NSPE NATIONAL SOCIETY OF PROFESSIONAL ENGINEERS

1200 E. Glen Ave., Peoria Heights, IL 61616

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 Ave.
Peoria Heights, IL 61616

Questions:
Please call 888.554.7190

Please complete this form and return to: NSPE Sponsored Plans, Pearl Insurance, 1200 E. Glen Ave., 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 DISABILITY INCOME INSURANCE APPLICATION

for Members of the **National Society of Professional Engineers**

Please print in ink or type. Initial and date any changes you make.

A. PERSONAL INFORMATION

Full Name (First, Middle Initial, Last)

Street Address | City | State (or Province) | ZIP

Phone Number (Daytime) | Phone Number (Work) | Fax Number

Social Security # | Email (For internal use only. Email address will never be sold or shared.)

Date Of Birth	Height	Weight	Sex
/ /	ft. in.	lbs.	◯ M ◯ F

Business Address | City | State (or Province) | ZIP

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

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

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

B. MEMBER AFFILIATION

Membership in NSPE is required for participation in this plan. Are you now a member of NSPE? ◯ Yes ◯ No

If yes, please provide NSPE Membership # _____

What is your occupation? _____ Main duties: _____

"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 normally are performed, or other location to which travel is required. Are you at "FULL-TIME WORK"? ◯ Yes ◯ No

Gross Annual Income:

Salary $ _____ Self-employment $ _____ (Self-employment Start Date: _____/_____/_____)

Bonus $ _____ Commission $ _____ **TOTAL $** _____

Your gross annual earned income must be at least $20,000 for you to be eligible for this coverage.

Be sure to complete all pages and sign the last page.

C. INSURANCE REQUESTED (Refer To Plan Information For Eligibility, Principal Sums, Premium And Coverage Description)

Coverage Requested? ◯ New ◯ Additional

Note: If you are increasing or altering present coverage in any way, do NOT indicate in "Item A" below only the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

You may choose any monthly benefit option, provided it and other disability income coverage you may have does not exceed 67% of your monthly gross earned income.

I hereby apply for the coverage indicated below, based upon all my statements made in this application:

◯ A. Member Monthly Benefit Option: $ _____

◯ B. Member Plan Option (choose one): ◯ PLAN C: Payable up to 5 years ◯ PLAN D: Payable up to age 65

◯ C. Member Waiting Period (choose one): ◯ 30-Day ◯ 60-Day ◯ 90-Day ◯ 180-Day

Do you now have or are you applying for other insurance which provides benefits if you are unable to work because of disability? ◯ Yes ◯ No
If "Yes," please list:

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

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: _____

D. STATEMENT OF HEALTH (Please Answer The Following And Give Details Of All "Yes" Answers Below)

1. To the best of your knowledge or belief, answer the following questions as they apply to you or your spouse (if proposed for insurance) :

   A. Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ◯ Yes ◯ No

   B. During the past five years, have you ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or 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, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss? ..... ◯ Yes ◯ No

   C. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? ..... ◯ Yes ◯ No

   D. Are you now pregnant? ..... ◯ Yes ◯ No

   E. Are you now disabled; applied, applying for, or receiving any disability or Workers' Compensation benefits; or on waiver of premium for life or health insurance? ..... ◯ Yes ◯ No

   F. **Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime, served time in prison because of a conviction, or have an arrest pending? ..... ◯ Yes ◯ No

   For residents of Minnesota and Connecticut ONLY, have you been convicted of a crime, served time in prison because of a conviction, or been convicted for any reason during the past 15 years? ..... ◯ Yes ◯ No

Be sure to complete all pages and sign the last page.

D. YOUR HEALTH (Continued)

If you answered "Yes" to the above questions A, B, or C, please explain the details below

Question # and Condition	Physician's name, full address, and phone number (required for processing) Attach sheet of paper if additional space is needed

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 you like to be contacted at? (_____)_____

E. FRAUD NOTICE (Please read before signing the application for insurance)

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:** 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 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.

Be sure to complete all pages and sign the last page.

F. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY

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 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 my protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated and 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.

Signature of Member **Date**

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

I wish to pay my premiums ◯ Quarterly ◯ Semi-annually ◯ Annually

For 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.

Be sure to complete all pages and sign the last page.