



TO APPLY: Complete this form and return to: USI AFFINITY, 14 Cliffwood Ave., Suite 310, Matawan, NJ 07747

(Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.)

PSXGDAACH

1. MEMBER INFORMATION:

Last Name	First Name	M.I.

Street Address	City	State	Zip Code

()	()
Home Phone Number	Office Phone Number

()	- -
Fax Number	Social Security Number

Home E-mail Address	Office E-mail Address

Date of Birth: / / Height: ft. in. Weight: lbs. Sex: Male Female

Marital Status: Married Divorced Single Widowed Civil Union* Domestic Partner*

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

Are you now a member of the Pennsylvania State Education Association? Yes No ID#:

Are you at FULL TIME WORK? "FULL TIME WORK" means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week. Yes No

Do you plan to reside outside the U.S. or Canada within the next 12 months? Yes No

If yes, Country(ies):

2. BENEFICIARY DESIGNATION: (Accidental Death & Dismemberment Coverage)

I make the following beneficiary designation with respect to any benefits payable following the covered loss of my life under the AD&D portion of this coverage.

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #

3. PAYMENT OPTION:

Periodic Billing (Choose only one): Annual Semi-Annual

4. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE:

A. Select your plan (check one): 12-Month Plan Two-Year Plan To Age 65 Plan

B. Monthly Benefit Option (in \$100 increments): \$

C. Waiting Period (check one): 60 Day 90 Day 180 Day* 365 Day* *Available only with "To Age 65" Plan

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED

4. INSURANCE REQUESTED: (Continued)

D. Optional Benefit Riders (check one or more, if desired):

- COLA (not available with the 12-Month Plan) AD&D Benefit Sum \$ _____
- In-Hospital Plan \$ _____ Accident Expense (check one): \$25 \$50
- Specified Injury (not available with 180-Day or 365-Day Waiting Periods)

E. Do you now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability? Yes No If yes, provide details (insurance 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, indicate which coverage and the date of termination:

6. STATEMENT OF HEALTH: (Please initial any changes you make on this form.)

To the best of your knowledge and belief, please answer these questions as they apply to you:

Yes No

- | | | |
|---|--------------------------|--------------------------|
| 1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Any other impairment? | | |
| 3. During the past five years you ever been counseled, treated or hospitalized for the use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past two years, have you participated in, or 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9. Have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? | <input type="checkbox"/> | <input type="checkbox"/> |

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED

6. STATEMENT OF HEALTH: (Continued)

If you have answered 'yes' to any questions above, give complete details below. (Attach a separate sheet if necessary, then sign and date it.)

Illness or Condition / Date of Onset / Duration / Treatment / Operations / Degree of Recovery and Date Name/Address of Physicians or other Medical Practitioners and Hospitals where confined or treated

7. AUTHORIZATIONS AND SIGNATURES:

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, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked. 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 in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and attests to having read the IMPORTANT NOTICE and Fraud Notices indicated below including how my 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.)

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED

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. **RESIDENTS OF CO, the following also applies:** Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

RESIDENTS OF AL/AR/LA/RI: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 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 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 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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

BE SURE TO COMPLETE ALL PAGES AND SIGN WHERE INDICATED