NATIONAL SOCIETY OF PROFESSIONAL ENGINEERS
1200 E. Glen Avenue, Peoria Heights, IL 61616-5348

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

Plan Administrator:
PEARL® INSURANCE
A DIVISION OF ONE80 INTERMEDIARIES
1200 E. Glen Avenue, Peoria Heights, IL 61616-5348

Please complete this form and return to: NSPE Sponsored Plans, Pearl Insurance, 1200 E. Glen Avenue, Peoria Heights, IL 61616-5348
Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE ENROLLMENT FORM
for Members of the **National Society of Professional Engineers**

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER INFORMATION

Full Name _____ Social Security Number _____

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Fax Number _____

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

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* ◯ Domestic Partner*

* Eligibility of *Domestic Partner/Civil Union* is determined by State Law.

Are you currently insured under any other NSPE Life Plan? ◯ Yes ◯ No If "Yes"" indicate which plan(s) and provide details below:

◯ Term Life ◯ 10-Year Level Term Life Person Insured _____ Amount $ _____

LIST BELOW ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Member (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
◯ Spouse ◯ Domestic Partner (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F
Child** (Name is Proposed for Insurance):	/ /	ft. in.	LBS.	◯ M ◯ F
Child** (Name is 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 of the U.S. or Canada?

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

Spouse: ◯ Yes ◯ No Country(ies) _____ How Long? _____

2. MEMBERSHIP AFFILIATION

Membership in NSPE is required for participation in this plan: NSPE Membership # _____

3. PAYMENT OPTION SELECTION

◯ **Option 1: Direct Billing:** Following your intitial billing, you will be billed (Choose one): ◯ Annual ◯ Semiannual (January 1 and July 1)

◯ **Option 2: Electronic Funds Transfer:** I request and authorize the NSPE Group Insurance Program to make semiannual withdrawals against the account specified on the attached voided check, statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdraws as if I had signed them, for the purpose of collecting premium contributions due under this Group Accidental Death & Dismemberment Insurance plan (Enclose a VOIDED check or deposit slip, as applicable.)

_____

Signature(s) as required on checks issued/withdrawals made against this account date

4. INSURANCE REQUESTED: Refer to Plan Information for eligibility, principal sums, premium, and coverage description.

I hereby apply for the following Accidental Death & Dismemberment coverage: ◯ **$50,000** ◯ **$100,000** ◯ **$150,000** ◯ **$200,000** ◯ **$250,000**

Check one: ◯ **Member Only** ◯ **Member and Family**

Note: If you select Family coverage, the benefit amounts for your spouse and children are based on your family status. See enclosed brochure for more details.

5. BENEFICIARY DESIGNATION: Insert name, relationship, and Social Security Number

I make the following beneficiary designation with respect to all the insurance on my life under this Group Accidental Death & Dismemberment 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 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.) (1) In naming more than one beneficiary, please 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 (Last, First, Middle Initial) | Relationship to Proposed Insured

Date of Birth | Social Security Number | Phone

6. FRAUD NOTICES

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:** 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. **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

By signing and dating this application, the member requests the insurance indicated, and the member and spouse (if proposed for coverage) attest that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature (Please Sign and Date in Ink) | Date

Spouse's Signature (Necessary Only if Spouse Coverage is Requested) | Date

DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

231672