REQUEST FOR *LIFE to 95*®
A GROUP LIFE INSURANCE PLAN

from New York Life Insurance Company ◆ New York, NY 10010

Applicant

_____
Title (Dr. / Mr. / Ms.), First Name, Middle Initial, Last Name

_____ _____
No. & Street *Day Phone*

_____ _____
City *State / Province* *Zip* *Evening Phone*

_____ _____ _____
Social Security # *E-mail** *Cell Phone*

**By providing your e-mail address, you authorize e-mail communications to you about your application and insurance. We do not sell, rent, trade or give away your personal information to anyone, and you will only receive e-mail pertaining to your application and insurance. Please visit www.AlumniLifeTo95.com to learn more about our privacy policy.*

Birth Date_____ Height_____ Weight_____ Gender_____ Occupation_____
Month / Day / Year *Ft. / In.* *Lbs.* *M / F*

My eligibility status is *(check one)*: ❑ Alumnus/a ❑ Student ❑ Eligible Family Member
If Eligible Family Member *(check one)*: ❑ Spouse ❑ Domestic Partner

Sponsoring college, university, or alumni/ae association:_____

	Yes	No
Do you intend to reside outside the United States or Canada within the next 12 months?	❑	❑

If "Yes," which country(ies) and how long?_____

1. Insurance Amount Requested. Refer to the brochure for amounts and coverage description. I request:

❑ $100,000 ❑ $75,000 ❑ $50,000 ❑ $25,000 ❑ Other $_____ *Amounts must be in $1,000 increments; minimum $10,000; maximum $100,000.*

2. Statement of Health. *To the best of your knowledge and belief, answer the questions as they apply to you.*

Name and Address of Applicant's Physician _____

	Yes	No
a. Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	❑	❑
b. During the past five years have you 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 disorders, thyroid disorder, blood disorder, albumin, blood or sugar in the urine, back trouble/disorder, arthritis or unexplained weight loss?	❑	❑
c. During the past five years have you been counseled, treated or hospitalized for the use of alcohol or drugs?	❑	❑

For "Yes" answers to question 2 above, please provide details in the space provided below. If more space is needed, use a separate sheet of paper signed and dated. If additional information is attached, check this box. ❑

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Name, Address, and Phone of Physicians, Hospitals, or Clinics Consulted

Please continue to read, complete, and sign the reverse side of this application.

3. Beneficiary Designation. I name the following to receive all the insurance on my life under this life insurance plan, and I revoke prior beneficiary designations. *(If you need more space, attach a separate sheet that you have signed and dated.)*

_____ % _____ _____
Title (Dr. / Mr. / Ms.),First Name, Middle Initial, Last Name *Relationship*

_____ % _____ _____

_____ % _____ _____

	Yes	No
Is the insurance applied for to replace, discontinue, or change an existing policy?	❑	❑

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, I request the insurance indicated; and I **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 my protected health information to MIB, Inc.; and **attest** to having read the **Important Notice** and **Fraud Notices** enclosed 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.

Applicant's Signature X _____ Date_____
(The Applicant signs here. Please sign in ink.)

G-30790-0
(previously G-16000-95)
Form GMA-EZ2 ED 12/2017 L95

If this application is approved, how would you like to pay premiums?
(Details of the approach you prefer will be sent to you and you can change your choice if you change your mind.)

Check one: ❑ Semiannual bills payable by check or ❑ Monthly automatic withdrawal from your bank account

I apply to become a Subscriber to the Collegiate Alumni Trust II. *CAT II enables members of sponsoring organizations to purchase insurance through a single group insurance policy. Subscribing to CAT II costs nothing but is required to become insured.* I request that any dividend resulting from my participation in this program be paid to the Sponsor named above or to any other entity designated by that Sponsor from time to time, unless I rescind this request by written notice to the Group Policyholder at least 90 days before the policy anniversary date.

Applicant's Signature X _____ Date _____
(The Applicant signs here. Please sign in ink.).

Coverage usually begins on the day your application is approved. However, after you receive approval, you may request another effective date, such as when existing insurance ends or a new financial obligation begins, or the day before your last birthday. To be eligible for coverage, you must be performing the normal activities of a person in good health of like age on that date.

Applicant signs two areas indicated above and mails this request to the Administrator:
Meyer and Associates ◆ 18 Washington Avenue ◆ Chatham, NJ 07928
800-635-7801 Weekdays 8:30AM-6:00PM ET ◆ www.AlumLifeTo95.com

IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request For Life Insurance

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.

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 applications 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 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 website 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 person 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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

7/15 ed.

New York Life Insurance Company

FRAUD NOTICES

Before signing your request for *Life to 95*, which includes a Statement of Health form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued.

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.

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 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.