ASCE | MEMBER ADVANTAGES

1200 E. Glen Ave., Peoria Heights, IL 61616

Request for Group Insurance From:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Plan Administrator:

PEARL® INSURANCE
1200 E. Glen Ave., Peoria Heights, IL 61616
Questions: Please call 800.650.ASCE(2723)

Please complete the information below and return to: ASCE Plan Administrator, 1200 E. Glen Ave., Peoria Heights, IL 61616-5348
Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

ASCE GROUP DISABILITY INCOME INSURANCE APPLICATION

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

1. MEMBER INFORMATION

Name		S.S.#
Street Address		
City	State (or Province)*	Zip Code
Home Phone	Work Phone	Fax Number
Home Email		For internal use only. Email address will never be sold or shared.

Marital Status: ❍ Married ❍ Divorced ❍ Widowed ❍ Single

Member Full Name	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	❍ M ❍ F

Spouse Full Name**	Date of Birth	Height	Weight	Sex
	/ /	ft. in.	lbs.	❍ M ❍ F

*Not available in VT, WA, U.S. Territories (except Puerto Rico), Quebec.
**Member must be insured for a minimum of $600 a month benefit for Spouse to be eligible for coverage. Spouse Benefits are not available to Residents of NH.

In the next 12 months, does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member: ❍ Yes ❍ No Country(ies) _____ How Long? _____

Spouse: ❍ Yes ❍ No Country(ies) _____ How Long? _____

2. MEMBER AFFILIATION—OCCUPATIONAL STATUS: Association Membership Is Required for Participation in This Plan

A. Are you now a member of ASCE? ❍ Yes ❍ No ASCE Membership #: _____ Exp. Date: ___ /___ /___

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 normally are performed, 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 $** _____

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

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

I hereby apply for the 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 monthly gross 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. Member Monthly Benefit Option: $ _____

❍ B. Member Plan Option (choose one): ❍ Career Plan ❍ Five-Year Plan

❍ C. Member Waiting Period (choose one): ❍ 30-Day ❍ 90-Day ❍ 180-Day ❍ 365-Day (Career Plan only)

❍ D. Spouse Benefit Option: (Two-year benefit period, $500 monthly benefit, 30-day waiting period))

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

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

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. STATEMENT OF HEALTH

To the best of your knowledge or belief, answer the following questions as they apply to you and your spouse (if proposed for insurance):		Member	Spouse
A.	Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	❍Y ❍N	❍Y ❍N
B.	During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	❍Y ❍N	❍Y ❍N
C.	During the past five years, have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs?	❍Y ❍N	❍Y ❍N
D.	Is any person to be insured now pregnant?	❍Y ❍N	❍Y ❍N
E.	Is any person to be insured now disabled; applied, applying for, or receiving any disability or Workers' Compensation benefits; or on waiver of premium for life or health insurance?	❍Y ❍N	❍Y ❍N
F.	During the past 24 months, has any person to be insured ever used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?	❍Y ❍N	❍Y ❍N
G.	*Except for the residents of Minnesota and Connecticut*, has any person to be insured been convicted of a crime, served time in prison because of a conviction, or have an arrest pending?	❍Y ❍N	❍Y ❍N
	For residents of Minnesota and Connecticut ONLY, has any person to be insured been convicted of a crime, served time in prison because of a conviction, or been convicted for any reason during the past 15 years?	❍Y ❍N	❍Y ❍N

Details (please complete if answered "YES" to A, B, or C): _____

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history. What time and telephone number would you like to be contacted at? _____

5. AUTHORIZATION AND DECLARATION OF PERSON GIVING A STATEMENT OF INSURABILITY

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, 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 [my/our] protected health information to MIB, Inc.; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated [above, below, on the reverse of this page, on the attached, enclosed], including how [my/our] information is exchanged with MIB, and that to the best of [my/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 _____

PLEASE SIGN AND DATE IN INK (NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

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

❍ **OPTION 1:** Direct Billing (Semi-Annual 2/1 & 8/1) ❍ **OPTION 2:** Electronic Funds Transfer (EFT) ❍ **OPTION 3:** Credit Card (CC)

Current 2017 Quarterly Premium Rates Per $150 Monthly Benefit
(as of 8/1/14 the rates are reduced)

Member Age	Career Plan	Five-Year Plan
30-DAY WAITING PERIOD		
<30	$3.27	$2.55
30-39	3.75	2.73
40-49	5.88	4.05
50-59	9.33	7.50
60-62 *	12.81	12.57
63-69 *+	11.49	11.40
70-74 *+‡	19.20	19.20
90-DAY WAITING PERIOD		
<30	$2.58	$1.62
30-39	3.03	1.77
40-49	4.92	2.91
50-59	7.95	6.12
60-62 *	10.68	10.41
63-69 *+	9.39	9.30
70-74 *+‡	15.18	15.18
180-DAY WAITING PERIOD		
<30	$2.19	$1.26
30-39	2.49	1.38
40-49	4.20	2.40
50-59	6.48	4.98
60-62 *	8.73	8.52
63-69 *+	7.11	7.02
70-74 *+‡	11.49	11.49
365-DAY WAITING PERIOD		
<30	$1.92	$1.08
30-39	2.19	1.20
40-49	3.75	2.04
50-59	5.64	4.47
60-62 *	7.74	7.53
63-69 *+	6.42	6.33
70-74 *+‡	10.41	10.41

Quarterly Premium Rate for $500 Spouse Monthly Benefit

Spouse's Age	Rate
<35	$16.20
35-39	24.84
40-44	41.04
45-49	60.48
50-54 *	81.00
55-59	101.52
60-64 ≠	122.04

* 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, depending on the plan chosen. Under the Career Plan, for a covered total disability starting before age 63, the maximum benefit period extends to insured's 65th birthday; and, for a covered total disability starting at age 63 but before the termination age date, the maximum benefit period is 24 months. Under the Five-Year Plan, for a covered total disability starting before age 60, the maximum benefit period is 60 months; for a covered total disability starting at age 60 but before age 63, the maximum benefit period extends to the insured's 65th birthday; and, for a covered total disability starting at age 63 but before the termination age date, the maximum benefit period is 24 months.

+On the premium due date on or immediately after reaching age 65, benefits in excess of $4,200 per month will reduce to $4,200, and on the premium due date on or immediately after reaching age 70, benefits in excess of $2,100 per month will reduce to $2,100.

‡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.

Note: Premium rates for monthly benefits or other modes of payment not shown are exact multiples of the applicable premium rates shown.

6. FRAUD NOTICE (PLEASE READ BEFORE SIGNING THE APPLICATION FOR INSURANCE)

FRAUD NOTICE – For Residents of all states except those listed below and **NEW YORK:** 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 bear 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. **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 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 and no 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.

1/13 ed.