APPLY NOW

Consider Your Eligibility
Before you request coverage, you must be a member in good standing of IEEE. Please wait until your application for membership is accepted before initiating insurance requests. If you have any questions regarding membership, please contact IEEE directly at 1-800-678-IEEE (4333).

Get Quicker, Easier Service When You Apply
The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while waiting for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your Application may be used as the basis for rescinding your insurance.

The Group 20-Year Level Term Life Insurance Plan is medically underwritten based on the information provided by you on the Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company'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 simple tests at your convenience. The exam and blood test will be paid for by the Plan.

Apply in Two Easy Steps

1. Refer to the Plan Details before completing the Application. Print the Application and indicate whether you are requesting coverage for your spouse and children.

2. Mail the completed Application to:
   Administrator, IEEE Group Insurance Program
   PO Box 9186
   Des Moines, IA 50306-9857

Send No Money Now. You will be billed for the appropriate premium upon approval of your Application.

If you have questions about your eligibility or the features of this Plan, call a Customer Service Representative toll-free at 1-800-493-IEEE (4333).

GROUP 20-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE INSTITUTE OF ELECTRICAL AND ELECTRONICS ENGINEERS, INC.

To Apply:
Complete This Form And Return To:
ADMINISTRATOR
IEEE GROUP INSURANCE PROGRAM
P.O. BOX 9186
Des Moines, IA 50306-9857

QUESTIONS?
Call: 1-800-493-IEEE (4333)
Email: IEEE@marshpm.com

IEEE

NEW YORK LIFE *The Company You Keep®*

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

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

1. Member Information:

(Please make any necessary corrections to your full name and address as shown below.)

Social Security #: ☐☐☐-☐☐-☐☐☐☐

Name_____

Home Phone: (_____)_____

Address_____

Work Phone: (_____)_____

Address_____

Fax: (_____)_____

City, State, Zip_____

Email Address:_____

Marital Status: ☐ Married/Date of Marriage: ____/____/____ (Mo./Day/Yr.) ☐ Divorced ☐ Single ☐ Widowed

Are you presently insured under any IEEE Group Life Insurance Plans? ☐ Yes ☐ No

If "Yes," indicate which Plan(s) and provide details (person insured and amount of insurance): ☐ Term Life ☐ Universal Life ☐ Level Term Life to Age 65 ☐ Permanent Whole Life ☐ 10-Year Level Term Life ☐ 20-Year Level Term Life

Details: _____

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. or Canada within the next 12 months?

Member: ☐ Yes, Country_____ ☐ No
If "Yes," for how long?_____

Spouse: ☐ Yes, Country_____ ☐ No
If "Yes," for how long?_____

	DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
Spouse*: _____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
Child(ren)*: _____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F
_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	☐ M ☐ F

* See Plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. Membership Affiliation:

Are you now a member of IEEE? ☐ Yes ☐ No Membership # _____ Exp. Date _____
(Membership in IEEE is required for participation in this plan. Affiliate members are not eligible.)

3. Payment Option:

(Choose only one)

☐ **OPTION 1: AUTOMATIC PAYMENT:** I request and authorize the IEEE Group Insurance Program, Inc., to make monthly withdrawals against the account specified on the attached ☐ voided check ☐ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group 20-Year Level Term Life Plan. (Enclose a VOIDED check or deposit slip, as applicable.)

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

☐ **OPTION 2: PERIODIC BILLING**: Semiannually *(March 1 and September 1)*

G-29215-0

4. Insurance Requested: (Refer to the Plan Information for eligibility, options and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:

a. Total* Member Amount Desired $_____

b. Total* Spouse Amount Desired $_____**

*** Increased coverage requested in this Application, if approved, will be issued in a separate, new Certificate of Insurance.**

**** Spouse coverage cannot exceed 100% of Member's coverage.**

c. TOBACCO/NICOTINE USE: Have you and/or your spouse (if proposed for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

If "Yes," when did such person last use tobacco or nicotine products? Member: _____/_____ (MONTH/YEAR) Spouse: _____/_____ (MONTH/YEAR)

d. INSURANCE REPLACEMENT:

RESIDENTS OF NEW YORK: **It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.**

Residents of NY: *Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?*

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

Residents of Other States: Is the insurance applied for intended to replace, discontinue or change an existing policy?

Member: ☐ Yes ☐ No Spouse: ☐ Yes ☐ No

All Residents:

Do you have other life insurance in force? If "Yes," total amount in all companies:

Member: $ _____ Spouse: $_____

Do you have other insurance applications pending? If "Yes," indicate amount and company:

Member: $_____ Company _____ Spouse: $_____ Company _____

5. Beneficiary Designation: (Insert name, relationship and address.)

I make the following beneficiary designation with respect to only the insurance requested in this application for Group 20-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member – or owner of the coverage, if other than the member – as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other IEEE Group 20-Year Term Life Insurance Certificate, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____ (Last First MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

☐ Primary ☐ Secondary %: _____

Beneficiary Name: _____ (Last First MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

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

Answer the following questions as they apply to you and all dependents to be insured:

		YES	NO
a.	Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐	☐
b.	Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	☐	☐

6. Statement of Health:

(Please initial and date any changes you make on this form.)

Answer the following questions as they apply to you and all dependents to be insured:

	YES	NO
c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	☐	☐
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐	☐
e. Is any person to be insured now pregnant?	☐	☐

f. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

	YES	NO
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐	☐
2. Arthritis, back trouble, bone or joint disorder?	☐	☐
3. Fainting spells, convulsions, or epilepsy?	☐	☐
4. Sugar, blood, albumin or pus in urine?	☐	☐
5. Diabetes, kidney trouble, ulcers or digestive disorder?	☐	☐
6. Disorder of breasts or reproductive organs or functions?	☐	☐
7. Nervous or mental disorder, emotional condition or psychiatric care?	☐	☐
8. Cancer, tumor or cyst?	☐	☐
9. Varicose veins, hemorrhoids or hernia?	☐	☐
10. Disorder of eyes, ears, nose or sinuses?	☐	☐
11. Thyroid, liver or respiratory disorder?	☐	☐
12. Alcoholism or drug habit?	☐	☐
13. Disorder of the blood?	☐	☐
14. Other health or physical impairment including:		
(i). Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐	☐
(ii). Any other disorder of the immune system?	☐	☐
(iii). Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?	☐	☐
(iv). Any other impairment?	☐	☐

g. Have you or your spouse (if proposed for insurance) had a parent, brother or sister who, prior to age 60, had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? *[Note: This question is <u>not</u> applicable to MD residents.]* ☐ ☐

h. Within the past two years, have you or your spouse (if proposed for insurance) participated in, or do either of you plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; organized: motorcycle racing, rodeo riding, snowmobiling, and/or any type of motorized racing; hang gliding; parasailing or bungee jumping? ☐ ☐

i. Driver's License No.: Member _____ Spouse _____
State in which issued: Member _____ Spouse _____
Have you or your spouse (if proposed for insurance) had a driver's license suspended or revoked, or had any moving violations, within the last five years? ☐ ☐

j. In the last 15 years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or *[For residents of CT and MN only: been arrested and convicted for any reason]* for all other residents have an arrest pending? ☐ ☐

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" GIVE COMPLETE DETAILS BELOW.

(If you need more space, use a **signed and dated** separate sheet. Please avoid the use of such terms as "etc.," "various" or "miscellaneous").

Question Letter/No.	Name of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and Address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

7. Declarations:

I request the group insurance shown above. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: insurance will become effective on the date approved by New York Life if I and any approved dependents are actively performing the normal activities of a person in good health of like age [NC residents: a person of like age] on that date and the initial contribution is paid within 31 days after the date I am billed. I understand that: (a) dependent insurance will not take effect unless my insurance is in effect on a premium paying basis; and (b) any person who is not performing his/her normal daily activities as required will not become insured until the day he/she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible. I understand that any dividend apportioned to the group policy will be paid to the Trustee of the Insurance Plan.

Fraud Warning Statements

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 DC, the following also applies: *An insurer may deny insurance benefits if false information materially related to a claim was provided by 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 LA: *Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.*

Residents of 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.*

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for insurance will not be accepted unless this AUTHORIZATION is signed. I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. 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, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs and other applications for insurance). New York Life may release information covered by this AUTHORIZATION to the Plan Administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Plan Administrator in writing at the address given on this form. My 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

Member's Signature X _____ **Date** _____
(PLEASE SIGN AND DATE IN INK.)

To the best of my knowledge and belief, the statements made regarding my health and tobacco/nicotine use are true and complete.

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

Owner Information, required if owner is other than the member. (If Owner is a Trust, please submit a copy of the document with this application.)

Full Name: Last | First | Middle Initial | Relationship to Proposed Insured | Daytime Phone

Mailing Address: Street | City | State | Zip Code

Tax ID# | DATE OF BIRTH (/ /) | SOCIAL SECURITY NUMBER (☐☐☐-☐☐-☐☐☐☐)

Owner's Signature X _____ **Date** _____
(NECESSARY ONLY IF OTHER THAN MEMBER)

9/06 ed

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