Your Guide To
Term Life Insurance

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

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.

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.

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.

Administered by: NBFSFA | P.O. Box 24279 | Winston Salem, NC 27114-4279
Questions? Call Toll-Free 888-200-5106
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
TERM LIFE PROTECTION

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: NBFS.

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.)

It’s easy to apply now for this valuable family insurance protection.

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.

<table>
<thead>
<tr>
<th>Coverage Amounts (female)</th>
<th>Coverage Amounts (male)</th>
</tr>
</thead>
<tbody>
<tr>
<td>AGE</td>
<td>Coverage Amount (female)</td>
</tr>
<tr>
<td>Under 30</td>
<td>$32.78</td>
</tr>
<tr>
<td>30-34</td>
<td>$32.78</td>
</tr>
<tr>
<td>35-39</td>
<td>$32.78</td>
</tr>
<tr>
<td>40-44</td>
<td>$32.78</td>
</tr>
<tr>
<td>45-49</td>
<td>$32.78</td>
</tr>
<tr>
<td>50-54</td>
<td>$32.78</td>
</tr>
<tr>
<td>55-59</td>
<td>$32.78</td>
</tr>
<tr>
<td>60-64</td>
<td>$32.78</td>
</tr>
<tr>
<td>65-69</td>
<td>$32.78</td>
</tr>
<tr>
<td>70</td>
<td>$32.78</td>
</tr>
</tbody>
</table>

Rates current as of 2022.

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.
APPLICATION FOR GROUP TERM LIFE INSURANCE
Complete this form and return to: P.O. Box 24279, Winston Salem, NC 27114-4279

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. (______) Benefitariy 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)

<table>
<thead>
<tr>
<th>Insured</th>
<th>Name</th>
<th>Age</th>
<th>Date of Birth (MM/DD/YY)</th>
<th>Place of Birth</th>
<th>Height</th>
<th>Weight</th>
<th>Sex (M/F)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member/Applicant</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spouse</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

AAMA_10/16
GMA-EZ2
P-30261-0
1540-1

PLEASE CONTINUE THIS APPLICATION ON THE REVERSE SIDE >>
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: NBFSAS P.O. Box 24279 • Winston Salem, NC 27114-4279 • Questions? Call 888-200-5106

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)

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.

<table>
<thead>
<tr>
<th>Question #</th>
<th>Member/Spouse</th>
<th>Condition</th>
<th>Date Occurred</th>
<th>Duration</th>
<th>Degree of Recovery</th>
<th>Name and Address of Physicians, Hospitals or Clinics Consulted</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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 life insurance applied for intended to replace, discontinue or change an existing policy?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Member/Spouse’s Signature X______________________________________________________________________Date______________________

(Required. Please sign and date in ink)