner is other than member

(If owner is a trust, please submit a copy of the document with this application)

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

Mailing Address City State/Province Zip Code Country of Residence Tax ID #

Date of Birth Social Security # Owner's Signature * _____ Date _____ (Necessary only if other than member)

Arkansas Insurance Producer License Number 235028
California Insurance Producer License Number 0F52897

For the 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.