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GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE ASSOCIATION OF JUNIOR LEAGUES INTERNATIONAL

THE ASSOCIATION OF JUNIOR LEAGUES INTERNATIONAL

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

To Apply: Complete This Form and Return To:
ADMINISTRATOR
AJLI GROUP INSURANCE PROGRAM
PO BOX 14536 • Des Moines, IA 50306

For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS? Call: 1-800-882-5547
customerservice.service@getamba.com

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address: _____
AMBA will not share your email information.

Member's Date of Birth: _____ Sex: ❑ M ❑ F
MO. DAY YR.

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. Weight _____lbs.

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)

❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Do you intend to reside outside the U.S. in the next 12 months?
Member: ❑ YES, Countries:_____ For how long? _____ ❑ No

Spouse: ❑ YES, Countries:_____ For how long? _____ ❑ No

	DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:_____	____/____/____	____ft. ____in.	_____lbs.	❑M ❑F
Spouse*:_____	____/____/____	____ft. ____in.	_____lbs.	❑M ❑F

Name (if proposed for insurance) First/MI/Last

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the Association of Junior Leagues International? ❑ Yes ❑ No Membership # _____

B. What is your occupation? _____

Main Duties: _____

C. "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 are normally performed. Are you at "FULL-TIME WORK"? ❑ Yes ❑ No

D. Gross Annual Income from: Salary $_____ Self-Employment $_____ (Self-employment start date _____)
(Mo./Day/Yr.)

Bonus $ _____ Commissions $_____

Total $ _____

E. YOUR ANNUAL NET EARNED INCOME $_____

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal service— before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes—for any twelve-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

3. Insurance Requested: Refer to the Plan Information/Plan Details for eligibility, options, and coverage description.

I request the following coverage: ❑ new ❑ additional

If you are increasing or altering your present amount of coverage, indicate the new TOTAL AMOUNT below.

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 60% of your AVERAGE MONTHLY INCOME, as defined in the brochure.

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

Your ANNUAL NET EARNED INCOME must be at least $20,000 for you to be eligible for this coverage.

Member **Monthly Benefit Option:** $_____**Waiting Period:** ❑ 180-day ❑ 90-day

Spouse Monthly **Benefit Option** if proposed for insurance)**:** $_____ **Waiting Period:** ❑ 180-day (Plan A) ❑ 90-day (Plan B)

Do you now have or are you now applying for any 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.) _____

Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the AJLI Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check, and such bank to process the withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Insurance Plan. (Enclose a voided check.)

_____

SIGNATURE (S) AS REQUIRED ON ALL CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT

❑ **Option 2:** Periodic Billing: ❑ Quarterly ❑ Annual ❑ Semiannual

A $2.00 billing fee will be included for modes other than Annual and EFT.

4. Statement of Health: Please initial and date any changes you make on this form.

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

	MEMBER		SPOUSE	
	YES	NO	YES	NO
1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?.....	❑	❑	❑	❑
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:				
a. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?.....	❑	❑	❑	❑
b. Other Health or physical impairment including:				
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	❑	❑	❑	❑
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?.....	❑	❑	❑	❑
(iii) Any other impairment?.....	❑	❑	❑	❑
3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?.....	❑	❑	❑	❑
4. Are you now pregnant?.....	❑	❑	❑	❑
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?.....	❑	❑	❑	❑

4. Statement of Health: ***(continued)*** Please initial and date any changes you make on this form.

		MEMBER		SPOUSE	
		YES	NO	YES	NO
6.	During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?.....	❑	❑	❑	❑
7.	Driver's License No.: _____ State in which issued: _____				
8.	During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?.....	❑	❑	❑	❑
9.	Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?.....	❑	❑	❑	❑
	If "Yes," please state when you last used tobacco or nicotine products and specify the product used:				
	_____ Mo/Yr _____ Product				
10.	**Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?.....	❑	❑	❑	❑
	For residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?.....	❑	❑	❑	❑

11. If you have answered any of the above Questions 1-10 "YES," give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

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 or MIB, LLC ("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 our protected health information to MIB, LLC; and **attest** to having read the IMPORTANT NOTICE and the Fraud Notices below, including how our 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.

Member's Signature_____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature_____ **Date** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED; PLEASE SIGN AND DATE IN INK)

PLEASE DO NOT SEND ANY PREMIUM UNTIL NEW YORK LIFE INSSURANCE APPROVES THIS APPLICATION. UNTIL APPROVAL IS GRANTED AND A EFFECTIVE DATE IS SPECIFIED NO COVERAGE IS IN FORCE FOR THIS COVERAGE.

5/21 ed.

FRAUD NOTICE – *For Residents of all states <u>except</u> 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. **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.

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.

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 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.

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income Insurance Plan

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, LLC ("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.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

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 application 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 life and health 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, LLC 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site 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 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 family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company **7/15 ed.**

AJLI Group Disability Income Insurance

Underwritten by New York Life Insurance Company

THE ASSOCIATION OF JUNIOR LEAGUES INTERNATIONAL

WHY DISABILITY INSURANCE IS SO IMPORTANT?

Just as life insurance helps replace earnings lost through death, disability insurance helps replace earnings lost when you are totally disabled due to an injury or sickness and unable to work. That's why we're making the Group Disability Income Insurance available especially for Junior League members.

WHO IS ELIGIBLE?

Members of the AJLI who are under age 60 and at FULL-TIME WORK can request coverage, provided they reside in the United States (except AK, DE, FL, LA, ME, MD, MO, MT, NV, NH, NM, NC, OH, OR, SD, TX, VT, UT, WA, WY and territories) and Puerto Rico and have an ANNUAL NET EARNED INCOME of at least $20,000. However, members on active duty in the armed forces are not eligible.

You can also request coverage for your lawful spouse, under age 60, at FULL-TIME WORK, and not on active military duty. A spouse who is also a member may be insured as a spouse or a member, but not both.

You decide how much monthly income insurance protection you want.

Only you know the amount of monthly insurance protection you would need should you become totally disabled . . . and the amount of protection you can afford to purchase. With this coverage, you can select from $500 to $5,000, not to exceed 60% of your AVERAGE MONTHLY INCOME, in monthly benefits in increments of $100. At age 60, your coverage will be reduced to a maximum of $2,000.

ACCIDENT AND SICKNESS DISABILITY BENEFITS

If you become totally disabled by a covered sickness or accidental injury and the disability begins before age 61, benefits will be paid for five years. For a total disability beginning on or after age 61 but prior to age 62, benefits will be paid for four years; for total disability beginning on or after age 62 but prior to age 63, benefits will be paid three years; for total disability beginning on or after age 63 but prior to age 65, benefits will be paid for 12 months.

The benefit period for disabilities due to mental disorder and chemical dependency is limited, as described in EXCLUSIONS AND LIMITATIONS.

APPROVED BY THE JUNIOR LEAGUE

The Junior League Group Disability Income Insurance Coverage has been carefully reviewed by the Junior League, which believes that this coverage, its administrator and its underwriter together represent quality coverage and service available for the cost.

DURATION OF BENEFITS

Monthly benefits will be paid up to the maximum benefit period. The duration of this period is based on your attained age when you become totally disabled. The benefit will end on the date: you fail to give required proof of continuing total disability; your total disability ends; the maximum benefit period ends; or you die.

YOUR PREMIUMS WAIVED IF YOU ARE DISABLED

After you receive disability benefits under this policy for six continuous months, your monthly premium will be waived for the duration of your disability. Of course, no premium can be waived for any period of disability for which benefits are not payable. When you stop receiving monthly benefits, premiums must again be paid when due.

RECURRING DISABILITIES

If the same disability is not separated by at least 90 or more continuous days of FULL-TIME WORK from the end of the previous disability period, both occurrences will be treated as the same disability.

CHOOSE THE WAITING PERIOD THAT SUITS YOUR BUDGET

You decide when benefits start being paid—90 days or 180 days—after the start of the disability. If you choose the longer of these two "waiting periods," your premiums will be more economical.

DEFINITION OF DISABILITY

Covered Total Disability

A Covered Total Disability is an incapacity that completely and continuously prevents you from doing the material and substantial duties of: your regular occupation during the waiting period and during the next 24 consecutive months. And, any occupation for which you have or may become qualified by reason of education, training or experience, after the waiting period and the initial 24 consecutive months period has elapsed. Such Covered Total Disability must begin while you have been insured under the Policy and be the result of: (1) an injury. For a Covered Total Disability to be considered to have resulted from an injury, the Covered Total Disability must begin within 90 days after an accident, if the accident occurs while you have been insured under the Policy. If more than 90 days has elapsed, such Covered Total Disability will be considered to have resulted from a sickness; (2) a sickness; or (3) an organ donation that you make, provided you have been insured under the Policy for at least six consecutive months on the day of such donation.

EXCLUSIONS and LIMITATIONS: No benefits are payable for any disability that is due or related to: A Crime or Illegal Occupation; a Preexisting condition (explained in detail within the brochure); Pregnancy, Childbirth or a Related Medical Condition except for a Complication of Pregnancy, a Self-Inflicted Injury, whether sane or insane; any disease or condition specifically excluded from your coverage; or a War Condition. No benefits are payable for any disability for which you are not under the regular care of a licensed physician or surgeon other than yourself or member of your immediate family or household. The Policy limits benefits for disabilities due to mental disorders or chemical dependency to 24 months; however this limitation does not apply while you are institutionalized.

IMPORTANT FEATURES

The Group Cost reflects the mass purchasing power of AJLI. Compare your existing coverage rates to our group rates and see if you can save.

When Coverage Becomes Effective

Your insurance will become effective the first day of the month immediately following the date your application is approved by New York Life, provided you remain at FULL-TIME WORK and your initial premium payment has been received. If you are not at FULL-TIME WORK on the effective date, coverage is deferred until the first day of the month on or next following the date you complete 90 consecutive days of FULL-TIME WORK.

When Coverage Ends

Your coverage will remain in force as long as you remain a Junior League member, pay your premiums as they come due, at FULL-TIME WORK, except for reasons of total disability covered under the group policy and the Master Policy is kept in force and insurance does not end for your class. Coverage terminates at age 65 for all insureds.

DEFINED TERMS

FULL-TIME WORK means the active performance for pay or profit of the regular duties of one's normal occupation on a basis of at least 30 hours each week at a place where such duties are normally performed or other location to which travel is required.

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal services before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes for any 12-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

AVERAGE MONTHLY INCOME means, as of any date: For a person who is self-employed, your: (a) wages, salaries, fees, commissions, and any other amounts received by such person for personal services; and (b) if the person's business is incorporated, the cost of fringe benefits and your share of the monthly net profit of the corporation, whether received or not received; or For a person who is not self-employed, your basic rate of monthly compensation from your employer, including commissions.

AVERAGE MONTHLY INCOME does not include income from bonuses, overtime pay or other extra compensation. As of any date, these income amounts are computed: 1. for the immediately preceding period which produces the highest average, as follows: the immediately preceding tax year; (b) the immediately preceding two tax years; or (c) the entire period, if less than 12 months; except that: Current earnings for a Covered Residual Disability, are computed for the most recent six months, or for the entire period if shorter, since you returned to work; 2. before deduction of any income taxes or social insurance taxes; and 3. after deduction of normal and usual business expenses that are deductible for income tax purposes.

PRE-EXISTING CONDITION: means an injury or sickness or any condition related to such injury or sickness for which a person has been medically diagnosed or treated by a doctor, including taking any medications during the 12 month period immediately before the covered person's certificate effective date. Preexisting Condition does not include: a) any such injury or sickness or condition for which such person has not consulted a doctor, received medical services or supplies or taken any education during the 12 month period immediately after he or she first becomes a covered person; (b) any such injury or sickness or condition after such person has been continuously insured under the Policy for 24 months; or (c) an injury or sickness or condition classified as an Impairment Restriction.

CURRENT 2025 QUARTERLY PREMIUM RATES

The insurance cost is based on the Waiting Period, Monthly Benefit, and on your attained age (for both you and your spouse) when coverage becomes effective. Cost for increases as you reach a higher age bracket. Premium contributions will vary depending upon the options and amounts chosen.

PLAN A: Benefits begin on the 181st day of covered disability.

Monthly Benefit	Under Age 30		30-39		40-49		50-59		60-64*	
	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE
$1,000	$11.00	$8.00	$12.00	$8.50	$27.00	$20.50	$65.00	$66.50	$78.50	$93.00
$2,000	$22.00	$16.00	$24.00	$17.00	$54.00	$41.00	$130.00	$133.00	$157.00	$186.00

PLAN B: Benefits begin on the 91st day of covered disability.

Monthly Benefit	Under Age 30		30-39		40-49		50-59		60-64*	
	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE	MEMBER	SPOUSE
$1,000	$12.00	$9.00	$13.00	$9.50	$31.00	$23.50	$72.50	$75.00	$86.50	$103.00
$2,000	$22.00	$16.00	$24.00	$17.00	$54.00	$41.00	$130.00	$133.00	$157.00	$186.00

*Renewal Only

These rates increase on the next premium due date following your attainment of ages 30, 40, 50 and 60. Your monthly benefit amount will be limited to a maximum of $2,000 on the premium due date coinciding with or next following the date you attain age 60. This reduction applies to the monthly benefit amount payable for total disability that commences prior to age 60 as well as total disability that commences after age 60. Coverage terminates upon attainment of age 65. The Company reserves the right to change premiums based on the experience of the group as a whole. If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option as well as paying annually.

HOW TO APPLY

1. Complete the enclosed Application Form. It is extremely important that you answer fully the questions about medical history on this form. New York Life will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage. Please note that New York Life retains the right to request additional medical information and may contact you directly.
2. Do not send any money until New York Life Insurance Company has approved your application and notifies you of the premium contribution due, based on the information you have provided.

If you choose the Electronic Funds Transfer (EFT) Option, be sure to include a voided check in addition to the check for the first payment due.

3. Mail the Application Form to:
   AJLI Group Insurance Program
   P.O. BOX 14536
   Des Moines, IA 50306

Residents of Puerto Rico:
Please send your completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

CONSIDER YOUR ELIGIBILITY

Before you request coverage, you must be a member in good standing of AJLI. Please wait until your application for membership is accepted before initiating your insurance requests. If you have any questions about your eligibility or the features of this plan, call a service representative toll-free at 1-800-882-5547 or e-mail: customerservice.service@getamba.com.

ABOUT YOUR REQUEST FOR COVERAGE

New York Life reserves the right to request medical information to determine an applicant's medical eligibility for coverage. Based on the age of the person proposed for insurance and the amount of coverage requested, a physical examination, EKG, blood test or other information may be required.

Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the program.

Request for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

HOW TO FILE A CLAIM

To file a claim, write the Administrator for claim forms.

This Group Disability Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
Under Policy Form GMR,
Group Policy No. G-30713-0/FACE

This Group Disability Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)
AJLI Group Insurance Program
P.O. Box 14536
Des Moines, IA 50306

Questions?
1-800-882-5547

Association Member Benefits Advisors, LLC
AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions, including costs, eligibility, renewability, limitations and exclusions are as set forth in the group policy issued by New York Life Insurance Company to the Association of Junior Leagues International, Inc.

AJLI incurs cost in connection with this program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs.

30-DAY FREE LOOK
If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated and you will receive a full refund – no questions asked!