

<i>SERFF Tracking Number:</i>	<i>NYPX-125863979</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance and Annuity Corporation</i>	<i>State Tracking Number:</i>	<i>40596</i>
<i>Company Tracking Number:</i>	<i>209-500, ET AL.</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>2008 & 2009 NB21 applications, et al</i>		
<i>Project Name/Number:</i>	<i>2008 & 2009 NB21 applications, et al/209-500, et al.</i>		

Filing at a Glance

Company: New York Life Insurance and Annuity Corporation

Product Name: 2008 & 2009 NB21 applications, SERFF Tr Num: NYPX-125863979 State: ArkansasLH
et al

TOI: L08 Life - Other

SERFF Status: Closed

State Tr Num: 40596

Sub-TOI: L08.000 Life - Other

Co Tr Num: 209-500, ET AL.

State Status: Approved-Closed

Filing Type: Form

Co Status:

Reviewer(s): Linda Bird

Author: SPI

Disposition Date: 10/23/2008

NYLProductCompliance

Date Submitted: 10/17/2008

Disposition Status: Approved

Implementation Date Requested:

Implementation Date:

State Filing Description:

General Information

Project Name: 2008 & 2009 NB21 applications, et al

Status of Filing in Domicile:

Project Number: 209-500, et al.

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Group Market Size:

Overall Rate Impact:

Group Market Type:

Filing Status Changed: 10/23/2008

State Status Changed: 10/23/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

Please see the attached Cover Letter.

Company and Contact

Filing Contact Information

SERFF Tracking Number: NYPX-125863979 State: Arkansas
Filing Company: New York Life Insurance and Annuity State Tracking Number: 40596
Corporation
Company Tracking Number: 209-500, ET AL.
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2008 & 2009 NB21 applications, et al
Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Sean Hebron, SENIOR CONTRACT
ASSISTANT

Sean_Hebron@nyl.com

51 Madison Avenue
New York, NY 10010

(212) 576-4809 [Phone]
(212) 447-4141[FAX]

Filing Company Information

New York Life Insurance and Annuity
Corporation

CoCode: 91596

State of Domicile: Delaware

51 Madison Avenue
Room 604

Group Code: 826

Company Type: Life

New York, NY 10010

Group Name:

State ID Number:

(212) 576-4809 ext. [Phone]

FEIN Number: 13-3044743

SERFF Tracking Number: NYPX-125863979 State: Arkansas
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 40596
Company Tracking Number: 209-500, ET AL
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Product Name: 2008 & 2009 NB21 applications, et al
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Filing Fees

Fee Required? Yes
Fee Amount: \$300.00
Retaliatory? Yes
Fee Explanation:
Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance and Annuity Corporation	\$300.00	10/17/2008	23267168

SERFF Tracking Number: NYPX-125863979 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	10/23/2008	10/23/2008

SERFF Tracking Number: NYPX-125863979 State: Arkansas
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 40596
Company Tracking Number: 209-500, ET AL.
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2008 & 2009 NB21 applications, et al
Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Disposition

Disposition Date: 10/23/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: NYPX-125863979 State: Arkansas
 Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 40596
 Company Tracking Number: 209-500, ET AL.
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 2008 & 2009 NB21 applications, et al
 Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Item Type	Item Name	Item Status	Public Access
Supporting Document	Application		No
Supporting Document	Cover Letter		Yes
Supporting Document	Certification/Notice		No
Form	Individual Life Insurance Application (Part I)		Yes
Form	Medical Questionnaire (Non-Medical - Application Part II)		Yes
Form	Medical Examiner's Report - Application Part II		Yes
Form	Receipt and Temporary Coverage Agreement (the "Agreement")		Yes
Form	Supplemental Application		Yes
Form	Hazardous Sports and Aviation Supplement		Yes

SERFF Tracking Number: NYPX-125863979 State: Arkansas
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 Company Tracking Number: 209-500, ET AL.
 TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
 Product Name: 2008 & 2009 NB21 applications, et al
 Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Form Schedule

Lead Form Number: 209-500

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	209-500	Application/ Enrollment Form	Individual Life Insurance Application (Part I)	Revised	Replaced Form #: 204-500 Previous Filing #:	51	209-500.PDF
	209-510	Application/ Enrollment Form	Medical Questionnaire (Non-Medical - Application Part II)	Revised	Replaced Form #: 204-510 Previous Filing #:	68	209-510.PDF
	209-525	Application/ Enrollment Form	Medical Examiner's Report - Application Part II	Revised	Replaced Form #: 204-525 Previous Filing #:	71	209-525.PDF
	21620.100	Application/ Enrollment Form	Receipt and Temporary Coverage Agreement (the "Agreement")	Revised	Replaced Form #: 204-525 Previous Filing #:	0	21620_100.PDF
	209-581	Application/ Enrollment Form	Supplemental Application	Initial		50	209-581.PDF
	7663.100	Application/ Enrollment Form	Hazardous Sports and Aviation Supplement	Initial		80	7663_100.PDF



INDIVIDUAL LIFE INSURANCE APPLICATION (PART I) TO:



- NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

- New Application, Amend Application, Reinstatement, Paid Change Request, Attained Age Term Conversion, Original Age Term Conversion, Exercising a rider: PPO, SPO, SPPO, GIR, GIR Face Increase, IER

A. Primary Insured

Form fields for Primary Insured: First Name, Middle Name, Last Name, Suffix, Sex, Date of Birth, Residence, Social Security No., Driver's License No., Country of Citizenship, Immigration Visa, Employer Name.

If age 18 or over, has Primary Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years? Yes No

If "Yes", provide type and date of last use (Month) (Year)

B. Contact Information

Contact Primary Insured at: Home Tel. Number, Business Tel. Number, Best Time to Call, Time zone, Special Instructions.

In which language and dialect(s) was the sales interview conducted? Language Dialect

Who acted as interpreter? Agent Other: First Name Last Name Relationship to Primary Insured

If the Primary Insured requires special services for the hearing impaired, indicate the service required.

C. Owner (if not Primary Insured)

For all ownership types, name, address, and tax identification information is required. UTMA/UGMA requires Custodian's information to be provided.

Type: Individual Trust Corp Partnership Charitable Organization UTMA/UGMA (Provide Custodian's information below)

Owner/Custodian: First Name, Middle Name, Last Name, Suffix, Sex, Date of Birth, Residence: Street, City, State, Country, Zip

Telephone Number () Social Security No. or Tax ID No. Exempt Applied for

Relationship to Primary Insured Country of Citizenship

Immigration Visa or Work Authorization (If other than a US citizen) Type Number Expiration: Month Year

Trust: Name of Trust, Date of Trust, State where Trust established, Name of Trustee(s), Relationship of Trustee(s) to Primary Insured, Beneficiary(ies) of Trust, Relationship of Trust Beneficiary(ies) to Primary Insured

Uniform Transfers to Minors (UTMA/UGMA) Name of Minor: First Middle Last Suffix Date of Birth (mm/dd/yyyy)

UTMA/UGMA for the state of Social Security No. or Tax ID No. Exempt Applied for



C. Owner (continued)

Successor Owner Primary Insured
First Name Middle Name Last Name Suffix Relationship to Primary Insured

Multiple Owners (Unless otherwise specified in Section Q, ownership will be joint with right of survivorship.)
First Name Middle Name Last Name Suffix Date of Birth (mm/dd/yyyy)

Residence: Street City State Country Zip

Telephone Number () Social Security No. or Tax ID No. Exempt Applied for

Relationship to Primary Insured Country of Citizenship

Immigration Visa or Work Authorization (If other than a US citizen)
Type Number Expiration: Month Year

D. Applicant (if not Primary Insured)

Same as Owner

If Primary Insured is under age 14 years 6 months, complete the following questions.

Amount of in-force insurance on parent(s) or guardian(s): \$ None

Are all other children in the family insured or to be insured for an amount at least equal to that on the Primary Insured? Yes No

First Name Middle Name Last Name Suffix Date of Birth (mm/dd/yyyy)

Social Security No. or Tax ID No. Exempt Applied for Relationship to Primary Insured

Residence: Street City State Country Zip

E. Payer (if not Primary Insured)

Same as Owner Applicant

First Name Middle Name Last Name Suffix Social Security No. or Tax ID No. Exempt Applied for

Residence: Street City State Country Zip Relationship to Primary Insured

Relationship to Owner (if other than Primary Insured) Date of Birth (mm/dd/yyyy)

F. Mode, Policy Date, Premium Financing, Qualified Plans, Premium Notices and Other Requests

(All modes not available on every plan or product)

For Check-O-Matic mode complete attached Check-O-Matic authorization form. For NYL-A-Plan, complete form 21237 and 21242. For Government Allotment, use form 16513.

Payment: Annual Semi-Annual Quarterly Monthly
Check-O-Matic Government Allotment NYLIFE Securities Single Sum

NYL-A-Plan # List Bill # MainStay #

Chosen Policy Date Preliminary term to (available on WL, MPWL and CWL only)

Policy Transfers/Premium Financing

- 1. Does the Proposed Insured, Applicant or Owner plan to transfer any right, title, or ownership interest in the policy being applied for to a third party, or has any of these parties ever transferred any rights, title or ownership in any life insurance policy to a third party?
2. Is any part of the premium for this policy being financed by a third party, or has the Proposed Insured, Applicant or Owner been offered any inducement, fee or compensation, including "free life insurance," as an inducement to purchase life insurance?
3. Has the Proposed Insured, Applicant or Owner, within the past twelve months, authorized any third party to have a life settlement or viatical company review their personal medical status?

Qualified Plans: 401(k) 401(a) 412(e)(3) Keogh 457 Pension Option

Other Requests: Reduced paid up at lapse Non-transfer Option

Split Dollar: Endorsement Split Dollar

Premium Notices

Send Premium notice to Owner's other US address:

Street City State Zip

The Owner may designate a secondary addressee to receive notice of past due premium/potential lapse of coverage.

Name Street City State Zip



G. Primary Insured's Beneficiary

Same as Owner Family Protection Standard Beneficiary Designation (includes Additional Insured and Children)

Named Beneficiaries (indicate order as 1st, 2nd, etc.) Per Stirpes (Can only be checked if all beneficiaries are individuals)

Order	Full Name (First, Middle, Last)	Relationship to Primary Insured	Share
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Trust

Name of Trust _____ Date of Trust _____

State where Trust established _____ Name of Trustee(s) _____

Relationship of Trustee(s) to Primary Insured _____ Beneficiary(ies) of Trust _____

Relationship of Trust Beneficiary(ies) to Primary Insured _____

Uniform Transfers to Minors (UTMA/UGMA)

Name of Custodian _____ as custodian for

Name of Minor _____ under the _____ Uniform Transfers/Gifts to Minors Act (UTMA/UGMA)

H. Current Health and Payment Information

Has the Proposed Insured or anyone proposed for coverage on the policy:

- 1. Within the last 90 days, been recommended by a physician or other medical practitioner to undergo diagnostic procedures or tests for any symptoms, illnesses or conditions? Yes No
- 2. Within the last 2 years, been unable to work or unable to attend school, or been disabled for one month or more?..... Yes No
- 3. Within the last 2 years, been admitted to a hospital or other medical facility for more than 5 consecutive days? Yes No

If "Yes" to #1, #2 or #3, do not collect deposit premium and provide name and details in Section Q.

Total amount paid \$ _____ If amendment, amount previously paid \$ _____

4. Complete the following questions for any Proposed Insureds actual age **24 months old or younger**:

- (a) Was the child born prematurely (less than 37 weeks gestation)? Yes No
- (b) Was the child's birth weight less than 5 pounds (2.27 kilograms)?..... Yes No
- (c) Has the child required hospitalization or been diagnosed with a birth injury, congenital disorder, deformity, heart murmur, developmental delay, mental retardation, or accidental injury?..... Yes No

If "Yes" to #4a, 4b, or 4c, provide name and details, including the name and address of physician or health care provider in Section Q.



I. Coverage Information

NYLIC		RIDERS				DIVIDEND OPTION
<input type="checkbox"/> Whole Life <input type="checkbox"/> Custom Whole Life Paid Up Age _____ <input type="checkbox"/> Modified Premium Whole Life Face Amount \$ _____ Premium \$ _____ <input type="checkbox"/> APL	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> DOT \$ _____ <input type="checkbox"/> LBR \$ _____	<input type="checkbox"/> OPP <input type="checkbox"/> COM Scheduled Bill \$ _____ <input type="checkbox"/> Unscheduled (Lump Sum) \$ _____	<input type="checkbox"/> CPB <input type="checkbox"/> CI # units _____ <input type="checkbox"/> PPO \$ _____	<input type="checkbox"/> 5YTR PI \$ _____ <input type="checkbox"/> 5YTR/oci 1 \$ _____ <input type="checkbox"/> 5YTR/oci 2 \$ _____	<input type="checkbox"/> IPTR \$ _____ <input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Pd Up Ad <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
<input type="checkbox"/> Survivorship Whole Life Face Amount \$ _____ <input type="checkbox"/> APL	<input type="checkbox"/> 2nd to Die <input type="checkbox"/> DOT \$ _____ <input type="checkbox"/> LTR \$ _____ <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> EPR \$ _____	<input type="checkbox"/> 1st to Die <input type="checkbox"/> LFD \$ _____ <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> OPP/PUA <input type="checkbox"/> COM Scheduled Bill \$ _____ <input type="checkbox"/> Unscheduled (Lump Sum) \$ _____		(Select one) <input type="checkbox"/> Pd Up Ad <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
<input type="checkbox"/> Increasing Premium Term Face Amount \$ _____ Premium \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____	<input type="checkbox"/> CI # units _____		<input type="checkbox"/> LBR <input type="checkbox"/> PPO \$ _____	<input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
<input type="checkbox"/> 5 Year Term Face Amount \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> LBR \$ _____	<input type="checkbox"/> 5YTR PI \$ _____ <input type="checkbox"/> 5YTR/oci 1 \$ _____		<input type="checkbox"/> 5YTR/oci 2 \$ _____ <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
Family Protection Face Amount \$ _____ (Insured 1) Face Amount \$ _____ (Insured 2)	<input type="checkbox"/> WP (Insured 1) <input type="checkbox"/> WP (Insured 2) <input type="checkbox"/> _____	<input type="checkbox"/> LBR				(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
<input type="checkbox"/> 20 Year Term Face Amount \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____	<input type="checkbox"/> LBR <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____			(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash
<input type="checkbox"/> _____ Face Amount \$ _____	<input type="checkbox"/> _____ \$ _____					<input type="checkbox"/> _____

NYLAZ		RIDERS			
<input type="checkbox"/> Term to Age 90 Face Amount \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____	<input type="checkbox"/> LBR <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____		
<input type="checkbox"/> _____ Face Amount \$ _____	<input type="checkbox"/> _____ \$ _____				

NYLIAC		RIDERS			
<input type="checkbox"/> Universal Life <input type="checkbox"/> ACSV <input type="checkbox"/> Universal Life - LTG IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) <input type="checkbox"/> _____ Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> MDW <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> GIR \$ _____ <input type="checkbox"/> LBR	<input type="checkbox"/> CI # units _____	<input type="checkbox"/> OCI 1 \$ _____ <input type="checkbox"/> OCI 2 \$ _____	<input type="checkbox"/> NLGR (N/A to UL-LTG) <input type="checkbox"/> 10 years <input type="checkbox"/> 20 years <input type="checkbox"/> to age 85 <input type="checkbox"/> to age 100 <input type="checkbox"/> _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____
<input type="checkbox"/> Instant Legacy - SPUL Single Premium \$ _____	Submit completed Simplified Medical Questionnaire - Part II				
<input type="checkbox"/> Survivorship Universal Life <input type="checkbox"/> ACSV <input type="checkbox"/> Survivorship Universal Life - LTG IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) <input type="checkbox"/> _____ Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> 1st to Die <input type="checkbox"/> FTD \$ _____	<input type="checkbox"/> NLGR (N/A to SUL-LTG) <input type="checkbox"/> 20 years <input type="checkbox"/> to age 100 <input type="checkbox"/> _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> EPR \$ _____	



NYLIAC RIDERS

<input type="checkbox"/> Variable Universal Life Accumulator <input type="checkbox"/> ACSV IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) <input type="checkbox"/> _____ Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> MDW <input type="checkbox"/> LER <input type="checkbox"/> GIR \$ _____ <input type="checkbox"/> LBR	<input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> CI # units _____ <input type="checkbox"/> GMDB <input type="checkbox"/> _____ <input type="checkbox"/> OCI 1 \$ _____ <input type="checkbox"/> OCI 2 \$ _____ <input type="checkbox"/> _____
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<input type="checkbox"/> Survivorship Variable Universal Life Accumulator <input type="checkbox"/> ACSV IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) <input type="checkbox"/> _____ Planned Premium \$ _____ Initial Premium \$ _____	1st to Die <input type="checkbox"/> FTD \$ _____ <input type="checkbox"/> EPR \$ _____	<input type="checkbox"/> GMDB (Younger Insured's Age 100) <input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> LER
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<input type="checkbox"/> Asset Preserver Face Amount \$ _____ Single Premium \$ _____ *Benefit Payment Option: (LTC is QCB in WA) <input type="checkbox"/> LTC 24 <input type="checkbox"/> LTC 36+ <input type="checkbox"/> LTC 48+ <input type="checkbox"/> _____	Submit completed Asset Preserver Application Supplement <input type="checkbox"/> _____ \$ _____ *Not all Benefit Payment Options available in all states
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<input type="checkbox"/> Single Premium Variable Universal Life Single Premium \$ _____ or Face Amount \$ _____	<input type="checkbox"/> LBR <input type="checkbox"/> _____ <input type="checkbox"/> _____ \$ _____
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Executive Benefits <input type="checkbox"/> CorpExec VUL _____ <input type="checkbox"/> CSVUL <input type="checkbox"/> CEUL <input type="checkbox"/> CSUL <input type="checkbox"/> BOLI _____ <input type="checkbox"/> _____ IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) (if applicable) <input type="checkbox"/> _____ Planned Premium \$ _____ Initial Premium \$ _____ Unisex Issue: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> ACSV (CSUL only) <input type="checkbox"/> LTR (CorpExec VUL only) <input type="checkbox"/> STR (CorpExec VUL, CSVUL, CEUL, CSUL only) <input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____
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<input type="checkbox"/> _____ Face Amount \$ _____ Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> _____ <input type="checkbox"/> _____ \$ _____ \$ _____
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Alternate and Additional Policy Requests (Complete plan, face amount, rider(s), rider amount, and dividend option requests below. If changes to other sections are being requested, provide instructions below or in Section Q.)

Alternate Additional Plan: _____ Face Amount: \$ _____
 Rider: _____ Rider Amount: \$ _____
 Dividend Option: _____

Instructions: _____



J. Personal Information

1. In the last 5 years, has the Primary Insured or any other Proposed Insured(s)

(a) had their driver's license suspended or revoked? Yes No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below including reason, driver's license # (if other than previously stated), State of license, and month and year of occurrence.

Name	Reason	License #	State	Date (month/year)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(b) plead guilty to, or been convicted of, or been imprisoned for any felony or misdemeanor, or are there any such charges currently pending? Yes No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below, including reason, State, County, and month and year of occurrence.

Name	Reason	State	County	Date (month/year)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

(c) been declined for issue, reinstatement or renewal of any type of life or health insurance? Yes No

If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage, give company name (including New York Life), reason and date.

Name	Company	Reason	Date (month/year)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

2. In the next 12 months does the Primary Insured or any Proposed Insured plan to travel or reside outside the U.S. or Canada? Yes No

If "Yes", indicate name of the person(s) applying for coverage, purpose of travel (personal or business), the country, the date(s) of travel and the duration(s) of stay.

Name	Purpose	Country	Date (month/year)	Duration
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

3. In the last 12 months has the Primary Insured or any other Proposed Insured engaged in, or intend to engage in within the next 12 months, any of the following: Yes No

If "Yes", check all that apply and complete Form Series 7663.

- SCUBA or skin diving; auto racing; motorcycle racing; power boat racing; snowmobile racing; all terrain vehicle (ATV) racing; or any other type of vehicle racing; sky diving; mountain climbing; helicopter skiing; cave exploration; hot air ballooning;
- rodeo riding; flying as civilian pilot; flying as a military pilot; ultralight; or hang-gliding;
- motorcycle, snowmobile, and/or all terrain vehicle (ATV) riding? – Circle all that apply. **(Form Series 7663 is not required if leisure/non-racing only.)**

Provide the following details:

Insured's Name _____ **Annual mileage** _____ **Vehicle used for** _____ **Safety helmet used?** Yes No

K. Other Coverage (List each Proposed Insured and details of other coverage)

Insured's Name	None	In Force	Pending	Company	Amount	Personal	Business
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	\$ _____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

What is the total amount of above pending coverage that will be placed in all companies for each insured? \$ _____

Use Section Q for Additional Details.

L. Financial Information

	Primary Insured	Other Insured	Owner if not Primary Insured
Current Annual Earned Income	_____	_____	_____
Current Annual Unearned Income	_____	_____	_____
Current Net Worth	_____	_____	_____



M. Business and Creditor Insurance

Question 1 must be completed for all Business and Creditor Insurance. Complete Questions 2, 3 and 4, as applicable. If more space is needed, use Section Q, Additional Details.

- 1. Will an employer, including a partnership, be the owner and beneficiary of the insurance applied for on the life of an employee or partner? Yes No

I, the Proposed Insured, acknowledge and agree that: (1) my employer intends to insure my life; (2) I have been notified of the amount of insurance applied for on my life; (3) my employer will be a beneficiary of any policy proceeds payable upon my death; and (4) coverage may continue after my employment terminates.

Proposed Insured's initials here: _____

Notice to Owner: If "Yes" is checked above, you may be subject to IRS record keeping and annual reporting requirements relating to employer-owned life insurance contracts. Please consult with your tax advisor.

- 2. (a) If BUY/SELL, what is the net income \$ and market value \$ of the business? (b) Does insured(s) have ownership in the business? (c) Are all owners being insured? Provide details and amounts. 3. (a) If KEY EMPLOYEE, provide reason why employee is key to the organization, and length of time employed. (b) Are all Key Employees being insured? Provide details and amounts. 4. If CREDITOR COVERAGE, what is the loan amount \$, term (years), and purpose? Purpose If creditor requires collateral assignment, include completed collateral assignment with application.

N. Term Conversion

Sections A, C, D, E, F, G and I of the application are also required for contractual conversions. For non-contractual conversions or changes, underwriting is required.

- 1. Policy Number Term Policy Term Rider Conversion of Other Company's Term Insurance These term coverages can be attained age converted (AATC): OCI DOT AD105 and after TL AD 85 and prior Conversion of Spouse Conversion of Child 1YT (Div. Opt.) Amount to be Converted: Term Policy \$ Term Rider \$ Amount Remaining In Force: Term Policy \$ Term Rider \$ (If no amount entered, remainder will be terminated) If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) New rider with underwriting required (Provide details in Section Q) Is a reduction in rating being requested? Yes No If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) Yes No If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy does not include this benefit, complete Sections J and P of this application. 2. Policy Number Term Policy Term Rider Conversion of Other Company's Term Insurance These term coverages can be attained age converted (AATC): OCI DOT AD105 and after TL AD 85 and prior Conversion of Spouse Conversion of Child 1YT (Div. Opt.) Amount to be Converted: Term Policy \$ Term Rider \$ Amount Remaining In Force: Term Policy \$ Term Rider \$ (If no amount entered, remainder will be terminated) If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) New rider with underwriting required (Provide details in Section Q) Is a reduction in rating being requested? Yes No If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) Yes No If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy does not include this benefit, complete Sections J and P of this application.

For Attained Age Term Conversions the following apply:

There will be no insurance in effect on the new policy prior to the policy date given in the policy or policy date specified here ___/___/___, and coverage on the new policy will not begin until the coverage being converted has been terminated.

I agree that any monies due from a Conversion of a NYLIC or NYLAZ policy to a NYLIC Life policy will be credited to the Dividend Option of the new life conversion policy. I agree that any monies due from a Conversion of a NYLIC or NYLAZ policy to a NYLIAC Life Policy will be credited to the Initial Premium, which will be increased to equal the credit applied to my NYLIAC policy when the credit is greater than the requested Initial Premium of the new life conversion policy.

SWL/SVUL/SUL policies pay a death benefit on the second death only, and no death benefits are payable on a first death.

The items in the Temporary Coverage Agreement and the Signature Section of this application apply even when a NYLAZ policy is being converted or when the new policy is issued by NYLIAC, a subsidiary of NYLIC.

O. Guaranteed Insurability Option Date (PPO and GIR)

Scheduled Option Date: Mo. ___ Day ___ Year ___

Date of marriage birth adoption Mo. ___ Day ___ Year ___ Submit proof of event.



Complete only for coverage on Additional Insureds

Additional Insured

Completion of Additional Insured Non-Medical Health Questionnaire is required.

First Name	Middle Name	Last Name	Suffix	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)
------------	-------------	-----------	--------	--	----------------------------

Residence: Street	City	State	Country	Zip
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<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax ID No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for	Driver's License No.	State	<input type="checkbox"/> None (Provide details in Section Q)	Relationship to Primary Insured
--	----------------------	-------	--	---------------------------------

Country of Citizenship	Country of Birth	State of Birth	How Long Living in the USA? <input type="checkbox"/> Since Birth or Years Months
------------------------	------------------	----------------	--

Immigration Visa or Work Authorization (If other than a US citizen) Type	Number	Expiration: Month	Year	Occupation
---	--------	----------------------	------	-------------------

Employer Name:	Street	City	State	Country	Zip
----------------	--------	------	-------	---------	-----

If age 18 or over, has Proposed Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years? Yes No

If "Yes", provide type _____ and date of last use (Month) _____ (Year) _____

If Proposed Insured is under age 14 years 6 months, complete the following questions.

Amount of in-force insurance on parent(s) and guardian(s): \$ _____ None

Are all other children in the family insured or to be insured for an amount at least equal to that on the Proposed Insured? Yes No

(If "No", provide details in Section Q)

Named Beneficiaries <input type="checkbox"/> Same as Owner <input type="checkbox"/> Trust <input type="checkbox"/> UTMA/UGMA (For Trust or UTMA/UGMA, provide details in Section Q) <input type="checkbox"/> Per Stirpes			
Order	Full Name (First, Middle, Last)	Relationship to Proposed Insured	Share
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Contact Information

Same as Primary Insured

Contact Primary Insured at: (List both and check primary) Home Tel. Number: (_____) _____ Business Tel. Number: (_____) _____

Best Time to Call: Between _____ AM PM and _____ AM PM (Please indicate widest time interval)

Time zone: EST CST MST PST AST HST Special Instructions, if any _____

In which language and dialect(s) was the sales interview conducted? Language _____ Dialect _____

Who acted as interpreter? <input type="checkbox"/> Agent <input type="checkbox"/> Other:	First Name	Last Name	Relationship to Proposed Insured
--	------------	-----------	----------------------------------

If the Proposed Insured requires special services for the hearing impaired, indicate the service required. _____

Children's Insurance Information (CI and Family Protection plan)

First Name	Middle Name	Last Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth (mm/dd/yyyy)	Relationship to Primary Insured	Social Security <input type="checkbox"/> No. _____ <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	_____
_____	_____	_____	<input type="checkbox"/> Male <input type="checkbox"/> Female	_____	_____	_____

Named Beneficiaries <input type="checkbox"/> Same as Owner			
Order	Full Name (First, Middle, Last)	Relationship to Proposed Insured	Share
_____	_____	_____	_____
_____	_____	_____	_____

- Has any child proposed for coverage, displayed any physical or mental impairment due to illness, injury or birth defect or is any child currently taking prescribed medication on a regular basis? (If "Yes", provide details, including reason, dosage, and frequency in Section Q)..... Yes No
- In the last 5 years, has any child proposed for coverage been hospitalized or been unable to attend school regularly? (If "Yes", provide details in Section Q) Yes No



Do Not Complete if Any Other Type of Medical Examination Part II is Required.

Additional Insured Non-Medical Health Questionnaire

First Name _____ Middle Name _____ Last Name _____ Height _____ft. _____in. Weight _____lbs.

(For each additional insured, please use a separate Additional Insured Non-Medical Health Questionnaire)

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (_____) _____ - _____
 Date of last visit: _____ / _____ / _____ Reason for visit: _____
 Treatment or medication provided: (Provide details, name and dosage) _____
2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
 - a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? Yes No
 - b. Elevated blood sugar or diabetes? Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? Yes No
 - k. Any psychiatric or mental health condition (include counseling or hospitalization)? Yes No
 - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? Yes No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
5. In the last two (2) years, has the Proposed Insured had any of the following for which advice of a medical professional was not sought: chest pain or pressure, blood in urine, rectal bleeding, blood in stool, loss of consciousness, recurrent shortness of breath, persistent cough, or persistent fever? (If "Yes", circle all conditions that apply) Yes No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
 - a. Had any surgery or been recommended to have surgery? Yes No
 - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more? Yes No
7. Among Proposed Insured's natural parents, brothers or sisters, is there any history of angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide relationship, age of onset and subsequent history in details below; provide type or location if cancer history.) Yes No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.) Yes No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
 - a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? Yes No
 - b. Does the Proposed Insured live in a facility that provides him or her with personal care? Yes No
 - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? Yes No
 - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) Yes No

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use Section Q.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset Mo. Year	Recovery Mo. Year	Doctors, Hospitals and Medical Facilities Info



Check-O-Matic (C-O-M) – New Business Cases Only

1. New York Life Insurance Company, New York Life Insurance and Annuity Corporation or NYLIFE Insurance Company of Arizona, as indicated in this application, will direct the transfer of funds from the account you designate. This transfer will be used to pay premiums on the policy (policies) and/or monthly Option to Purchase Paid-up Additions (OPP) premiums. This transfer will be done each month on a regular schedule established by us. You will not receive premium notices while this arrangement is in effect.
2. This arrangement does not change the premium due dates specified in the policy and it does not extend any of the grace or late periods for paying these premiums. The policy or policies will lapse at the end of the grace or late period if the premium remains unpaid.
3. Any policy included under this arrangement is subject to our minimum and maximum premium and OPP premium rules.
4. The arrangement will apply to the policies listed below and will cover all future premiums and any current premiums that have not yet been paid.

Complete information below:

Primary Insured's Name: _____

Policy Number _____

Indicate Type:

Single Check-O-Matic Check-O-Matic OPP Savings Account

Multiple Check-O-Matic Previous Case Reference Number or Policy Number _____

Add to Check-O-Matic Previous Case Reference Number or Policy Number _____

Concurrent Insured's Name _____ Date of Birth: ____/____/____

**If using a checking account, attach a sample check marked "VOID" here.
Please attach with clear tape on top edge of check. (DO NOT STAPLE).
A deposit slip is not acceptable for checking accounts.**

If using a savings account, attach a sample deposit slip marked "VOID" here.

If the payment is coming from a 3rd party payer, the payer MUST complete the 3rd Party Payer Information.

3rd Party Payer Information

A 3rd party payer is someone other than the designated Policyowner or insured of the policy. If payment is coming from a 3rd party, the payer will need to complete the information below. **If this information is not provided, your request for the Check-O-Matic premium payment option cannot be processed.**

Name: _____ Date of Birth: _____
 First Name Middle Initial Last Name

Address (Street, City, State, and Zip Code REQUIRED. P.O. Box not acceptable): _____

Relationship to the Policyowner: _____

Authorization Statement for Check-O-Matic (applies to Premium payments only)

I understand that I may discontinue this payment arrangement by notifying the Insurer. The Owner of each policy may discontinue it for his or her own policy. The arrangement ends on the day the Insurer receives the notice.

By initialing below I/We authorize New York Life Insurance Company or one of its subsidiaries to make monthly withdrawals from the account named above. I/We also authorize the Financial Institution named above to debit my/our account accordingly:

Initials of Depositor(s) X _____ Is the Depositor the Policyowner? Yes No
If "No", Depositor is Primary Insured Applicant Payer (Check all that apply)



Statement of Agreement

Those Persons Who Sign This Application Agree That:

1. All of the statements, which are part of the application, are correctly recorded, and are complete and true to the best of the knowledge and belief of those persons who made them. Answers that are not true and complete may, subject to the policy's Incontestability Provision, invalidate coverage.
2. No agent or medical examiner has any right to accept risks, make or change contracts, or give up New York Life Insurance Company's, New York Life Insurance and Annuity Corporation's or NYLIFE Insurance Company of Arizona's rights or requirements.
3. "Cash Paid" with the application with respect to a new policy or additional benefit, provides a limited amount of temporary coverage for up to 90 days, if the terms and conditions of the Temporary Coverage Agreement are met. Temporary coverage is not provided if a policy or benefit is applied for under the terms of a conversion privilege or a guaranteed insurability option, or if reinstatement is applied for.
4. The policy date is the date from which premiums are calculated and become due. The effective date is the date the policy is delivered and the first premium is paid. Unless temporary coverage is obtained, coverage does not begin until the effective date. If the policy date is earlier than the effective date of coverage, the Policyowner pays a premium calculated beginning on that earlier policy date although coverage does not begin until the effective date.
At the time of application, or on or before the effective date, the Applicant or Policyowner can select a policy date. The policy date may be chosen to correspond to the effective date, to obtain a lower premium rate based on a younger insurance age, because it is preferable to pay premiums on that date or have policy values accrue as of that date, or for other reasons. If no Chosen Policy Date is selected, and if no temporary coverage is obtained, the date that the policy is issued will be the policy date. It is further agreed and understood that if the policy applied for is a universal life product, interest will not be credited on the policy until the premium is received by the service office.
5. By paying premiums on a basis more frequently than annually, that is monthly, quarterly, semi-annually, NYL-A-Plan, or by Check-O-Matic, the total premium paid during one year's time will be greater than if the premium were paid once each year, or annually. In other words, the cost of paying annualized periodic payments will be more than the cost of paying one annual premium. This applies to all products issued by New York Life Insurance Company and NYLIFE Insurance Company of Arizona.
6. **WARNING:** The arrangement of a sale, transfer or assignment of this policy, prior to or within a period of time specified by state law after the date the policy was issued, to a third party, such as a viatical settlement entity, a life settlement entity, other secondary market provider or premium financing entity, may violate the law of your state of residence. If there are any questions pertaining to these matters please consult with your legal advisor.

Fraud Warnings:

FOR ARKANSAS AND NEW MEXICO: 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 DISTRICT OF COLUMBIA: 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.

FOR NEW JERSEY: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Illustration

Do not complete this section if:

1. A signed illustration is not required by law; or
2. An illustration was signed and matches the policy applied for.

I, the Applicant, did not sign an illustration because:

- An illustration was not shown or given to me.
- An illustration was shown or given to me, but the policy applied for is different from the illustration.
- An illustration was displayed to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished. The illustration on the screen included the following personal and policy information:

Type of Policy _____ Proposed Insured _____

Initial Death Benefit _____ Rating/Class _____

Dividend Option _____ Age _____ Sex _____

I acknowledge that I did not sign an illustration for the reason stated above and I understand that an illustration matching the policy as issued will be provided for signature no later than at the time the policy is delivered.



Tax Certification

Under penalties of perjury, I (as the Owner named in Section A or C) certify that: (1) the Social Security or Employer ID Number shown in this application is my correct taxpayer identification number, or I am awaiting a number to be issued to me (noted as "applied for" in Section A or C) AND (2) I am not subject to backup withholding because: (a) I am exempt from backup withholding; or (b) I have not been notified by the IRS that I am subject to backup withholding as a result of a failure to report all interest or dividends; or (c) the IRS has notified me that I am no longer subject to backup withholding (Cross out item 2 if the IRS has notified you that you are subject to backup withholding.) and (3) I am a U.S. person (including a U.S. resident alien).

ACKNOWLEDGEMENT

I, the Proposed Insured, have been given a copy of "Information Practices Related to Underwriting Your Application" which tells how New York Life Insurance Company, New York Life Insurance and Annuity Corporation and NYLIFE Insurance Company of Arizona obtain and use data about me. It includes the notice required by the State and Federal Fair Credit Reporting Acts and a description of MIB, Inc. (Medical Information Bureau). I know that my application cannot be processed if I do not sign the Authorization below.

AUTHORIZATION

In this Authorization, "I" means the Proposed Insured, "the Insurer" means New York Life Insurance Company, New York Life Insurance and Annuity Corporation, and NYLIFE Insurance Company of Arizona and their respective agents, employees, and representatives. In order to see if (and on what basis) I qualify for the insurance applied for or any other insurance offered by any of the insurers identified above, I authorize the following:

MEDICAL INFORMATION: Physicians or practitioners; hospitals; medical or medically related facilities; pharmacies, pharmacy benefit managers or medical information retrieval services; laboratories; insurance companies; or MIB may give to the Insurer (or any consumer reporting agency acting on its behalf) and to any of its reinsurers, at my request, copies of the record or other data that they may have about my physical and mental health, and my prescription drug history. This includes all protected health information and any health information I have previously requested be withheld from further disclosure, and including my history, their findings, diagnoses and treatment. Mental health professionals may provide their records of my diagnosis, functional status, treatment plan, symptoms, prognosis, progress to date, medication prescription and monitoring, and clinical test results.

OTHER UNDERWRITING INFORMATION MIB, other insurance companies and consumer reporting agencies may give to the Insurer and to any of its reinsurers data about: my driving record; any criminal activity or association; hazardous sport or aviation activity; use of alcohol or drugs; any claim of eligibility for disability income benefits; and other applications for insurance.

EXAMINATIONS AND TESTS The Insurer may obtain physical examinations or medical tests deemed necessary to underwrite my application. These tests (where permitted by law) may include, but are not limited to, electrocardiograms, chest x-rays and tests of blood and urine to determine, among other things, exposure to causative agents of disease (for example, exposure to the AIDS virus) and the presence of drugs. However, a separate notification/authorization form will be provided with respect to testing for the AIDS virus.

INVESTIGATIVE CONSUMER REPORT The Insurer may obtain an investigative consumer report and may give the consumer reporting agency information concerning the amount and type of my coverage and my use, if any, of tobacco. The report may add to or confirm the types of data mentioned above. It may also contain data about: my identity; age; residence; marital status; past and present jobs (including work duties); economic conditions; driving record; personal and business reputation in the community; and mode of living; but will not include any information relating directly or indirectly to sexual orientation.

IDENTIFICATION To obtain the data described above, the Insurer may give my name, address, and date and place of birth to the above persons or organization.

RELEASE OF INFORMATION TO OTHERS When necessary, the Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data to MIB. However, this will not be done in connection with information relating to the AIDS virus.

I also authorize the release of these same types of data about any of my children who are to be insured. This Authorization may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this Authorization at anytime by notifying the Insurer in writing. This revocation will not be effective to the extent the Insurer or any other person already has disclosed or collected information or taken other action in reliance on it. The information the Insurer obtains through this Authorization may become subject to further disclosure. For example, the Insurer may be required to provide it to an insurance regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this Authorization. A photocopy of this Authorization and request form shall be as valid as the original. I know that I may request a copy of this Authorization. (Please provide a copy to me. _____ initial if requested).

The Internal Revenue Service Does Not Require Your Consent To Any Provision Of This Document Other Than The Certifications Required To Avoid Backup Withholding.

Signatures

By signing below, I/We understand that I/We acknowledge and agree to all of the statements and representations made in this application, including sections entitled Business and Creditor Insurance (if applicable), Statement of Agreement, Illustration (if applicable), Check-O-Matic (if applicable), Tax Certification, Acknowledgement and Authorization. I/We accept and adopt as true all statements made by the Proposed Insured(s) in this application.

_____ Signed at _____ On _____
Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months) (City, State) (MM/DD/YYYY)

_____ Title if signed on behalf of Corporation, Trust, etc.
Signature of the Owner if Other than the Primary Insured

_____ Signature of Other Insured
Signature of Applicant if Other than Primary Insured or Owner

_____ Signature of Other Insured
Signature of Other Insured

Other Required Signature

I Certify I have truly and accurately recorded all answers given to me.

_____ Countersigned by Licensed Resident Agent (if required)
Signature of Agent/Witness

_____ Countersigned Code #
Signature of Agent/Witness



NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
 NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
 NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Questionnaire (Non-Medical – Application Part II)

First Name _____ Middle Name _____ Last Name _____ Male Female Date of Birth (mm/dd/yyyy) _____ Height _____ ft. _____ in.
 Weight _____ lbs.

Social Security No. or Tax ID No. Exempt Applied for _____ Policy No./Tracking No. _____

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (_____) _____ - _____
 Date of last visit: _____ / _____ / _____ Reason for visit: _____
 Treatment or medication provided: (Provide details, name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? Yes No
 - b. Elevated blood sugar or diabetes? Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? Yes No
 - k. Any psychiatric or mental health condition (include counseling or hospitalization)? Yes No
 - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? Yes No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
5. In the last two (2) years, has the Proposed Insured had any of the following for which advice of a medical professional was not sought: chest pain or pressure, blood in urine, rectal bleeding, blood in stool, loss of consciousness, recurrent shortness of breath, persistent cough, or persistent fever? (If "Yes", circle all conditions that apply) Yes No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
- a. Had any surgery or been recommended to have surgery? Yes No
 - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more? Yes No
7. Among Proposed Insured's natural parents, brothers or sisters, is there any history of angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide relationship, age of onset and subsequent history in details below; provide type or location if cancer history.) Yes No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details below.) Yes No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? Yes No
 - b. Does the Proposed Insured live in a facility that provides him or her with personal care? Yes No
 - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? Yes No
 - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) Yes No

Give full details (including addresses and phone numbers of doctors) for all questions answered "Yes" above. If more space is needed, please use another form.

Ques. No.	Reason – Include diagnosis, treatment, medication, surgery and outcomes	Onset		Recovery		Doctors, Hospitals and Medical Facilities Info
		Mo.	Year	Mo.	Year	

By SIGNING BELOW, I/WE DECLARE THAT, to the best of my/our knowledge and belief, all the answers given in this Part II are correctly recorded, complete and true. I/We also understand that the Insurer will rely upon the answers in this Part II in determining if (and on what basis) life insurance may be issued on the life of the person proposed for coverage, and that this Part II will be attached to and made part of any such life insurance policy.

Dated at _____ on _____ / _____ / _____
 (City, State) (mm/dd/yyyy) Signature of Person Proposed for Coverage
 Witnessed by _____
 Signature of Parent or Guardian, if person examined is under age 14 years and 6 months



NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
 NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
 NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

Medical Examiner's Report – Application Part II

First Name _____ Middle Name _____ Last Name _____ Male Female Date of Birth (mm/dd/yyyy) _____

Social Security No. or Tax ID No. Exempt Applied for _____ Policy No./Tracking No. _____

1. Primary physician or health care provider information: None Name _____
 Address _____ Phone number (_____) _____ - _____
 Date of last visit: _____ / _____ / _____ Reason for visit: _____
 Treatment or medication provided: (Provide details, name and dosage) _____

2. List all prescribed medications taken on a regular basis in the last 12 months: (Include reason taken, dosage and frequency) _____

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? Yes No
 - b. Elevated blood sugar or diabetes? Yes No
 - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? Yes No
 - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? Yes No
 - e. Multiple sclerosis; epilepsy, seizures; mental retardation; memory loss or other neurological disorder? Yes No
 - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? Yes No
 - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? Yes No
 - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? Yes No
 - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? Yes No
 - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? Yes No
 - k. Any psychiatric or mental health condition (include counseling or hospitalization)? Yes No
 - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? Yes No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? Yes No
5. In the last two (2) years, has the Proposed Insured had any of the following for which advice of a medical professional was not sought: chest pain or pressure, blood in urine, rectal bleeding, blood in stool, loss of consciousness, recurrent shortness of breath, persistent cough, or persistent fever? (If "Yes", circle all conditions that apply)..... Yes No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
- a. Had any surgery or been recommended to have surgery? Yes No
 - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) Yes No
 - c. Been unable to work, unable to attend school or been disabled for 30 days or more? Yes No
7. Among Proposed Insured's natural parents, brothers or sisters, is there any history of angina, heart disorder, stroke, diabetes or cancer? (If "Yes", please provide relationship, age of onset and subsequent history in details on Page 2; provide type or location if cancer history.) Yes No
8. Has Proposed Insured lost weight in the last year? (If "Yes", please provide how many lbs. lost and reason in details on Page 2.) Yes No
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home?... Yes No
 - b. Does the Proposed Insured live in a facility that provides him or her with personal care? Yes No
 - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? Yes No
 - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) Yes No

Give full details on Page 2 for all questions answered "Yes" above.



- NEW YORK LIFE INSURANCE COMPANY (NYLIC)
- NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC)
- NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ)

RECEIPT AND TEMPORARY COVERAGE AGREEMENT (the "Agreement")
(limited in amount)

Received from _____ on _____ the sum of \$ _____.
This amount is specified in Section H. of the application Part I bearing the same date and number as this receipt.

Agent's Signature

In this Agreement, the words "we", "us", and "our" mean the Insurer checked above and the words "you" and "your" mean the Applicant. We acknowledge receipt of your application for a life insurance policy, and of your payment to us in the amount noted above. Any check tendered must be made payable to New York Life Insurance Company or New York Life Insurance and Annuity Corporation or NYLIFE Insurance Company of Arizona, as shown above. Any check received will be subject to collection. **Do not** make any check payable to the Agent and **do not** leave the Payee section of the check blank. This Agreement is not transferable.

If the application modifies a previous application and a payment was made in connection with the previous application, this receipt replaces and cancels any receipt which was previously given for that payment. We shall have no liability on account of the previous receipt or any temporary coverage provided under it. Our liability on account of any payment made with this application shall be as provided under this receipt and its Temporary Coverage Agreement below.

Subject to the conditions set forth below, the above payment provides a limited amount of temporary life insurance coverage on the Proposed Insured from the date coverage begins, as defined below, to the date coverage terminates, as defined below. **If question 1, 2 or 3 of Section H of the application Part I are answered "Yes" or are left blank, no money may be paid with the application whether to us or to the Agent.** In this case, no coverage will be provided under this Agreement. However, the application should still be submitted to us for evaluation **WITHOUT PAYMENT.**

In determining whether to issue the policy that you have applied for, if all the conditions for coverage in Section 1 below have been met, we will not consider information concerning changes in the health of any person proposed for coverage, where such change occurs after the effective date of this Agreement and while this Agreement is in effect.

1. Coverage Provided:

Except as specifically stated otherwise in this Agreement, temporary life insurance will be subject to all terms of the policy applied for. While this Agreement is in effect, coverage is provided under this Agreement only if the following requirements are fully met. (If these requirements are not fully met, any cash payment made will be refunded to the Applicant at the address given in the Application Part I.):

- A. Submission of the application Part I with Sections A-I completed, with all statements complete and true to the best of the knowledge and belief of the persons who made them;

- B. Collection of your payment submitted with your application, provided any check submitted is honored for payment when presented;
- C. Question 1, 2 and 3 of Section H of the Application Part I must be answered "No" for all persons proposed for coverage;
- D. The Application Part I is signed by all required parties, including the Applicant, the Proposed Insured(s) (if other than the Applicant), and Agent.

2. No Coverage Provided:

- There is no coverage provided under this Agreement:
- A. For suicide or intentionally self-inflicted injury of any of the proposed insureds, while sane or insane;
 - B. For any Spouse's Paid-Up Insurance Purchase Option attached to or included in the policy being applied for;
 - C. For a policy or benefit that is applied for under the terms of a contractual conversion privilege or guaranteed insurability option. If that policy or benefit does not require our approval to put it in force, it will take effect as soon as the requirements of that privilege or option have been met;
 - D. If reinstatement of a policy is being applied for;
 - E. Where question 1, 2 or 3 of Section H of the Application Part I are answered "Yes" or are left blank, or are answered falsely;
 - F. If we are prohibited by any state or federal law, regulation or order from doing business with or participating in a transaction involving any person identified as a Proposed Insured, Owner, Applicant, Payer or Beneficiary in your application for a life insurance policy.

3. Amount and Period of Coverage:

A. Maximum Amount of Coverage:

The following amounts will apply depending on the policy applied for:

- (1) All Policies except Survivorship Policies. While this Agreement is in effect, we will provide coverage having the same benefits and subject to the same terms as the policy applied for had it become effective. However, the **aggregate coverage** on account of all the temporary coverage for all Insurers listed above, under this and any other receipt, on the person proposed for coverage in the application for all benefits (including Accidental Death Benefits and any other benefits) shall in no event exceed \$1,000,000 in total. Such liability shall be further limited for any disability waiver of premium benefit so that the amount that may be waived does not exceed \$300 per month.

(2) Survivorship Policies. Survivorship Policies are policies under which the base policy death benefit is payable only when two Proposed Insureds have died. The temporary coverage will provide the same benefits as the policy applied for. It will also be subject to the same provisions, conditions, exceptions, limitations and reductions that would apply under the policy had it become effective. However, the temporary coverage will provide the lesser of:

- (i) The amount of the life insurance proceeds applied for in the applications. This includes Accidental Death Benefits and other benefits, if applicable; or
- (ii) \$2,000,000 in total for all insurers listed above.

This benefit will be paid to the designated beneficiary if the Proposed Insureds die while the temporary coverage is in effect. No benefits will be payable under this Agreement upon the death of only one of the Proposed Insureds. However, we will pay benefits under an applied for rider that is to be attached to the policy, if such rider would pay benefits upon the death of that Proposed Insured. If one of the Proposed Insureds dies while this coverage is in effect and the other is found to be insurable, we will issue the policy. Such liability shall be further limited for any waiver of premium benefits so that the amount that may be waived does not exceed \$300 per month. The total benefit limit applies to all insurance applied for on all persons proposed for any coverage in the applications and any other Temporary Coverage Agreement.

B. Date Agreement Begins:

This Agreement and the coverage provided under it will begin on the date the Application Part I is signed by all required parties, provided:

- (1) The sum paid in exchange for this Agreement is enough to provide at least one month's coverage for the face amount of insurance and one month's coverage for all riders that are

being applied for. For policies that require a single premium payment, the sum paid in exchange for this Agreement must be the full single premium payment for the face amount of insurance and any riders being applied for; and

- (2) All of the requirements in Section 1 of this Agreement have been met.

C. Date Agreement Terminates:

This Agreement and the coverage provided under it will terminate on the earliest of the following dates:

- (1) 90 days after the date this Agreement becomes effective;
- (2) The date of our notice to the Applicant(s) that the application has been declined;
- (3) The date of the Applicant(s) written request for a full refund of the payment, in which event all coverage will be void from the start;
- (4) The date the policy is put in force, at which point all coverage shall be provided by the policy.

4. Refund of Payment:

If temporary life insurance is not payable under this Agreement (except for the reason that the policy has been put in force), we will refund your payment made with respect to the policy.

If temporary life insurance becomes payable under this Agreement, the payment received will be applied as the first premium for the life insurance applied for. We will refund an appropriate part of your payment made with respect to the policy if our liability under this Agreement is, pursuant to Section 3(A), less than it would have been under the policy applied for.

5. Limitation of Authority:

No Agent or medical examiner has any right to accept any risk, make or change contracts, give up any of our rights or requirements, or change the provisions of this Agreement.



- New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010
- New York Life Insurance and Annuity Corporation (A Delaware Corporation), 51 Madison Avenue, New York, NY 10010
- NYLIFE Insurance Company of Arizona (Not licensed in every state), 4343 North Scottsdale Road, Suite 220, Scottsdale, AZ 85251

INSURED: _____ POLICY NUMBER: _____

SUPPLEMENTAL APPLICATION – STATEMENT TO INSURER BEFORE DELIVERY OF A POLICY

IF NO CASH WAS PAID WITH THE APPLICATION, OR IF COVERAGE IS CURRENTLY NOT IN EFFECT UNDER THE TEMPORARY COVERAGE AGREEMENT, the Policy Owner must complete this section.

Since the date of the signing of the application Part I or, if later, any Part II or Supplemental Application, has the insured or any other person who is proposed for coverage: (1) had or been advised by a member of the medical profession to have, any medical treatment, test or diagnostic procedure for any symptoms, illness or condition? or (2) been admitted to a hospital or other medical facility?

NO YES If "YES", please provide details including names and addresses of medical professional, hospital or medical facility:

I understand that if this question is answered "YES", then cash cannot be accepted and this policy cannot be delivered.

X _____ Date: _____
 Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months)

X _____ X _____
 Signature of the Owner if Other than the Primary Insured Signature of Other Insured

Agent's Signature: X _____ Date: _____



- NEW YORK LIFE INSURANCE COMPANY (NYLIC) 51 Madison Avenue, New York, NY 10010
- NEW YORK LIFE INSURANCE AND ANNUITY CORPORATION (NYLIAC) (A Delaware Corporation) 51 Madison Avenue, New York, NY 10010
- NYLIFE INSURANCE COMPANY OF ARIZONA (NYLAZ) (Not Licensed in Every State) 4343 North Scottsdale Rd., Suite 220, Scottsdale, AZ 85251

*Please complete and sign this form if the hazardous activity question on the Application Part I is answered "Yes".
Only the areas applicable to the client should be completed.*

HAZARDOUS SPORTS AND AVIATION SUPPLEMENT

First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	Policy No./Tracking No.
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A) SCUBA Diving and/or Skin Diving

1. What is your certification? Basic Open Water Advanced Specialty Dive Master Instructor Master Instructor Master Scuba Diver None
2. How many dives have you done in the last 12 months? _____
3. How many dives do you plan in the next 12 months? _____
4. What is the average depth you dive? _____ feet
5. What is the maximum depth you have dived? _____ feet
6. Do you do any diving for work or as part of your job? Yes No If "Yes", please provide details. _____
7. Do you do any specialty diving? Yes No If "Yes", provide type: Wreck Cave Salvage Ice Other _____
8. Do you ever dive alone? Yes No If "Yes", please provide details. _____

B) Auto racing/Motorcycle racing/Power Boat racing/Snowmobile racing/All Terrain Vehicle (ATV) racing/other type vehicle racing

1. What type of racing do you do? (Check all that apply and provide details for each below.)
 Drag Formula Sports Car Stock Sprint Go-Karts Off-Road Moto-cross All Terrain Vehicle (ATV)
 Hill-Climb Ice Hydroplane Scramble Midget Offshore Speedway Other
 If "Other", please provide details. _____
2. What is the length of track/course? _____ miles
3. What type of vehicle do you race? (Top fuel, funny car, stock, super stock, etc.) _____
4. What is your best Elapsed Time (ET)? _____ (hours/minutes/seconds)
5. How many races have you done in the last 12 months? _____
6. How many races do you plan to do in the next 12 months? _____
7. What is your maximum speed attained? _____ (mph/knots)
8. What class, division, or category do you race in? _____
9. What type of track do you race on? Straight Oval Open Road Other If "Other", please provide details. _____
10. What sanctioning body do you belong to? _____

C) Sky Diving

1. What type of jumps do you do? Free-fall Static Line Tandem BASE (please specify) _____
2. How many jumps have you done in the last 12 months? _____
3. How many jumps do you plan to do in the next 12 months? _____
4. Do you participate in any competitive jumping? Yes No If "Yes", please provide details. _____
5. Are you a member of a skydiving association? Yes No If "Yes", please provide details. _____
6. Are you a professional or do any jumping for work? Yes No If "Yes", please provide details. _____

D) Mountain Climbing

1. What type of climbing do you do? Hiking (Class 1) Scrambling (Class 2) Easy (Class 3) Moderate (Class 4)
 Technical (Class 5) Artificial Aid (Class 6)
2. How many years have you been climbing? _____
3. How many climbs have you done in the last 12 months? _____
4. How many climbs do you plan to do in the next 12 months? _____
5. What is the average time grade of your climbs? I II III IV V VI Unknown
6. Do you belong to any climbing organizations or clubs? Yes No If "Yes", please specify. _____
7. Do you climb outside the lower 48 states? Yes No If "Yes", please provide details. _____
8. Do you ever climb alone? Yes No If "Yes", please provide details. _____

E) Helicopter Skiing

1. How many times have you heli-skied in the last 12 months? _____
2. How many times do you plan to heli-ski in the next 12 months? _____
3. Have you heli-skied or do you plan to heli-ski outside the U.S.? Yes No If "Yes", please provide details (country, dates). _____
4. Do you always use a professional guide? Yes No If "No", please provide details. _____



F) Cave Exploration (Spelunkers)

- 1. How many times a year do you go caving? _____
- 2. Have you done or do you plan to do this outside the U.S.? Yes No If "Yes", please provide details (country, dates). _____
- 3. Have you engaged in any underwater activities during caving? Yes No If "Yes", please provide details. _____

G) Hot Air Ballooning

- 1. How many hours a year do you spend hot air ballooning? _____
- 2. How high do you fly? _____ feet
- 3. Do you balloon over lakes, mountains or oceans? Yes No
- 4. Have you ever ballooned competitively? Yes No If "Yes", please provide details. _____

H) Rodeo Riding

- 1. What specific events do you participate in? (Check all that apply): Bronco Riding Bull Riding Steer Wrestling Calf Roping Team Roping events
 Other If "Other", please provide details. _____
- 2. Do you compete professionally? Yes No If "Yes", please provide details. _____

Aviation Supplement Section

A) Civilian

- 1. Type of pilot's license? Student Private Commercial Instructor Airline Transport (ATR) Recreational
- 2. What type of aircraft do you fly? Single Engine Multi-Engine Glider Helicopter Other
If "Other", please provide details. _____
- 3. Are you instrument flight rated (IFR)? Yes No
- 4. How many total hours have you flown as a pilot? _____ hours
- 5. How many hours have you flown in the last 12 months? _____ hours
- 6. How many hours do you plan to fly in the next 12 months? _____ hours
- 7. Have you had any flying accidents? Yes No If "Yes", please provide full details. _____
- 8. Do you fly outside the United States? Yes No If "Yes", please provide details. _____
- 9. Have you received any reprimands, fines, warnings, or had restrictions put on your flying? Yes No If "Yes", please provide full details. _____
- 10. Have you flown or intend to fly any experimental or home-built aircraft? Yes No If "Yes", please provide full details. _____
- 11. Do you do crop-dusting, aerobatic, barnstorming or any unusual type flying? Yes No If "Yes", please provide details. _____
- 12. Do you fly for pay? Yes No If "Yes", check all that apply:
 Air Taxi Charter/Ferry Cargo/Freight Corporate Medical Airlift Firefighting
 Other If "Other", please provide details. _____

B) Military

- 1. What branch of service are you in? _____
- 2. What is the designation of the aircraft you fly (eg. F-18, C130)? _____
- 3. How many hours have you flown in the last 12 months? _____ hours
- 4. How many hours do you plan to fly in the next 12 months? _____ hours
- 5. What are your primary flying assignments/duties? Pilot Co-Pilot Navigator Other Crew Member
- 6. Where are you currently stationed? _____
- 7. Any change in assignment anticipated? Yes No If "Yes", please provide location. _____
- 8. Have you ever been a test pilot, flown a prototype or experimental aircraft, or performed with an aerobatic team? Yes No
If "Yes", please provide full details. _____

C) Ultralight/Lighter than Air

- 1. How many hours per year do you fly? _____ hours
- 2. Have you had any accidents or ever been injured when using an Ultralight? Yes No If "Yes", please provide full details. _____
- 3. Do you have a pilot's license? Yes No

D) Hang-Gliding

- 1. How many hours per year do you hang-glide? _____ hours
- 2. Where do you hang-glide? _____
- 3. Have you had any accidents or ever been injured when using a hang-glider? Yes No If "Yes", please provide full details. _____

Signatures

I DECLARE, to the best of my knowledge and belief, that all of the answers given on this supplement are correctly recorded, complete and true.

X _____
Signature of Proposed Insured (Parent or Guardian, if under 14 years 6 months)

Date: _____

GO Code _____ Agent Code _____

X _____
Signature of Agent/Witness

Agent Last Name (Print) _____

SERFF Tracking Number: NYPX-125863979 *State:* Arkansas
Filing Company: New York Life Insurance and Annuity *State Tracking Number:* 40596
Corporation
Company Tracking Number: 209-500, ET AL.
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: 2008 & 2009 NB21 applications, et al
Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: NYPX-125863979 State: Arkansas
Filing Company: New York Life Insurance and Annuity Corporation State Tracking Number: 40596
Company Tracking Number: 209-500, ET AL
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: 2008 & 2009 NB21 applications, et al
Project Name/Number: 2008 & 2009 NB21 applications, et al/209-500, et al.

Supporting Document Schedules

Review Status:

Satisfied -Name: Cover Letter

10/17/2008

Comments:

Attachment:

Cover Letter.PDF

October 14, 2008

Hon. Julie Benafield Bowman
Insurance Commissioner
Arkansas Insurance Department
Division of Compliance
Life and Health
1200 West Third Street
Little Rock, AR 72201-1904

Re: New York Life Insurance and Annuity Corporation (NYLIAC)
Part I Application Form 209-500, et al.
NAIC #: 82691596
FEIN #: 13-3044743

Dear Commissioner:

We are enclosing for your Department's approval new application forms and related forms for use when applying for individual life insurance products. We are planning to introduce these new forms in May 2009 or as soon thereafter as administratively possible.

The following forms are enclosed:

- (1) a Part I application 209-500 to replace our Part I form 204-500.03 which was previously approved on 1/24/2004;
- (2) a Medical Questionnaire (Non-Medical - Application Part II) form 209-510 to replace the Non-medical Part II form 204-510.03 which was previously approved on 1/24/2004;
- (3) a Medical Examiner's Report – Application Part II, form 209-525, that will replace the Medical Examiner's Report – Part II, form 204-525.03 which was previously approved on 1/24/2004;
- (4) a Receipt and Temporary Coverage Agreement, Form 21620.100 that will replace the 21620 (02/04) that was previously approved on 7/18/2003;
- (5) a new Supplemental Application – Statement to Insurer Before Delivery of Policy, Form 209-581 to replace 204-581 that was previously approved on 7/18/2003;
- (6) a new Hazardous Sports and Aviation Supplement 7663.100;

The enclosed forms are designed for use by New York Life Insurance Company and its two subsidiary companies, New York Life Insurance and Annuity Corporation and NYLIFE Insurance Company of Arizona. The forms will be filed for use by each of those companies under separate cover.

The Part I application is a general application form that will be used to apply for individual life insurance products. The form has been significantly redesigned. Questions have been reworded and reordered to make it easier to use and collect needed information.

The Plan section has been updated to include all currently available products. A blank space has been included at the end of each Company's Plans for temporary use in order to apply for new products that are introduced before the application form can be updated to include the new product. We have made changes to improve collection of information on beneficiaries, other coverage and contact information (including a secondary addressee for notification in case of

potential lapse of the policy). New questions for proposed insureds over age 70 or under age 2 have been added to the non-medical questionnaire. We have added questions concerning policy transfers and premium financing and added a warning to our Statement of Agreement section concerning stranger-owned life insurance. We have removed any questions related to past travel. The application includes a section that will be completed only if Additional Insureds are to be covered under the policy. Additional copies of these questions will be available to ensure that we obtain necessary information for all Additional Insureds proposed for coverage. Some changes have been made in our efforts to minimize the number of state variations of this form. For example this application includes a list of fraud warnings required in a number of jurisdictions so this application may be used in multiple jurisdictions. We have also modified the question we ask concerning AIDS and testing positive for HIV.

The Medical Questionnaire (Non-Medical – Application Part II) and the Medical Examiner's Report- Application Part II have been revised to conform to the new format and questions in the Part I application.

Replacement questions are included in a separate form "Important Notice: Replacement of Life Insurance or Annuities", form 22190.100 which was approved by your Department on 10/10/2007. Both the applicant and the agent must sign this form, and it is required that one copy be left with the applicant and another copy be submitted with every Part I application. A Part I application will not be processed without a signed Replacement form.

The Receipt and Temporary Coverage Agreement (the Agreement) form provides a limited amount of temporary life insurance coverage on the proposed insured(s) from the date coverage begins to the date coverage terminates if cash is taken with the application. The primary differences between this new form and the form it replaces are changes to reflect changes in the new Part I application and to state that no coverage will be provided under the Agreement for any Spouse's Paid-Up Insurance Purchase Option attached to the policy being applied for.

The Supplemental Application – Statement to Insurer Before Delivery of Policy, is designed to update details furnished on an Application Part I or Part II. When temporary coverage is not in effect, we will ascertain, prior to delivery of the policy and accepting the first premium, whether a proposed insured has undergone a significant change in insurability since a Part I or Part II application was taken.

The new Hazardous Sports and Aviation Supplement is used to provide more details if the applicant has indicated on the Part I application that the proposed insured participates in hazardous activities.

Add PSs here.

We would appreciate receiving your Department's approval of the enclosed forms, at your earliest convenience. If there are any questions regarding this filing, you may call me toll free at 1-877-464-0198 or email me at Linda_E._LoPinto@newyorklife.com.

Sincerely,



Corporate Vice President
Individual Life Department