APSIT
INSURANCE FOR SCIENCE PROFESSIONALS

Please complete this form and return to: APSIT Insurance Plan Administrator, PO BOX 3930, Peoria, IL 61612-3930 Questions: Please call 800.272.1637

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

APSIT GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

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 _____ Social Security # _____

Street Address _____

City _____ State (or Province)** _____ Zip _____ Email *(For internal use only. Email address will never be sold or shared.)* _____

Work Phone _____ Fax Number _____ Home Phone _____ Cell Phone _____

May we contact you via text message? ◯ YES ◯ NO Marital Status: ◯ Married ◯ Divorced ◯ Widowed ◯ Single

Are you currently insured under this or any other APSIT Life Plans? ◯ YES ◯ NO If Yes, indicate which plan(s) and provide details below (person insured and amount of insurance):

◯ Group Term Life ◯ 10-Year Level Term Life Details: _____

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

Child*	Date of Birth	Sex
	/ /	◯ M ◯ F

Child*	Date of Birth	Sex
	/ /	◯ M ◯ F

†Member date of birth must also be provided when requesting spouse coverage only. Member coverage must be in force to request spouse and child coverage.
*See Plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

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

Member: ◯ YES ◯ NO If Yes, list country(ies): _____ For how long? _____

Spouse: ◯ YES ◯ NO If Yes, list country(ies): _____ For how long? _____

**Not available in NC, SD, OR, VT, U.S. Territories (except Puerto Rico), or Quebec

2. MEMBER AFFILIATION

I am a member of *(check all that apply)*:

◯ Acoustical Society of America
◯ American Geophysical Union
◯ American Association for the Advancement of Science -PHYS
◯ American Association of Physicists in Medicine
◯ American Association of Physics Teachers
◯ American Astronomical Society
◯ American Crystallographic Association
◯ American Institute of Aeronautics and Astronautics
◯ American Meteorological Society
◯ American Nuclear Society
◯ American Physical Society
◯ Astronomical Society of the Pacific
◯ AVS
◯ Biomedical Engineering Society
◯ Biophysical Society
◯ The Combustion Institute
◯ Council on Undergraduate Research-P/A
◯ Cryogenic Society of America
◯ The Electrochemical Society
◯ Geological Society of America, Inc.
◯ Health Physics Society
◯ IEEE Nuclear & Plasma Sciences Society
◯ International Centre for Diffraction Data
◯ Laser Institute of America
◯ Materials Research Society
◯ Microscopy Society of America
◯ National Society of Black Physicists
◯ Optical Society of America
◯ Sigma Pi Sigma
◯ Society for Applied Spectroscopy
◯ Society of Physics Students
◯ Society of Rheology
◯ Society of Vacuum Coaters
◯ SPIE

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

3. INSURANCE REQUESTED: REFER TO PLAN INFORMATION FOR ELIGIBILITY, PRINCIPAL SUMS, PREMIUM, AND COVERAGE DESCRIPTION

A. I HEREBY APPLY FOR THE FOLLOWING GROUP 10-YEAR LEVEL TERM LIFE COVERAGE:

◯ **Member Option:** Insurance Requested: $ _____ ◯ **Child Option:*** ◯ $10,000 ◯ NONE

◯ **Spouse Option:*** Insurance Requested: $ _____ *Member coverage must be in force to request spouse and child coverage.

An administrative fee of $.50 will be added to your premium bill for all modes other than annually.

B. TOBACCO/NICOTINE USE

Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Member: ◯ YES ◯ NO If Yes, please state when you last used tobacco or nicotine and specify the product: Product: _____ Last used: _____

Spouse: ◯ YES ◯ NO If Yes, please state when you last used tobacco or nicotine and specify the product: Product: _____ Last used: _____

C. INSURANCE REPLACEMENT: IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK

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 a 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 you decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. ◯ YES ◯ NO

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 OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing policy? **Member:** ◯ YES ◯ NO **Spouse:** ◯ YES ◯ NO

ALL RESIDENTS: Do you have other life insurance in force? ◯ YES ◯ NO If Yes, total amount in all companies: **Member:** $ _____ **Spouse:** $ _____

Do you have other insurance applications pending? ◯ YES ◯ NO If Yes, indicate amount and company:

Member: $ _____ Company: _____ **Spouse:** $ _____ Company: _____

4. BENEFICIARY DESIGNATION: INSERT NAME, RELATIONSHIP, AND SOCIAL SECURITY NUMBER

I make the following **beneficiary designation** with respect to all the insurance on my life under this **Group 10-Year Level Term Life Insurance Plan** and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.) (1) In naming more than one beneficiary, please note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. (2) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name *(Last, First, Middle Initial)* _____ Date of Birth _____

Relationship to Member _____ Social Security # _____

Address _____ Phone Number _____

5. STATEMENT OF HEALTH:

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:		Member	Spouse
A.	Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	◯ Y ◯ N	◯ Y ◯ N
B.	During the past five years have you 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, pus, or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	◯ Y ◯ N	◯ Y ◯ N
C.	During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?	◯ 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 be best to contact you? _____

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE

6. 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. 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 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 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 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.

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, 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; any person proposed for insurance consents to authorize the disclosure of information to and from the providers noted in the attached IMPORTANT NOTICE including making a brief report of my protected health information to MIB, Inc.; and the member and any person proposed for insurance attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how information is exchanged with MIB, and that to the best of their knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: *(PLEASE SIGN AND DATE IN INK)* Date

Spouse's Signature: *(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)* Date

OWNER INFORMATION, REQUIRED IF OWNER IS OTHER THAN THE MEMBER (IF OWNER IS A TRUST, PLEASE SUBMIT A COPY OF THE DOCUMENT WITH THIS APPLICATION).

Full Name *(Last, First, Middle Initial)* Relationship to Proposed Insured

Street Address City State Zip

Tax ID # Date of Birth Social Security # Phone

Owner's Signature Date

172882

BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE