Group Disability Income Insurance

ASME SETTING THE STANDARD
ASME INSURANCE PROGRAM

For American Society of Mechanical Engineers Members And Their Spouses

Underwritten by New York Life Insurance Company

INSURE YOUR INCOME—YOUR MOST VALUABLE ASSET

Your most important asset is your ability to earn income. 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. A reliable source of disability income protection is this Group Disability Income Insurance exclusively for ASME members.

Even if you have some disability insurance through your employer, it may not be enough. Many employers provide only a short-term salary continuation policy or short-term disability income policy. This Policy can beused to supplement benefits provided by your employer policy or as primary protection.

This Policy is designed to provide you with a regular monthly income when you are totally disabled and unable to work as the result of a covered illness or injury.

WHO IS ELIGIBLE?

ASME members under age 70 who are at FULL-TIME WORK are eligible to request coverage, provided their gross annual income is at least $20,000.

"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 performed.

This coverage is only available to residents of the United States (except VT and territories) and Puerto Rico. This coverage is not available to residents of Canada.

If you have any questions or would like additional information, please call the Administrator at 1-800-289-ASME(2763).

You may request coverage for your lawful spouse who is under age 60, not insured as a member and actively performing the normal activities of a person in good health of like age with the same resident requirements as for members. Your spouse can be working for you, for someone else, or be a homemaker. You, the member, must be insured for a minimum of $600 a month for your spouse to be eligible.

HOW IT WORKS

YOU CHOOSE YOUR COVERAGE, MONTHLY BENEFIT AND WAITING PERIOD

Choice of Three Policies: The Career Policy, the Five-Year Policy, or the Inflation-Fighter Career Policy.

All three policies pay monthly benefits when you are Totally Disabled: prevented by a covered illness or injury from performing the material and substantial duties of your usual occupation, provided you are not otherwise working for pay or profit.

Benefits begin at the end of the waiting period, provided you are Totally Disabled.

Note: Benefits for disabilities due to Mental Disorders are limited to a maximum of 24 months, regardless of Policy choice.

Definition of Total Disability for Spouse: Incapacity, due to a covered illness or accident, which prevents you to perform the material and substantial duties of the spouse's regular occupation for pay or profit or from performing all the customary duties of a homemaker, provided he/she is not engaged in any occupation for pay or profit.

Career Policy: If you are Totally Disabled before age 63, benefits are payable up to age 65. There is a two year maximum benefit for Total Disabilities starting at ages 63 through 74.

Five-Year Policy: Benefits are payable up to five years for Total Disabilities starting before age 60. For Total Disabilities starting at ages 60 through age 62, benefits may continue up to age 65. For Total Disabilities starting at ages 63 through 74, benefits may continue for up to two years.

Inflation-Fighter Career Policy: This Policy offers disability coverage that, once benefits begin, can help keep pace with the rate of inflation. Monthly benefits will be adjusted annually from the date of disability if you are Totally Disabled prior to age 63. Adjustments may be made to the Monthly Benefit paid in the second and each succeeding year. The Adjustment amount will be based on the Consumer Price Index for Urban Consumers (CPI-U) up to a maximum 5% increase per year and an overall maximum increase of one times the original benefit.* Once you are no longer disabled and benefit payments stop, the Monthly Benefit returns to the original option amount.

Benefits are payable up to age 65 for Total Disabilities starting before age 63. After age 62, the inflation-fighter feature is no longer applicable and, for Total Disabilities starting at ages 63 through 74, benefits will be payable in accordance with the basic Career Policy (i.e., up to two years maximum).

*A "catch up" feature allows disabled members to receive benefit increases in excess of the 5% annual maximum if the prior years' compounded rates of inflation were less than 5% annually. Contact the Administrator for additional details on this feature.

Choice of Monthly Benefits–Up to $7,500 per Month

You have a wide choice of Monthly Benefit Options, from $150 to $7,500 (in $150 units). However, members age 65 through 69 may not request a Monthly Benefit Option in excess of $3,750. The option you choose, together with any other disability income insurance you may have, cannot exceed 60% of your gross monthly earned income. Depending on your state of residence, you may be eligible to receive disability benefits under a state policy. You may wish to check if your state offers this type of benefit.

QUESTIONS?



1-800-289-ASME (2763) **ASME.service@getamba.com** **www.asmeinsurance.com**

NOTE: On the premium due date on or immediately after reaching age 65, benefits in excess of $3,750 per month will reduce to $3,750, and on the premium due date on or immediately after reaching age 70, benefits in excess of $1,800 per month will reduce to $1,800.
Gross monthly earned income means 1/12th of your wages, salaries, commissions, fees and other amounts received for personal services - before deduction of income or social insurance taxes and after deduction of the normal business expenses which are deductiblefor income tax purposes - for the immediately preceding 12-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

Choice of Waiting Periods

You also have a choice of four waiting periods before benefit payments begin: 30, 90, 180, or 365 days. A waiting period is the number of consecutive days that you must be Totally Disabled before benefits commence. You should choose one that will provide benefits when your employer-provided salary continuation insurance runs out. Coverage with a longer waiting period is less expensive.

Spouse Benefit Available: If you apply for, or are covered under, either member coverage, you may apply for coverage for your lawful spouse, to provide $500 in benefits per month, payable up to 2 years, with 30-day elimination (waiting) period.

FEATURES

Note: Benefits for Rehabilitation, Covered Partial Disability, Specific Indemnities and Non-Disabling Injuries Due to Accident, Transplants and Survivor Benefits will NOT apply to spouse coverage. Waiver of Premium only applies when member premium contributions are waived.

Waiver of Premium

After you have been Totally Disabled for six consecutive months and you begin to receive benefits for Total Disability, all future premium contributions under this coverage will be waived for as long as you receive benefits for that disability.

Waiver of premium for spouse coverage applies only when member premium contributions are waived.

Membership Dues Waived During Disability

Once you begin to receive benefits for Total Disability, future membership dues becoming due will be paid for you by the ASME Group Disability Income. (Contact the Administrator for information about how to submit your dues for payment.)

Benefits for Recurring Disability

Successive periods of disability which are due to the same or related causes will be considered a single period of disability unless separated by return to FULL-TIME WORK for three consecutive months or more.

Rehabilitation Benefit

This benefit is designed to help certain disabled individuals return to the work force. Under this provision, a professional rehabilitation staff reviews case histories and identifies those individuals who appear to have the greatest likelihood of rehabilitation. Individuals selected by New York Life Insurance Company will be offered the option of participating in a rehabilitation program at no cost to them. Participation is voluntary and benefits will not be reduced due to participation in the program. Additionally, participation in a rehabilitation program for more than a total of 24 months will not be approved in connection with one period of Covered Total Disability.

Partial Disability Benefit

While you are recovering from a Covered Total Disability, you may be eligible to receive a partial disability benefit even though you return to work. If you return to work immediately following a period of Covered Total Disability for which benefits were payable, you may continue to receive your monthly disability benefit until the earlier of the maximum benefit period payable for Covered Total Disability or 24 monthly payments. However, the amount of your Monthly Benefit Option, together with all other disability income benefits and income you earn that month, cannot exceed 80% of your average gross monthly earned income for the 12 months before Covered Total Disability started.

Specific Indemnities & Non-Disabling Injuries Due to Accident

For specified fractures and dislocations due to an accident, you are guaranteed a minimum payment according to a schedule described in the Certificate of Insurance, regardless of whether or not you are actually disabled. Also, if you are injured but not disabled, you may receive up to one-fourth of one month's indemnity for doctor's bills and x-ray expenses.

Organ Transplant Benefit

If you have been insured under this policy for at least six months and undergo a surgical procedure to donate an organ for transplant, you will be considered Totally Disabled. No waiting period will apply, and benefits will be payable from the first day of Covered Total Disability.
However, any portion of the Monthly Benefit Option which became effective in the six months immediately prior to such organ donation will not be payable for this Covered Total Disability.
If you suffer a Covered Disability as a result of an organ donation, you Elimination Period will be 0 days.

Survivor Benefit

If you die – from any cause – while receiving benefits for Total Disability, a death benefit equal to three times the Monthly Benefit Option in force on the date of your death will be paid to your surviving relative(s) in the following order of survival: your spouse; or your children, equally; or your brothers and sisters, equally; otherwise, if there is no surviving relative, to the executor or administrator of your estate.

YOUR COST

Quarterly Premium Contributions

The insurance cost is based on your attained age (spouse age for spouse coverage) when coverage becomes effective and increases on the premium due date on or immediately after the date you (your spouse) reach a higher age bracket.

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life on any premium due date and on any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insureds. For example, a class of insureds is a group of people with the same issue age. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustee under Trust Agreement with the American Society of Mechanical Engineers.

Premium contributions will vary depending on the options and amounts chosen.

CURRENT 2025 QUARTERLY PREMIUM CONTRIBUTIONS PER $150 MONTHLY BENEFIT

30-Day Waiting Period

Member's Age	Career Policy No Premium Credit	Career Policy With 15% Premium Credit	Inflation-Fighter Career Policy No Premium Credit	Inflation-Fighter Career Policy With Premium Credit	Five-Year Policy No Premium Credit	Five-Year Policy With 15% Premium Credit
Under 30	$4.15	$3.52	$5.00	$4.25	$3.30	$2.81
30-39	$4.40	$3.74	$5.30	$4.51	$4.05	$3.44
40-49	$6.95	$5.91	$8.05	$6.84	$5.10	$4.34
50-59	$10.40	$8.84	$11.55	$9.82	$8.75	$7.44
60-62*	$13.15	$11.18	$14.35	$12.20	$13.15	$11.18
63-69*+	$11.90	$10.12	$11.90**	$10.12**	$11.90	$10.12
70-74*+	$16.80	$14.28	$16.80**	$14.28**	$16.80	$14.28

90-Day Waiting Period

Member's Age	Career Policy No Premium Credit	Career Policy With 15% Premium Credit	Inflation-Fighter Career Policy No Premium Credit	Inflation-Fighter Career Policy With Premium Credit	Five-Year Policy No Premium Credit	Five-Year Policy With 15% Premium Credit
Under 30	$2.30	$1.96	$3.15	$2.68	$1.65	$1.40
30-39	$2.45	$2.08	$3.35	$2.85	$2.20	$1.87
40-49	$4.30	$3.66	$5.40	$4.59	$2.90	$2.47
50-59	$7.15	$6.08	$8.30	$7.06	$5.70	$4.85
60-62*	$9.00	$7.65	$10.20	$8.67	$9.00	$7.65
63-69*+	$7.90	$6.72	$7.90**	$6.72**	$7.90	$6.72
70-74*+	$12.40	$10.54	$12.40**	$10.54**	$12.40	$10.54

180-Day Waiting Period

Member's Age	Career Policy No Premium Credit	Career Policy With 15% Premium Credit	Inflation-Fighter Career Policy No Premium Credit	Inflation-Fighter Career Policy With Premium Credit	Five-Year Policy No Premium Credit	Five-Year Policy With 15% Premium Credit
Under 30	$1.90	$1.75	$2.75	$2.60	$1.25	$1.10
30-39	$2.05	$1.90	$2.95	$2.80	$1.60	$1.45
40-49	$3.70	$3.55	$4.80	$4.65	$2.05	$1.90
50-59	$5.85	$5.70	$7.00	$6.85	$4.30	$4.15
60-62*	$7.40	$7.25	$8.60	$8.45	$7.40	$7.25
63-69*+	$6.00	$5.85	$6.00**	$5.85**	$6.00	$5.85
70-74*+	$9.60	$9.45	$9.60**	$9.45**	$9.60	$9.45

365-Day Waiting Period

Member's Age	Career Policy No Premium Credit	Career Policy With 15% Premium Credit	Inflation-Fighter Career Policy No Premium Credit	Inflation-Fighter Career Policy With Premium Credit	Five-Year Policy No Premium Credit	Five-Year Policy With 15% Premium Credit
Under 30	$1.70	$1.45	$2.55	$2.17	$1.05	$0.89
30-39	$1.85	$1.57	$2.75	$2.34	$1.35	$1.15
40-49	$3.35	$2.85	$4.45	$3.78	$1.80	$1.53
50-59	$5.55	$4.72	$6.70	$5.70	$3.80	$3.23
60-62*	$6.45	$5.48	$7.65	$6.50	$6.45	$5.48
63-69*+	$5.40	$4.59	$5.40**	$4.59**	$5.40	$4.59
70-74*+	$8.80	$7.48	$8.80**	$7.48**	$8.80	$7.48

QUARTERLY PREMIUM CONTRIBUTIONS FOR $500 SPOUSE MONTHLY BENEFIT OPTION
30-Day Waiting Period
Maximum Benefits payable up to 2 years

Spouse's Age	Career Policy No Premium Credit	Career Policy With 15% Premium Credit
Under 35	$15.00	$12.75
30-39	$23.00	$19.55
40-44	$38.00	$32.30
45-49	$56.00	$47.60
50-54	$75.00	$63.75
55-59	$94.00	$79.90
60-64++	$113.00	$96.05

The 15% premium credit is effective through 4/30/2026. Future premium credits are based on experience and are not guaranteed.

*For disabilities commencing on or after the premium due date on or immediately after reaching ages 60 and 63, the maximum benefit period is reduced as previously described.

**Inflation-Fighter benefits apply only to disabilities beginning prior to age 63. Starting with age 63, benefits revert back to those provided by the basic Career Policy.

+On the premium due date on or immediately after reaching age 65, coverage in excess of $3,750 per month will reduce to $3,750, and on the premium due date on or immediately after reaching age 70, benefits in excess of $1,800 per month will reduce to $1,800.

■ Renewal only at age 70 and after. Coverage terminates at member age 75.

++Renewal only starting at age 60. Coverage terminates on the premium due date on or immediately after the spouse reaches age 65.

How to Calculate the Quarterly Cost

To find the quarterly insurance cost for benefits in excess of $150 (one unit) per month, multiply the cost shown at your age, for your choice of benefits, policy, and waiting period, by the number of $150 units desired.

FOR EXAMPLE: If you are age 44 and choose the Career Policy with a 30-day waiting period, and a $1,050 monthly benefit (7 units), multiply $6.95 ($5.91 with the 15% premium credit) by 7 = $48.65 ($41.37 with the 15% premium credit). This is your quarterly cost.

If you wish to pay annually, the premium is four times the quarterly premium; if you prefer to pay semiannually, the premium is two times the quarterly cost. If you wish to pay monthly with the Electronic Funds Transfer (EFT) Option, divide the quarterly cost by three.

ADDITIONAL INFORMATION

Effective Date

Note: Residents of NC: Any reference to "performing the normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application.

You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you are performing the normal activities of a person in good health on that date. If you are not performing your normal activities as required, coverage will not become effective until the day you are performing such normal activities provided such date is within three months of the date, insurance would have been effective and you are still eligible for insurance. For spouse coverage, member coverage must be in force.

Payment of a premium contribution for insurance does not mean that there is any coverage before the effective date as specified by New York Life.

Note: There are instances where the company may be able to offer insurance (at the same premium) by eliminating coverage for a specific impairment or disease.

When Coverage Ends

Once coverage is validly in force, it may be continued to the premium due date on or immediately after you reach age 75, unless you cease FULL-TIME WORK, other than for reasons of disability; cease to be an ASME member; fail to pay premium contributions when due; enter full-time active duty in the armed forces (coverage may be restored upon termination of Active Duty Status, subject to policy guidelines); or the group policy is modified or terminated by the Trustee or New York Life Insurance Company to end insurance for the group of insureds to which you belong, or the day before the day the policy terminates. Spouse coverage will terminate when member coverage ends or, if earlier, at spouse at age of 65, if premiums are notpaid, or upon divorce or legal separation.

Exclusions and Limitations

The Policy does not provide member or spouse benefits for: any disability that occurs during or is due or related to intentionally self-inflicted injury while sane or insane, declared or undeclared war or any act thereof, military service, or incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; or any disability that is due or related to pregnancy or childbirth (except complications thereof), any disability that does not require a doctor's regular care (regular care of doctor does not include yourself, a close relative or a household member) or any impairment or disease specifically excluded from your coverage.

The Policy limits benefits for disabilities due to Mental Disorders to a maximum of 24 monthly payments. No benefits will be paid unless the disability occurs while you are insured under the Policy and you are under the care of a licensed physician or surgeon other than yourself (or member of your immediate family or household) during the period of disability. Benefits will not be paid for a disability that is classified as or related to a PRE-EXISTING CONDITION for up to two years following the effective date of coverage.

A Preexisting Condition is defined as an illness or any condition related to such illness for which a person consults a doctor, receives medical services or supplies or takes any medication during the 12 month period immediate before the effective date of insurance, if such illness or condition is not fully disclosed on the application for insurance, Any Impairment Restriction, or illness or condition for which the insured has not consulted a doctor, taken medication or received medical services during the 12 month period following the effective date or coverage or which was fully disclosed on the application for insurance, is not considered a Preexisting Condition.

CERTIFICATE OF INSURANCE

When you become insured you will be sent a Certificate of Insurance summarizing your insurance coverage. This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms are set forth in the policy issued by New York Life to the Trustee under Trust Agreement with the American Society of Mechanical Engineers.

HOW TO APPLY

The Group Disability Income Insurance is medically underwritten based on the information provided by you on the application. It is important that you complete the form truthfully and completely; failure to supply accurate information may invalidate coverage. Your application is subject to New York Life's approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience, at no cost to you. We also request that you provide the following information for everyone you are requesting coverage on as well as on any named beneficiary: full name, address, date of birth, Social Security number, and telephone number. Please call 1-800-289-2763 to complete this request. If you prefer enclose a separate piece of paper with this information together with your application.

1. Refer to the sections describing benefits and premium costs as you fill out the application. Remember, only ASME members (as described under Who Is Eligible) may apply.
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 completed application with your check to:

   ASME 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

CONSIDER YOUR ELIGIBILITY

Before you request coverage, you must be a member in good standing of ASME. 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 policy, call a service representative toll-free at 1-800-289-ASME(2763) or e-mail: asme.service@getamba.com.

MEDICAL REQUIREMENTS

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

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

Requests 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 the proper forms.

30-DAY FREE LOOK

When you receive your Certificate of Insurance, read it carefully. If you're not completely satisfied with the terms of your new insurance, simply return your Certificate, without claim, within 30 days and your premium will be promptly refunded, and your insurance will then be invalidated.

Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-12501-2
on Policy Form GMR-FACE/G-12501-2

Administered by:

Association Member Benefits Advisors, LLC (AMBA)

ASME Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

1-800-289-ASME (2763)
www.asmeinsurance.com
Email: ASME.service@getamba.com

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

The ASME Insurance Trust incurs cost in connection with this program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. ASME also receives a fee for the license of its name and logo for use in connection with the program.

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QUESTIONS?

1-800-289-ASME (2763) ASME.service@getamba.com www.asmeinsurance.com

Group Disability Income Insurance Plan

ASME SETTING THE STANDARD
ASME INSURANCE PROGRAM

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

To Apply:
Send no money now.
Complete this form and return to:
Administrator
ASME Insurance Program
P.O. Box 14533
Des Moines, IA 50306

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

Questions? 1-800-289-ASME (2763)

1 MEMBER INFORMATION

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.
(Please make any necessary corrections to your preprinted name, address and member no.)

Name _____ (Last Name) _____ (First) _____ (Initial)
Address _____
City _____ State _____ ZIP _____

Please check one:
☐ Home address
☐ Business address

Preferred Phone ( )

Social Security _____

Member's Date of Birth _____ (Mo./Day/Yr.) Sex: ☐M ☐F Height ____ ft ____ in. Weight ____ lbs.

Email _____ (For internal use only for important announcements, time-sensitive bulletins or member notifications. Neither ASME nor the Plan Administrator will sell or rent your email address under any circumstances.)

Marital Status: ☐Married ☐Divorced ☐Single ☐Widowed ☐Civil Union† ☐Domestic Partner†

†Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Do you intend to reside outside the United States in the next 12 months?

☐Yes, Countries _____ For How Long? _____ ☐No

2 MEMBER AFFILIATION - OCCUPATIONAL STATUS:

a. Are you now a Member of ASME? ☐Yes ☐No Membership# _____ _____
Exp. (Membership in ASME is required for participation in the Plan.)

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 _____
Bonus $ _____ Commissions $ _____
Total $ _____

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

G-12501-2

Please complete all pages and sign on page 3

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

I hereby apply for the following coverage: ☐ **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 60% of your GROSS MONTHLY EARNED INCOME (as defined in the Brochure). If you have been self-employed for less than one year, your monthly benefit is limited to $1,050 with a 90-day waiting period under the Five-Year Plan.

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

a. Monthly benefit option: $ _____

b. Benefit period (choose one): ☐ Career Plan ☐ Five-Year Plan ☐ Inflation-Fighter Career Plan

c. Waiting period (choose one): ☐ 30-day ☐ 90-day ☐ 180-day ☐ 365-day

d. I wish to apply for Spouse Coverage: (Two-Year Benefit Period; $500 Monthly Benefit Option; 30-day Waiting Period) ☐ Yes ☐ No

_____ Spouse's Social Security # _____

SPOUSE'S NAME LAST FIRST INITIAL

Spouse's Date of Birth: _____ Height: _____ ft _____ in. Weight _____ lbs. Sex ☐ M ☐ F

MO. DAY YR.

Do you or your spouse (if proposed for insurance) 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

e. Payment option selected:

☐ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the ASME Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Disability Income Insurance Plan. (Enclose a VOIDED check, as applicable.)

_____

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

☐ **OPTION 2: PERIODIC BILLING:** ☐ Annual ☐ Semiannual ☐ Quarterly

f. Do you or your spouse, if proposed for insurance, now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability? ☐ Yes (please list below) ☐ No

Proposed Insured	Company Plan	Monthly Benefit	Benefit Period

g. Do you intend to discontinue any of the disability insurance listed in "f," 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 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 YES	Member NO	Spouse YES	Spouse NO
1. Is any person to be insured now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐	☐	☐
2. During the past five years, has any person to be insured 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?	☐	☐	☐	☐

4 Statement of Health: (continued)

	Member YES	Member NO	Spouse YES	Spouse NO
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐	☐	☐	☐
4. Is any person to be insured now pregnant?	☐	☐	☐	☐
5. Is any person to be insured 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?	☐	☐	☐	☐
6. During the past two years, has any person to be insured 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.: Member _____
Spouse _____
State in which issued: Member _____
Spouse _____

8. During the past five years, has any person to be insured had his or her driver's license suspended, revoked, or had any moving violations?

9. Except for Residents of Minnesota and Connecticut, has any person to be insured 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 only, has any person to be insured 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.	Name of Proposed Insured	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

5 Authorization and Signature

I understand that New York Life 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 authorize hereby 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, 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 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 Fraud Notices indicated below, including how our information is exchanged with MIB, and that to the best of our 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)

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

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Fraud Notices

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. **For 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.

For 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 DC, 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 is 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 any 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 whopresents, helps or has presented a fraudulent claim for 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 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.

IMPORTANT NOTICE:

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

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.**