Group Term Life Insurance Protection for AAMA members

Choose a Coverage Amount to Help Provide the Insurance Protection that Meets Your Needs and Your Budget

$100,000 – For the "Busy Years" when your responsibilities are the greatest — at semi-annual rates for as little as $28.50.*

$50,000 – For those of you who may have some insurance at work, but need extra insurance protection that stays with you even if you change jobs — at semi-annual rates for as little as $14.25.*

$10,000 – For those who are just starting out, or on a tight budget — at semi-annual rates for as little as $2.85.*

* Rates are semi-annual and are based on age. Examples assume lowest age bracket for a female.

Who May Apply

All members of the American Association of Medical Assistants in good standing, under age 65, are eligible to apply for this plan. Your lawful spouse, under age 65, may also apply for this plan even if you don't. You may also insure your unmarried, dependent children age 15 days to under 19 years (under 25 if a full-time student). (Subject to state variations.)

Convenient To Apply

Everything you need to apply today is in this package. Just complete and sign the application and return it to the address on the form, along with a check for your first premium payment (annual or semi-annual), made payable to the plan administrator: Forrest T. Jones & Company, Inc..

Pays In Addition To Any Other Insurance You May Already Have

This plan stays in force until your coverage ends at age 70, even if you change jobs. And it pays in addition to any other insurance you have.

30 Day Free Look

When you receive your Certificate of Insurance, read it carefully. If you are 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. Your insurance will then be invalidated.

Sponsored by: American Association of Medical Assistants

Because this Group Term Life insurance plan is designed to help meet the needs of AAMA members across the nation, it has received the sponsorship of the American Association of Medical Assistants. This means you can buy with confidence.

Administered by: Forrest T. Jones & Company, Inc., P.O. Box 418131, Kansas City, MO 64141-8131
Questions? Call Toll-Free 800-821-7303

Licensed and appointed agent: Edward Klayman, Insurance License Numbers: AR:166052 CA:0B75061

Underwritten by: New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010 on Policy Form GMR

See reverse for more information about the plan, coverage options, and insurance premiums »

Your Guide To Term Life Insurance

A group plan designed specifically for members of the American Association of Medical Assistants

WHEN COVERAGE BEGINS

In most cases, no medical exam is required. To apply, answer the questions on the enclosed application. Even if you have a health condition, you may still qualify. If a medical exam is required, it will be scheduled at your convenience, at home or at work, and at no cost to you.

** Issuance of a Certificate of Insurance or payment of benefits may depend upon the answers given in the application and the truthfulness of those answers.

COVERAGE STAYS THE SAME

The benefits in some term life plans decrease as you get older. In this plan, the coverage amount you choose remains the same. Coverage ends at age 70.

RENEWAL TERMS

You cannot be canceled as long as you pay your premium when due, insurance does not end for your class, are under age 70, and the group policy stays in force. Insurance for your dependent children will end if your insurance ends under the group policy; the group policy is changed to end dependents' life insurance; the person ceases to be a dependent; or premium is not paid for the dependent when due. You cannot be singled out for a rate increase. Rates increase only as you enter a new five-year age bracket, or if rates are adjusted for the entire group.

EXCLUSION

Suicide within two years of coverage will be limited to a return of premiums, plus interest.

INCONTESTABILITY

The validity of any amount of insurance which has been in force for two years during the insured's life will not be contested except for non-payment of premium contributions.

CONVERSION OPTION

If your insurance ends for a reason other than nonpayment of premium, you may buy an individual life insurance policy from New York Life during the conversion period, without providing evidence of insurability. The amount of the new policy may be limited depending on the reason your insurance ends. See certificate for details.

LIVING BENEFITS

The AAMA Group Term Life Insurance Plan includes an Accelerated Death Benefit that allows you or your spouse, if applying, to receive up to 50% of your coverage — in advance — if you are diagnosed with a terminal illness with 24 months or less to live. Receipt of living benefits may be taxable. Consult your tax advisor for details.

PREMIUMS WAIVED FOR DISABILITY

The plan also includes a provision that provides continuation of coverage without any premiums being paid if you become totally disabled as defined in the group policy before age 60, provide the required proof, and continue to be totally disabled for at least 9 consecutive months. Continuation of insurance without premium payment will end on the date the total disability ends, proof of the total disability is not provided to New York Life, or you attain age 70.

This is a brief description of the features of the plan. It is not a contract. Complete terms, conditions, limitations and exclusions are set forth in the Group Policy G-30261-0/FACE issued by New York Life Insurance Company to the American Association of Medical Assistants. The Association incurs costs in connection with providing oversight and administrative support for the sponsored plan. To provide and maintain this valuable membership benefit, they are reimbursed for these costs. The Association may also receive a fee in connection with the plan.

Your Choice of Coverage Amounts Ranging from $10,000 to $100,000

Economical Semi-Annual Rates

Coverage Amounts (female)

AGE	$100,000	$50,000	$25,000	$10,000
Under 30	$28.50	$14.25	$7.13	$2.85
30-34	$38.00	$19.00	$9.50	$3.80
35-39	$47.50	$23.75	$11.88	$4.75
40-44	$66.50	$33.25	$16.63	$6.65
45-49	$118.50	$59.25	$29.63	$11.85
50-54	$194.50	$97.25	$48.63	$19.45
55-59	$303.50	$151.75	$75.88	$30.35
60-64	$336.50	$168.25	$84.13	$33.65
65-69*	$611.50	$305.75	$152.88	$61.15
70	Insurance Ends			

Coverage Amounts (male)

AGE	$100,000	$50,000	$25,000	$10,000
Under 30	$57.00	$28.50	$14.25	$5.70
30-34	$61.50	$30.75	$15.38	$6.15
35-39	$90.00	$45.00	$22.50	$9.00
40-44	$147.00	$73.50	$36.75	$14.70
45-49	$246.50	$123.25	$61.63	$24.65
50-54	$431.50	$215.50	$107.75	$43.10
55-59	$763.00	$381.50	$190.75	$76.30
60-64	$796.50	$398.25	$199.13	$79.65
65-69*	$1,389.00	$694.50	$347.25	$138.90
70	Insurance Ends			

Rates current as of 2016.

RIGHT TO CHANGE BENEFITS, RATES OR TERMINATE THE PLAN - Changes to the group policy are subject to agreement between New York Life and the Group Policyholder. Rates can be changed by New York Life on any premium due date and on any date in which benefits are changed.

*Renewal Only. For annual premiums, double the rates shown. Rates also apply to spouses. All Dependent Children 15 days and older: $6.00 (semi-annual) for $5,000 benefit. Premiums apply when insurance becomes effective and increase as you or your spouse enter a new age bracket.

SMRU #: 1714094

APPLICATION FOR GROUP TERM LIFE INSURANCE

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

Complete this form and return to: Forrest T. Jones & Company, Inc., P.O. Box 418131, Kansas City, MO 64141-8131

Member Information *Please print or type*

Name of Association American Association of Medical Assistants

Name _____ Social Security # _____
First Middle Last

Address _____
Number Street City State Zip

Home Phone No.(_____)_____ Work Phone No.(_____)_____ Email _____

Beneficiary _____ Relationship _____ Beneficiary Soc. Sec. # _____

Beneficiary Phone No.(_____)_____ Beneficiary Address _____

Name and Address of Member/Applicant's Physician _____

(Unless otherwise requested, your spouse, if living, will be the beneficiary. Otherwise, your beneficiary will be your children, parents, siblings, or estate, in that order.)

Spouse Information *Please print or type*

Name _____ Social Security # _____
First Middle Last

Address ❑ Same as Member _____ Email _____

Beneficiary _____ Relationship _____ Beneficiary Soc. Sec. # _____

Beneficiary Phone No.(_____)_____ Beneficiary Address _____

Name and Address of Spouse's Physician _____

(Unless otherwise requested, the member/applicant will be the beneficiary of any spouse and/or children insurance applied for.)

Insurance Requested (Refer to the brochure for eligibility, options and coverage description)

I hereby apply for the following coverage(s): ❑ New ❑ Additional

Life Insurance for Member/Applicant: $_____ ($10,000 to $100,000, $10,000 increments)

Life Insurance for Spouse: $_____ ($10,000 to $100,000, $10,000 increments) ❑ Life Insurance for Child(ren)

Up to $250,000 of coverage is available. Contact the Plan Administrator for more information and rates. Unmarried, dependent children are eligible for $5,000 of coverage. One economical premium covers all eligible dependent children, no matter how many are being covered.

Select your preferred payment mode

I wish to pay: ❑ Quarterly ❑ Semi-annually ❑ Annually

Complete the following for the member and spouse (if spouse coverage is requested)

Insured	Name	Age	Date of Birth (MM/DD/YY)	Place of Birth	Height	Weight	Sex (M/F)
Member/ Applicant					ft. in.	lbs.	
Spouse					ft. in.	lbs.	

Statement of Health *(Please initial any changes you make on this form.)*

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

A. Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ❑ Yes ❑ No

B. During the past five years has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood 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? ❑ Yes ❑ No

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE »

Statement of Health *(continued)*

C. During the past five years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs?
❑ Yes ❑ No

If you have answered "Yes" to any Questions, give complete details below. If more space is needed, use a separate sheet of paper, signed and dated. If additional information is attached, check "Yes" in the box at the right. ❑ Yes ❑ No

Question #	Member/ Applicant	Spouse	Condition	Date Occurred	Duration	Degree of Recovery	Name and Address of Physicians, Hospitals or Clinics Consulted

Insurance Replacement

RESIDENTS OF NEW YORK – IMPORTANT REPLACEMENT INFORMATION: 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 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 decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. 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 ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy?
Member ❑ Yes ❑ No Spouse ❑ Yes ❑ No

Please read the following, then sign and date below to apply

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 protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices in the attached, 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 X_____ Date_____
(Required. Please sign and date in ink)

Spouse's Signature X_____ Date_____
(Required, if applying)

PLEASE REPLY TODAY! It takes just minutes to apply and help provide you and your family with this solid group life insurance protection.
Complete the application and return to: Forrest T. Jones & Company, Inc., P.O. Box 418131, Kansas City, MO 64141-8131 • Questions? 800-821-7303

Please Retain This Important Information

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For Your Term Life 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, Inc. ("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 applications 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 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, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590. Information for consumers about MIB may be obtained on its website 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 person 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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company

7/15 ed.

FRAUD NOTICES

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 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.

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 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.

7.2013.ed.