Group Disability Income Insurance

For Members of the Alumni Association of the University of Michigan

Underwritten by New York Life Insurance Company

DISABILITY INSURANCE WHAT IT IS AND WHY YOU MAY NEED IT

Your ability to earn an income is a significant asset. Even if you are young and healthy, a serious illness or injury could put you out of work for months or even years—thus jeopardizing your livelihood. Adequate disability insurance coverage helps protect your family from financial catastrophe that could result from the loss of your income. Group Disability Income Insurance, sponsored by AAUM, can be a reliable source of disability income protection. You probably insure your home, car, even your life. Help protect your income too.

WHO IS ELIGIBLE?

AAUM Members who are under age 60 and at FULL-TIME WORK can request coverage, provided they reside in the United States (except 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. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation on the basis of at least 30 hours per week at the place where such duties are normally performed. Not available in all states at this time. Contact the Administrator about availability in your state.

"Gross ANNUAL 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.

It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

HOW TO HELP DETERMINE YOUR NEEDS

Before you can determine what you may need, you should understand what disability coverage you might already have. Below is a brief description of the traditional mainstays for this coverage. Consider carefully how each one may benefit you.

Employer-provided disability benefits are available to many AAUM members. But even if your employer offers disability insurance, don't assume you're adequately protected.

The amount of coverage provided and the length of time benefits are paid vary widely with each policy. Find out from your employer what kind of benefits you could expect. Specifically, you should ask:

A. How long after I become disabled must I wait before benefits begin? (This is known as a "Waiting Period.")
B. How long are benefits paid during disability?
C. What percentage of my salary will these payments represent?

Social Security You should contact your local Social Security office to determine what benefits would be available to you. Don't assume this program will provide adequate insurance protection in the event of any disability—it may not.

Worker's Compensation benefits may be paid in instances where an accident or illness has occurred at your place of work, or as a result of your employment. Your chances of having a job-related injury and subsequently receiving Worker's Compensation benefits are probably low. Like employer-provided policies, benefits vary widely.

Individually purchased disability insurance offers a variety of options and benefits. These policies help bridge the gap between disability benefits you may be eligible to receive and the income level you will need without your regular paycheck. Most disability income insurance policies cover only a percentage of your full salary, usually 50 to 70%. (You may not need to replace your entire salary as you may save significantly on taxes, transportation, clothing and other work-related expenses.)

THE AAUM GROUP DISABILITY INCOME INSURANCE COVERAGE

Other, less comprehensive policies may pay benefits only if you are unable to work at any occupation. The AAUM Disability Income Insurance Coverage pays benefits for the first 2 years when you are unable to perform the material duties of your regular job as result of an injury or sickness. "Of your regular job" is an important distinction which adds to the value of this insurance policy. "Your regular job" is that which you were performing on the day before the disability began.

After the first 2 years, Monthly Benefits will continue for three more years provided you are unable to perform the material duties of any gainful job for which you are reasonably fit by training, education or experience. The maximum benefit period is 5 years, for disabilities commencing before age 66. For disabilities commencing at later ages, the maximum benefit period is as follows:

For Disability Beginning	Monthly Benefits May Continue
Before age 66	Up to 5 years
At age 66 but before 67	Up to 4 years
At age 67 but before 68	Up to 3 years
At age 68 but before 69	Up to 2 years
At age 69 but before 70	Up to 1 year

For disabilities due to mental disorders or substance abuse, the benefit period will be limited as noted in EXCLUSIONS AND LIMITATIONS.

HOW IT WORKS

This policy is designed to provide you with a regular monthly income when you are Totally Disabled and unable to work as a result of a covered injury or sickness.

SELECT THE DOLLAR AMOUNT OF YOUR MONTHLY BENEFIT

You may apply for benefits ranging from $100 to $10,000 a month, in $100 increments.

Total disability benefits you receive from this policy and from any other income replacement policies (including Worker's Compensation, Social Security, employer-sponsored salary continuation, group or franchise policies or retirement programs) you may have or for which you are applying may not exceed 50% of your AVERAGE MONTHLY INCOME. This is the monthly average of your ANNUAL EARNED INCOME for the following period that produces the highest figure: preceding tax year; preceding two tax year; or the entire period, if less than 12 months.

At age 65, a monthly benefit in excess of $2,000 will be reduced to $2,000, with a corresponding adjustment in premium. This reduction will not apply if you are on claim and receiving benefits.

SUCCESSIVE PERIODS OF DISABILITY

Successive periods of disability will be considered one period of disability unless they are due to unrelated causes, or separated by a return to active work for 6 or more continuous months. A separate waiting period will apply for each separate period of total disability.

CHOOSE THE WAITING PERIOD

The Waiting Period establishes when your monthly benefits can begin. You can request that benefits begin on the 61st, 91st or 181st day of your disability. The longer you choose to wait, the more economical your premium will be.

WAIVER OF PREMIUM

If you become totally disabled and the disability is one for which benefits are payable for at least six months, premiums due thereafter will be waived for as long as you continue to receive benefits. When you stop receiving monthly benefits, premiums must again be paid when due.

RENEWABILITY AND TERMINATION

The insurance company cannot terminate coverage or change premiums on an individual basis: It may only do so on a class-wide basis. While the Group Policy remains in force, you can remain insured until age 70, provided you do not cease FULL-TIME WORK, as defined, for reason other than total disability and pay premiums on time. Coverage terminates if you enter Active Duty, cease to be a resident of the United States or are on foreign travel for longer than 12 months.

A person's insurance will end at the earliest of the date the group policy ends; the date insurance ends for his/her class; the end of the period for which the last premium has been paid by him/her; the date the person ceases full-time employment for reasons other than total disability.

EXCLUSIONS AND LIMITATIONS

No benefits are payable for any period of disability during which you are not under the direct care and treatment of a licensed physician. Benefits are not payable for disability due to: war or act of war, military service, preexisting condition (see below), intentionally self-inflicted injuries whether sane or insane, or your participation in (except as a victim) or incarceration for a crime or illegal activity. Benefits are not payable during the Waiting Period.

The benefit period for disability due to mental, nervous or emotional disorders, alcoholism and drug addiction will be limited to a maximum of 24 monthly benefits while such disability continues.

TERMS OF COVERAGE

PRE-EXISTING CONDITIONS

No benefits will be paid for any disability which is a result of a pre-existing condition. A pre-existing condition is an injury or sickness for which a person incurred charges, received medical treatment, consulted a physician or took prescribed drugs during the 12 months immediately before the insured's Effective Date of Insurance. Benefits are not payable for a disability due to a pre-existing condition until the earlier of: 12 consecutive months during which you have not consulted a physician, took medication, or received medical services or supplies, or; 24 months.

YOUR EFFECTIVE DATE

Insurance for the Disability Income Insurance coverage becomes effective on the the date the application is approved by New York Life Insurance Company, provided the first premium has been paid. You must be at FULL-TIME WORK on the date insurance is to take effect. If not, insurance will take effect on the day you resume such work.

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!

CURRENT 2025 SEMIANNUAL PREMIUMS PER $100 MONTHLY BENEFIT

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

Member's Age	Benefits Start on 61st Day (60-Day Waiting Period)	Benefits Start on 91st Day (90-Day Waiting Period)	Benefits Start on 181st Day (180-Day Waiting Period)
Under 30	$3.00	$2.20	$1.65
30-34	4.00	3.20	2.40
35-39	5.20	4.20	3.25
40-44	7.00	5.20	3.76
45-49	10.60	8.20	6.78
50-54	17.00	12.40	9.86
55-59	27.80	21.00	16.23
60-69*	27.80	21.00	14.62

*Renewal rates only. Only those under age 60 may apply. Insurance terminates at age 70.

Rates will not be changed unless they are changed for all insureds in your classification, or when you reach the next age category.

Coverage greater than $2,000 will be reduced to $2,000 upon attainment of age 65.

This Group Disability **Insurance Is Underwritten By:**

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. 30945-0
on Policy Form GMR-FACE/G-30945-0

This Group Disability **Insurance Is Administered By:**

Association Member Benefits Advisors, LLC (AMBA)
AAUM Group Insurance Program
P.O. BOX 14533
Des Moines, IA 50306

Any questions?
1-888-560-2586
www.alumniplans.com/aaum

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 are as set forth in the group policy issued by New York Life Insurance Company to the Alumni Association of the University of Michigan.

AAUM incurs costs in connection with this sponsored Program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The AAUM also receives a fee for the license of its name and logo for use in connection with this coverage.

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.

3. Mail the Application Form to this address:
   AAUM Group Insurance Program
   P.O. BOX 14533
   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

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 are free of charge.

10/21 ed.
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GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE ALUMNI ASSOCIATION OF THE UNIVERSITY OF MICHIGAN

TO APPLY:
Send no money now.
Complete this form and return to:
ADMINISTRATOR
AAUM **GROUP INSURANCE PROGRAM**
P.O. BOX 14533 • 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: 1-888-560-2586
customerservice.service@getamba.com

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

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

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the Alumni Association of the University of Michigan? ❑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 $ _____

"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.

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

3. Insurance Requested: Refer to the Policy Information/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 in item A. 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 50% 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:

A. **Monthly Benefit Option:** $_____(not to exceed 50% of your AVERAGE MONTHLY INCOME)

B. **Benefit Period:** Five Year Policy

C. **Waiting Period:** ❑ 60-day ❑ 90-day ❑ 180-day

D. Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the AMBA 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 Policy. (Enclose a voided check.)

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

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

E. 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

F. Do you intend to discontinue any of the disability insurance listed in "e," above, if the coverage applied for is approved? ❑ Yes ❑ No
(If "YES," please indicate which coverage and the date it will be terminated.) _____

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.

	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.

		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.	**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?.....	❑	❑

10. If you have answered any of the above Questions 1-9 "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:

FRAUD NOTICE – ***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. **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 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.

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 PR: 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.

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, 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 our protected health information to MIB, Inc.; and **attests** to having read the IMPORTANT NOTICE attached and the Fraud Notices indicated above, 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)

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.

5/19 ed.

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, 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.

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, Inc. 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 **8/12 ed.**