Appraisal Institute
INSURANCE TRUST

Please complete this form and return to: Appraisal Institute Insurance Trust Insurance Plan Administrator, PO Box 3930, Peoria, IL 61612-9806 Questions: Please call 800.222.9958

Residents of Puerto Rico, please return application to:
Global Insurance Agency, P.O. Box 9023918 San Juan, Puerto Rico 00902-3918

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

GROUP DISABILITY INCOME INSURANCE PLAN

Please Print In Ink Or Type. Do Not Use Correction Fluid Or Gel Pens. Initial And Date Any Changes You Make.

1. MEMBER INFORMATION

Full Name _____ Social Security Number _____

Street Address _____ City _____ State _____ ZIP _____

Home Phone _____ Work Phone _____ Fax Number _____

Email (For internal use only. Email address will never be sold or shared.) _____

Please check one: ◯ Home Address ◯ Business Address Are you presently enrolled in this plan? ◯ Yes ◯ No

Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single ◯ Civil Union* * Eligibility of *Civil Union partners* is determined by State Law.

LIST BELOW ONLY THOSE INDIVIDUALS APPLYING FOR COVERAGE	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
AI Professional (Full Name):	/ /	ft. in.	LBS.	◯ M ◯ F

In the next 12 months, do you intend to reside outside of the U.S. or Canada? ◯ Yes ◯ No

Country(ies) _____ How Long? _____

2. MEMBERSHIP AFFILIATION—OCCUPATIONAL STATUS

A. To participate in this plan you must be in good standing with the Appraisal Institute. AI ID# _____

B. What is your occupation: _____ Main Duties: _____

C. **"FULL-TIME WORK"** means the active performance for pay or profit of the regular duties of one's normal occupation on a basis of at least 30 hours each week at a place where such duties are performed, including work-at-home, or other location to which travel is required. Are you at **Full-Time Work**?: ◯ Yes ◯ No

D. Gross Annual Income: Salary $_____ Self-employment $_____ (Self-employment Start Date: ____/____/_____)
Bonus $_____ Commission $_____ **TOTAL $** _____

3. INSURANCE REQUESTED: Refer to plan information for eligibility, principal sums, premium, and coverage description.

I HEREBY APPLY FOR THE COVERAGE: ◯ **New** ◯ **Additional** (Group Disability is NOT AVAILABLE to residents of VT or WA.)

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.

Long-Term Disability: You may choose any Monthly Benefit Option from $500 to $5,000 (in $100 units) provided it and other disability income coverage you may have does not exceed 60% of your Monthly Gross Earned Income (as defined in the brochure).

Short-Term Disability: You may choose any Monthly Benefit Option from $300 to $2,000 (in $100 units) provided it and other disability income coverage you may have does not exceed 70% of your Monthly Gross Earned Income (as defined in the brochure).

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

◯ **A. Professional Monthly Benefit Option: $** _____

◯ **B. Professional Disability Plan:** ◯ **Long-Term** (30-day waiting period) ◯ **Long-Term** (90-day waiting period) ◯ **Short-Term** (30-day waiting period)

◯ **C. Future Purchase Option** (available only if Long-Term Plan is selected and you are under age 50):
Amount Desired $_____ (Not to exceed monthly Disability Benefit Amount)

3. INSURANCE REQUESTED Continued

Do you now have, or are you applying for, other insurance which provides benefits if you are unable to work because of a disability? ◯ Yes ◯ No If "Yes," please list:

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? ◯ Yes ◯ No

If "Yes," please indicate which coverage and the date it will be terminated: _____

4. AI PROFESSIONAL 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:

(California residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.)

1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ◯ Yes ◯ No
2. During the past five years, have you ever been treated for or medically diagnosed by a physician or other medical care practitioner as having:
   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? ..... ◯ Yes ◯ No
   b) Other health or physical impairments including:
      (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ..... ◯ Yes ◯ No
      (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? ..... ◯ Yes ◯ No
      (iii) Any other impairment? ..... ◯ Yes ◯ No
3. During the past five years have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? ..... ◯ Yes ◯ No
4. Are you now pregnant? ..... ◯ Yes ◯ No
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? ..... ◯ Yes ◯ No
6. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang-gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of organized motorized racing? ..... ◯ Yes ◯ No
7. Driver's License: No: _____ State Issued: _____
8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations? ..... ◯ Yes ◯ No
9. *Except for 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? ..... ◯ Yes ◯ No
10. F*or Residents of Minnesota or Connecticut only*, 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? ..... ◯ Yes ◯ No
11. **If you have answered "Yes" to any of the above Questions 1-10, 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(s) 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. PAYMENT OPTION SELECTION

◯ **Direct Billing** Following your initial billing, you will be billed twice a year on January 1 and July 1.
You can also access a secure website where you can register to have your premium withdrawn from your bank account or charged to your credit card.

6. FRAUD NOTICES

For Residents of all states except those listed below: 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:** 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 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 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.

7. AUTHORIZATION AND SIGNATURE

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, 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 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 in the IMPORTANT NOTICE, including mailing a brief report of my protected health information to MIB, Inc, and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, 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.

AI Professional's Signature (Please Sign and Date in Ink) Date

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.
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

8/2017 ed.