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 844.282.2442

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 TERM LIFE 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.)

Marital Status	Date Of Birth	Height	Weight	Sex
◯ Married ◯ Divorced ◯ Widowed ◯ Single	/ /	ft. in.	lbs.	◯ M ◯ F

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

C. YOUR COVERAGE

Amount Desired: $ _____ Please Indicate ◯ New Coverage ◯ Change in Coverage

DEPENDENT LIFE: Spouse: $ _____ Child(ren) ◯ Yes ◯ No

At any time during the last 12 months, have you smoked cigarettes or cigars, or used a pipe, chewing tobacco, nicotine chewing gum, or snuff?

MEMBER ◯ Yes ◯ No SPOUSE ◯ Yes ◯ No

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assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue, or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. ◯ Yes ◯ No
Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? ◯ Yes ◯ No

Residents of ALL OTHER STATES: Is the Insurance applied for intended to replace, discontinue, or change an existing policy? ◯ Yes ◯ No

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Be sure to complete all pages and sign last page. DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

D. BENEFICIARY

Beneficiary: _____
Full Name Relationship

IF DEPENDENT COVERAGE IS DESIRED, COMPLETE THE FOLLOWING.	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Spouse (Name is Proposed for Insurance):	/ /	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

By applying for this insurance, do you intend to replace, discontinue, or change an existing policy of life insurance? ◯ Yes ◯ No

E. YOUR HEALTH

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

1. Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ◯ Yes ◯ No
2. During the past five years, has any person to be insured 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 psychotnerapeutic 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
3. During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? ..... ◯ Yes ◯ No

If you answered "yes" to any of the above medical questions, please explain the details below

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

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

FRAUD NOTICE – 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

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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.

G. 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 and any person proposed for insurance 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/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated [above, below, on the reverse of this page, on the attached, enclosed], including how [my/our] information is exchanged with MIB, and that to the best of [my/our] knowledge and belief, the answers provided to the questions are true and complete.

Signature of Member Date

Signature of Spouse (if proposed for insurance) Date

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