

SERFF Tracking Number: FRCS-125641375 State: Arkansas
Filing Company: New York Life Insurance Company State Tracking Number: 39040
Company Tracking Number: 4874
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: AC IR Application Filing
Project Name/Number: NYLASN/64/64

Filing at a Glance

Company: New York Life Insurance Company

Product Name: AC IR Application Filing

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: FRCS-125641375 State: ArkansasLH

SERFF Status: Closed

State Tr Num: 39040

Co Tr Num: 4874

State Status: Approved-Closed

Co Status: None

Reviewer(s): Linda Bird

Author: Exselsa Cartwright

Disposition Date: 05/22/2008

Date Submitted: 05/19/2008

Disposition Status: Approved

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

General Information

Project Name: NYLASN/64

Project Number: 64

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: Submitted on or about this same date.

Explanation for Combination/Other:

Market Type: Group

Submission Type: New Submission

Group Market Size: Small and Large

Overall Rate Impact:

Group Market Type: Employer

Filing Status Changed: 05/22/2008

State Status Changed: 05/22/2008

Deemer Date:

Corresponding Filing Tracking Number:

Filing Description:

These forms are new and are not intended to replace any previously approved forms.

The Company proposes to use these applications and questionnaires as necessary to underwrite its approved policy forms. If the original application indicates an issue that warrants additional investigation, one or more of these questionnaires will be used. The Company will attach the completed questions to the application.

The purpose of these forms is to enroll eligible persons and their eligible dependents in group term life and/or accident

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/health insurance plans. (e.g., term life, AD&D, Major Medical Disability Income, Office Overhead Expense, or Hospital Indemnity coverage). The applications may be used to offer coverage alone or in conjunction with any other line of coverage offered dependent on specific plan design.

We have also enclosed, on an informational basis, Explanations of Variable for forms GMA-AC-IR and GMA-L/H-TELE-SUPP that summarizes the intended use of the forms and provides an explanation of the illustrative and variable language. This variable language is indicated in the shaded areas of the forms.

Company and Contact

Filing Contact Information

(This filing was made by a third party - FC01)

Exselsa Cartwright, Compliance Specialist exselsa.cartwright@firstconsulting.com
 1020 Central (800) 927-2730 [Phone]
 Kansas City, MO 64105 (816) 391-2755[FAX]

Filing Company Information

New York Life Insurance Company CoCode: 66915 State of Domicile: New York
 51 Madison Ave. Group Code: 826 Company Type:
 New York, NY 10010 Group Name: State ID Number:
 (800) 280-3551 ext. [Phone] FEIN Number: 13-5582869

Filing Fees

Fee Required? Yes
 Fee Amount: \$440.00
 Retaliatory? No
 Fee Explanation: The domicile fee is zero. The fee in your state is \$20 per form filed separately from policy. Therefore, the fee in your state is \$20 X 22 forms = \$440.00.
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance Company	\$440.00	05/19/2008	20398906

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Linda Bird	05/22/2008	05/22/2008

SERFF Tracking Number: *FRCS-125641375* *State:* *Arkansas*
Filing Company: *New York Life Insurance Company* *State Tracking Number:* *39040*
Company Tracking Number: *4874*
TOI: *L08 Life - Other* *Sub-TOI:* *L08.000 Life - Other*
Product Name: *AC IR Application Filing*
Project Name/Number: *NYLASN/64/64*

Disposition

Disposition Date: 05/22/2008

Implementation Date:

Status: Approved

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice		Yes
Supporting Document	Application		Yes
Supporting Document	Statement of Variability		Yes
Form	Enrollment Form		Yes
Form	Supplement to Application		Yes
Form	Alcohol Use Questionnaire		Yes
Form	Back Pain Questionnaire		Yes
Form	Blood Disorder/AIDS Questionnaire		Yes
Form	Blood Pressure Questionnaire		Yes
Form	Bone/Joint Disorder Questionnaire		Yes
Form	Cancer Questionnaire		Yes
Form	Colon Questionnaire		Yes
Form	Diabetes Questionnaire		Yes
Form	Drug Use Questionnaire		Yes
Form	Fibromyalgia Questionnaire		Yes
Form	Gastrointestinal Disorder Digestive Questionnaire		Yes
Form	Financial Questionnaire		Yes
Form	Financial Questionnaire for Life Insurance Coverage		Yes
Form	Financial Questionnaire Supplement		Yes
Form	Hazardous Sports and Aviation Questionnaire		Yes
Form	Headache Questionnaire		Yes
Form	Heart Questionnaire		Yes
Form	Psychiatric Questionnaire		Yes
Form	Respiratory Disorder Questionnaire		Yes
Form	Seizure Questionnaire		Yes

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Form Schedule

Lead Form Number: GMA-AC-IR

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	GMA-AC-IR	Application/ Enrollment Form	Enrollment Form	Initial		50	GMA-AC-IR.pdf
	GMA-L/H-TELE-SUPP	Application/ Enrollment Form	Supplement to Enrollment Application Form	Initial		50	GMA-LH-TELE-SUPP.pdf
	GQA-L/H-AL	Application/ Enrollment Form	Alcohol Use Enrollment Questionnaire Form	Initial		60	GQA-LH-AL.pdf
	GQA-L/H-BCK	Application/ Enrollment Form	Back Pain Enrollment Questionnaire Form	Initial		85	GQA-LH-BCK.pdf
	GQA-L/H-BD	Application/ Enrollment Form	Blood Disorder/AIDS Enrollment Questionnaire Form	Initial		81	GQA-LH-BD.pdf
	GQA-L/H-BP	Application/ Enrollment Form	Blood Pressure Enrollment Questionnaire Form	Initial		78	GQA-LH-BP.pdf
	GQA-L/H-OS	Application/ Enrollment Form	Bone/Joint Disorder Enrollment Questionnaire Form	Initial		70	GQA-LH-OS.pdf
	GQA-L/H-CAN	Application/ Enrollment Form	Cancer Enrollment Questionnaire Form	Initial		57	GQA-LH-CAN.pdf
	GQA-L/H-COL	Application/ Enrollment Form	Colon Questionnaire Enrollment Form	Initial		67	GQA-LH-COL.pdf
	GQA-L/H-DIA	Application/ Enrollment Form	Diabetes Enrollment Questionnaire Form	Initial		53	GQA-LH-DIA.pdf
	GQA-L/H-DU	Application/ Enrollment Form	Drug Use Enrollment Questionnaire Form	Initial		50	GQA-LH-DU.pdf

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GQA-L/H-FIBRO	Application/ Fibromyalgia Enrollment Questionnaire Form	Initial	77	GQA-LH-FIBRO.pdf
GQA-L/H-GI	Application/ Gastrointestinal Enrollment Disorder Digestive Form Questionnaire	Initial	50	GQA-LH-GI.pdf
GQA-DI-FQ-06	Application/ Financial Enrollment Questionnaire Form	Initial	50	GQA-DI-FQ-06.pdf
GQA-L-FQ	Application/ Financial Enrollment Questionnaire for Life Form Insurance Coverage	Initial	50	GQA-L-FQ.pdf
GQA-DI-FQ2-06	Application/ Financial Enrollment Questionnaire Form Supplement	Initial	66	GQA-DI-FQ2-06.pdf
GQA-L/H-HAZ	Application/ Hazardous Sports Enrollment and Aviation Form Questionnaire	Initial	77	GQA-LH-HAZ.pdf
GQA-L/H-H	Application/ Headache Enrollment Questionnaire Form	Initial	69	GQA-LH-H.pdf
GQA-L/H-HRT	Application/ Heart Questionnaire Enrollment Form	Initial	66	GQA-LH-HRT.pdf
GQA-L/H-Psych	Application/ Psychiatric Enrollment Questionnaire Form	Initial	66	GQA-LH-PSYCH.pdf
GQA-L/H-RD	Application/ Respiratory Disorder Enrollment Questionnaire Form	Initial	67	GQA-LH-RD.pdf
GQA-L/H-SZ	Application/ Seizure Enrollment Questionnaire Form	Initial	68	GQA-LH-SZ.pdf



New York Life Insurance Company

- A Mutual Company Founded in 1845 -

51 Madison Avenue, New York, NY 10010

GROUP LIFE and ACCIDENT and HEALTH INSURANCE ENROLLMENT FORM

ABC Logo
Phone Number

Complete this form and:

Return to:

XYZ Administrators, Inc.

Any Street

Any Where, US 00000

Or

Submit electronically through this Website

Or download a copy of the form,

Complete and mail to the above address

Printer Friendly version available
In order to view this document you must have Adobe 6.0 or better

Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

Questions? Call 1-800-222-0000- Email: ABC@XYZ.com

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE

1. MEMBER INFORMATION

Last Name: DOE First: JOHN Initial: A ABC ID Number: 7890
 Billing Address Street: ANY STREET City: ANY CITY State/Province: ANY STATE Zip Code: 12345
 Home Address Street: ANY STREET City: ANY CITY State/Province: ANY STATE Zip Code: 12345
 Home Phone No.: (123) 456-9278 Office Phone Number: (123) 456-7890 Fax Number: (123) 456-7800 E-Mail Address: JDOE@ABC.COM

Date of Birth: 10/1/70 Height: 6 ft. 0 in. Weight: 170 lbs. Sex: M F

Marital Status: Married Widowed Divorced Single
 I am a: Member of Employee of ABC COMPANY
 Domestic Partner Civil Union Other Please Explain

Date you Became a Member or Date of Employment: 01/01/03 Social Security No: 123-45-6790

Are you currently on active duty in the armed forces? Yes No
 Are you currently in the Military Reserves or National Guard? Yes No
 If yes, have you received notice of deployment overseas? Yes No
 If yes, please advise date of deployment and where you are being deployed?

SPOUSE INFORMATION

Last Name: N/A First: N/A Initial: N/A Maiden Name:
 Social Security No: N/A I am a Member of ABC: Yes No

Please provide the following information if different from above

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Home Address Street City State/Province Zip Code

Billing Address Street City State/Province Zip Code

Home Phone No. Office Phone Number Fax Number E-Mail Address

Are you presently insured by any ABC plan? Member Yes No Spouse Yes No

If yes, provide details.

Do you intend to reside outside the U.S. or Canada in the next 12 months?

Member: Yes Country No Spouse: Yes Country No

If yes, for how long?

SEND CORRESPONDENCE TO: Member Home Billing Address E-mail Address Spouse Home Billing Address E-mail Address

2. PAYMENT OPTION SELECTED: Please select one of the following payment options:

OPTION 1: AUTOMATIC PAYMENT

I request and authorize ABC Insurance Program, Inc. to make Quarterly Semi-Annual Annual withdrawals against the account specified on the attached voided check statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED AGAINST THIS ACCOUNT DATE

OPTION 2: CREDIT CARD PAYMENT

I request and authorize ABC Insurance Program, Inc. to make Quarterly Semi-Annual Annual charges against the credit card specified below, or any credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan.

VISA MasterCard Account Number Exp. Date

CARDHOLDERS NAME AS IT APPEARS ON CARD X CARDHOLDER SIGNATURE DATE

OPTION 3: PERIODIC BILLING

Quarterly Semi-Annual Annual

3. OCCUPATIONAL STATUS:

a) What is your occupation? CLERK Main Duties SALES

b) FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed. Are you now at FULL-TIME WORK? Yes No

c) Gross Annual Income from: Salary \$ 50,000 Self Employment \$ Bonus \$ Commissions \$ Total \$ 50,000

d) ANNUAL NET EARNED INCOME \$ 35,000 Is ANNUAL NET EARNED INCOME more than 25% above or below your previous year? Yes No If yes, what was your ANNUAL NET EARNED INCOME last year? \$ If yes, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? \$

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal services - before deduction of income or social insurance taxes and after deduction of the normal business expense which is deductible for income tax purposes - for any twelve month period.

Your gross ANNUAL NET EARNED INCOME must be at least \$20,000 for you to be eligible for this coverage.

e) What is your net worth? \$ 100,000

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4. DEPENDENT INFORMATION: If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 25).

Full Name (First, Last, Middle Initial)	Date of Birth (mo/day/yr)	Height (Ft., In)	Weight (Lbs.)	Sex
Spouse's Full Name				
Child				
Child				
Child				

5. INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Additional

NOTE: If you are increasing or altering present coverage in any way, do not indicate on line (a) below just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

A. TERM LIFE INSURANCE: Member Coverage Available in \$50,000 Increments from \$100,000 to \$2,000,000.

Amount Requested:

Total Member Amount Desired \$ 100,000

One of the following must be checked:

Member Only Member & Spouse Member & Children Member & Family

Total Spouse Amount Desired \$

RESIDENTS OF NEW YORK – IMPORTANT REPLACEMENT INFORMATION: It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against to withdrawn from, reduced in value, by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help decide whether the replacement is on your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above.
Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?
Member: Yes No Spouse: Yes No

RESIDENTS OF OTHER STATES:
Is the insurance applied for intended to replace, discontinue or change an existing policy?
Member: Yes No Spouse: Yes No

ALL RESIDENTS
Do you have other life insurance in force? If "yes", total amount in all companies:
Member: \$ Spouse: \$

Do you have other insurance applications pending? If "yes", indicate amount and company:
Member: \$ Company Spouse: \$

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B. ACCIDENTAL DEATH & DISMEMBERMENT:

Please check one:

Please check one:

Member's Coverage \$150,000 \$100,000 \$50,000 Spouse's Coverage* \$100,000 \$50,000

* Member must be insured in order for spouse to be eligible. Spouse coverage may not exceed member's coverage.

C. MAJOR MEDICAL:

Please check one:

Cost Advantage PPO Conventional Indemnity

Please check one:

Deductible: \$ 500 \$1,000 \$1,500

One of the following must be checked:

Member Only Member & Spouse Member & Children Member & Family

Is this coverage meant to replace any group medical care insurance which was in force for at least 18 months (without a break in coverage of more than 63 days) on yourself or any other person to be insured? Yes No

If yes, please attach a copy of the certificate of creditable coverage from the prior insurance plan.

D. DISABILITY INCOME INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Additional

NOTE: If you are increasing or altering present coverage in any way, do not indicate on line (a) below just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

Group Disability Income:

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 60% of your AVERAGE MONTHLY INCOME as defined in the brochure.

I hereby apply for the coverage indicated below, based upon all my statements made in this Request Form:

Member

a) Benefit Period: Five-Year Plan Two-Year Plan

b) Monthly Benefit Option: \$ _____ Waiting Period: 30-day 90-day 180-day 365-day

c) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? Yes No

If "Yes," please list:

Company	Plan	Monthly Benefit	Benefit Period

d) Future Purchase Option (\$500 to \$2,000 in \$100 Units) \$ _____

e) Cost of Living Adjustment (COLA) Option _____

f) "Own Occupation Plus" Definition Option _____

Spouse

a) Benefit Period: Five-Year Plan Two-Year Plan

b) Monthly Benefit Option: \$ _____ Waiting Period: 30-day 90-day 180-day 365-day

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c) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? Yes No

If "Yes," please list:

Company	Plan	Monthly Benefit	Benefit Period

E. PROFESSIONAL OVERHEAD EXPENSE INSURANCE:

POE Plan Maximum Benefit Period (Plan 1 – 15-day/12-month, Plan 2 – 30-day/24-month) Plan _____

POE monthly benefit amount (\$300 to \$20,000 in \$100 units) \$ _____

1. What was your average monthly amount of eligible overhead expenses in past 6 months? \$ _____

2. If practicing as partnership or corporation, for what percentage of these were you responsible? _____ %

3. What was your average number of employees in past 6 months? _____

F. Hospital Indemnity (Up to \$100 Daily Benefit in \$10 Units)

Amount on Spouse and Children may not exceed amount on Member Member Daily Benefit \$ _____

Spouse Daily Benefit \$ _____

Child(ren) Daily Benefit \$ _____

YOU WILL BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE TO ASK ABOUT YOUR MEDICAL HISTORY

	PLACE	DAY	TIME OF DAY	
Best place and time to contact you (Choose one of each)	<input type="checkbox"/> Residence	<input checked="" type="checkbox"/> Weekdays	<input type="checkbox"/> Morning (7:00 – 12:00)	<input checked="" type="checkbox"/> Afternoon (12:00 – 5:00)
	<input checked="" type="checkbox"/> Business	<input type="checkbox"/> Weekends	<input type="checkbox"/> Evening (5:00 – 8:00)	<input type="checkbox"/> Night (8:00 – 11:00)

6 BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life and/or AD&D Insurance Plan, and if I am already covered under the plan(s), I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy(ies). (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Beneficiary Name: DOE JOE B. BROTHER 222-78-4789
Last First Middle Initial Relationship Social Security #

Beneficiary Address: ANY STREET ANY CITY ANY STATE 45678
Street City State/Province Zip Code

I request the group insurance shown on the reverse side or as selected through this online transaction. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I understand that the coverage afforded will be in consideration of the answers and statements set forth above and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy. I also understand that this application is to be attached to and made a part of the certificate.

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I understand that: (a) insurance will become effective on the first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed, and I represent that I am actively performing any and all duties of my occupation and any approved dependents are actively performing the normal activities of a person in good health of like age (or with respect to North Carolina residents, actively performing the normal activities of a person of like age) on the approval date; (b) any person who is not performing such duties/activities as required will not become insured until the day he/she is performing such duties/activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the ABC Insurance Plan.

The following Fraud Notices apply to any and all supplemental applications used with respect to this request for coverage:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

OR RESIDENTS OF CO, the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

FOR RESIDENTS OF D.C., the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant.

RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

RESIDENTS OF LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

RESIDENTS OF NY: For Health Only, any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

RESIDENTS OF VA: any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

RESIDENTS OF WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed.

I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its subsidiaries or the plan administrator regarding the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided might include information that may predate the time frame stated on the medical questions section, if any, of this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, or other insurance companies. If I have requested enrollment for medical coverage, New York Life may use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

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 any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other governmental agencies. 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 acknowledge that if I am requesting medical coverage, my authorized agent or I will receive a copy of this signed AUTHORIZATION, and that in all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION.

By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information to the providers noted, and I represent that to the best of my knowledge and belief, the answers to the questions are true and complete.

Member's Signature X John Doe 5/1/08
(Please sign and date in ink) Date

By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information to the providers noted, and I represent that to the best of my knowledge and belief, the answers to the questions are true and complete.

Spouse's Signature X _____
(Necessary only if spouse coverage is requested) Date

Eligible Dependent Signature X _____
(Necessary only if dependent coverage is requested and the eligible dependent is over the age of majority) Date

Owner Information (required if owner is other than member)

Name: _____
Last First Middle Initial Relationship to Proposed Insured Daytime Phone

Mailing Address: _____
Street City State Zip Code

Social Security #: _____ Date of Birth / / Tax ID # _____

Owner's Signature X _____
(Necessary only if other than member) Date

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**SUPPLEMENT TO THE REQUEST FOR THE ABC ASSOCIATION
 XXX INSURANCE PLAN**

Information about the Proposed Insured

ABC Member: (last/first/middle initial) <u>DOE JOHN A</u>	The Proposed Insured is the <input checked="" type="checkbox"/> Member <input type="checkbox"/> Spouse <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Civil Union Partner	Sex <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	Date of Birth <u>10/01/90</u> (mm/dd/yy)
Name of Spouse: (last/first/middle initial) <u>N/A</u>			

STATEMENT OF INSURABILITY

Please review your answers to the following questions, which were given to our Tele Underwriter on (mm/dd/yy): 05/01/08
 Please initial any changes that you make.

1. PHYSICAL MEASUREMENTS

a) Height: 6 ft. 0 in. Weight: 170 lbs. b) Any weight change in last year? Yes No

c) If "Yes", please provide amount and reason: Amount: _____
 Reason: _____

	YES	NO
2. a) Females only: Are you currently pregnant? If "Yes", give expected due date (mm/dd/yy): _____	<input type="checkbox"/>	<input type="checkbox"/>
b) Females only: Have you ever experienced complications of pregnancy? If "Yes", give details: _____	<input type="checkbox"/>	<input type="checkbox"/>
3. a) Have you ever applied for insurance that was declined, postponed, rated, rescinded, cancelled or modified in any way or have you ever been denied renewal or reinstatement?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b) Have you ever received or claimed benefits or a pension for sickness, injury or impairment or are you satisfying an elimination period?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
4. Do you contemplate any medical or surgical treatment or are you receiving any treatment or taking any medication at the present time?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
5. During the past <u>five</u> years have you ever been medically diagnosed by a physician as having or been treated for:		
a) abnormal blood pressure, chest pain, phlebitis, or any other disease/disorder of the heart or blood vessels?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
b) ulcer, jaundice, chronic diarrhea, gallbladder or liver disease/disorder, or any other disease/disorder of the stomach, intestines, rectum, colon, or digestive system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
c) asthma, allergies, bronchitis, emphysema, COPD (Chronic Obstructive Pulmonary Disease), tuberculosis or any other lung or respiratory disease/disorder?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
d) abnormal urine, venereal disease, or any disease/disorder of the kidneys, bladder, prostate, breast or reproductive organs?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
e) rheumatic/arthritis disease, fibrositis, ruptured disc, back or neck pain, knee problems, whiplash, amputation or any other disease/disorder, injury or deformity of the spine, joints, bones or muscles?	<input type="checkbox"/>	<input checked="" type="checkbox"/>
f) convulsions, seizures, epilepsy, paralysis, numbness, stroke, dizziness, loss of consciousness, recurrent headaches or migraines, or any other disease or disorder of the brain or nervous system?	<input type="checkbox"/>	<input checked="" type="checkbox"/>

G-XXXXXX

- | | | |
|--|--------------------------|-------------------------------------|
| | YES | NO |
| g) stress, anxiety, depression, nervous state, fatigue, or any psychiatric disorder ? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| h) diabetes, thyroid or any other endocrine disease/disorder? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| i) anemia, leukemia, or any other disease/disorder of the blood, lymph glands or immune system, chronic fatigue or fibromyalgia? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| j) any disease/disorder of the skin, eyes, ears, nose or throat, including loss of speech? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| k) cancer, tumor, cyst? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| l) any other illness, disease/disorder or condition not noted above? | <input type="checkbox"/> | <input checked="" type="checkbox"/> |

6. Other than in #5 Above:

- a) Have you during the past five years consulted any physician or practitioner for any reason- including routine or annual physical examinations or check-ups?
- b) If "Yes", were there any diagnoses or any adverse findings or were you advised to have further examinations?
- c) Have you had an EKG, blood tests, x-rays or other diagnostic tests?

7. Details To "Yes" Answers Include the results of all physical examinations and check - ups.

Please indicate Question #	Date	Name and address of Physician and Hospital, if any	Include (when applicable) all information as to nature of Illness or Injury, Symptoms, Number of Attacks, Duration, Treatment and Results

G-XXXXXX

8. a) Do you drink alcoholic beverages?

If "Yes", please record number of glasses in each category.

AMOUNT	WINE	BEER	LIQUOR
DAILY			
WEEKLY			
MONTHLY			

b) If "No", in the past five years have you consumed any alcoholic beverages?

If "Yes", please record number of glasses in each category.

AMOUNT	WINE	BEER	LIQUOR
DAILY			
WEEKLY			
MONTHLY			

c) During the past five years have you ever consumed more alcohol than as indicated in 8a) or 8b)?

If "Yes", please provide dates & details.

DATES	DETAILS

d) During the past five years have you ever consulted a physician, received treatment, been charged with impaired driving or been convicted due to the influence of alcohol and/or drugs?

e) During the past five years have you ever used sedatives, analgesics, hypnotics, tranquilizers or stimulants?

f) During the past five years have you ever used marijuana, hashish, cocaine, narcotics, hallucinogens or any other drugs not prescribed by a physician or obtained over the counter?

g) During the past 24 months, have you used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum?

If "Yes", indicate how long you used tobacco products or tobacco cessation products and date last used

How long: _____ Date Quit: _____ / _____ / _____

Do you understand that the answer to this question may result in a reduced premium, and that if it is not true, coverage may be invalidated?

9. a) During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?

If "Yes", please describe: _____

b) Driver's License No.: Member _____
Spouse _____

State in which issued: Member _____
Spouse _____

c) During the past five years, have you had your driver's license suspended, or revoked, or had any moving violations?

If "Yes", please provide details: _____

G-XXXXX

YES NO

d) Have you ever received disciplinary action from your professional licensing body?

If "Yes", please provide details: _____

e) Except for residents of Minnesota and Connecticut: in the last five years, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?

For residents of Minnesota and Connecticut only:

In the last five years, have you been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?

If "Yes", please provide details: _____

YES NO

10. Family History

Have any of your parents, brothers, or sisters prior to age 60 been medically diagnosed by a physician as having or been treated for cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease or neuro-muscular or mental disorder?

(If "Yes", please identify and give details below) _____

LIVING			Deceased	
Family Member	Age	State of Health	Age	Cause of Death
Father				
Mother				
Sister(s)				
Brother(s)				

Declaration

I have read this Statement of Insurability and any applicable Questionnaire(s) indicated below and declare that to the best of my knowledge and belief my answers are true and complete. I understand any material misrepresentation shall render the contract voidable at the option of the Insurer, subject to the incontestability provision.

Alcohol Use Questionnaire Back Pain Questionnaire Blood Disorder Questionnaire
Blood Pressure Questionnaire Bone/Joint Disorder Questionnaire Cancer Questionnaire

Colon Questionnaire Diabetes Questionnaire Drug Use Questionnaire Fibromyalgia Questionnaire
Gastrointestinal / Digestive Disorder Questionnaire Headache Questionnaire

Heart Questionnaire Psychiatric Questionnaire Respiratory Disorder Questionnaire Seizure Questionnaire
Aviation and Hazardous Activities Questionnaire

Financial Questionnaire

Name of Proposed Insured: JOHN A. DOE
(PLEASE PRINT)

Signature of Proposed Insured: John A. Doe

Signed at: ANY CITY City ANY STATE State/Prov Date 05 - 01 - 08 Month Day Year

G-XXXXXX

EXPLANATION OF VARIABLE

GMA-L/H-TELE-SUPP

GENERAL

1. References to "Member" will appear as illustrated, "Employee" may replace or be added to Member or a generic term such as "Applicant" may be substituted. References to spouse may be included or be replaced by domestic partner and/or civil union partner. or may not be included depending on plan design.
2. In the bottom left code, the reference to "G-xxxxxx" will be replaced by the applicable Policy number. The bottom right corner may contain an edition date of the initial application and may be changed to a different edition date if the application is subsequently revised.

HEADING

1. The form heading will appear as illustrated or various insurance coverages may be added or depending on plan design.
2. The Administrator's or Policyholder's name, logo and address may be added or changed as required.

STATEMENT OF INSURABILITY

1. Item 5. "five years" - may be modified to provide for a period of less than five years but in no event more than five years.
2. Item 6. "five years" - may be modified to provide for a period of less than five years but in no event more than five years.
3. Item 8. (b, c, d, e, f) "five years" -may be modified to provide for a period of less than five years but in no event more than five years.
Item (g) may deleted or if included may be modified to provide for a period of less than 24 months but in no event more than 24 months.
4. Item 9. (a, b, c) - will appear as illustrated or may be modified to provide for a lesser time period or deleted dependent on product design or a particular Policyholder's underwriting criteria.
5. Item 10. will appear as illustrated or may be modified to provide for a lesser time period or deleted dependent on product design or a particular state's requirements for questions of this type or maybe deleted or modified to comply with particular state regulations.

DECLARATION

1. "I have read:" - will appear as illustrated or may be modified to delete the Questionnaire section.
2. The Questionnaire section maybe modified or deleted dependent on a particular Policyholder's underwriting criteria.



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

ALCOHOL USE QUESTIONNAIRE

ABC Member: (Last / First / MI) <u>DOE JOAN A</u>	Date of interview <u>5/1/08</u>
Name of Proposed Insured –if other than Member (Last / First / MI)	

1. Do you drink alcoholic beverages? Yes No

If "Yes",

a) How many do you have weekly? 2 (1 drink = 1 beer, 1 1/4 oz. liquor = 5 oz wine)

b) What most closely describes how often you drink?

- Daily
 1 to 4 times a month
 1 to 3 times a week
 Less than once per month

2. During the last 5 years did you ever drink more than at the present? Yes No

If "Yes",

a) What was your past weekly consumption?

b) How often did you drink?

c) How many years did you drink at this level?

d) During the past 5 years have you been counseled or referred for counseling regarding your use of alcohol?

3. During the past 5 years have you received any medical advice or treatment or entered and/or attended any rehabilitation program for alcohol use? Yes No

If "Yes", please provide complete details:

4. During the past 5 years, have you had your driver's license suspended, or revoked, or had any moving violations while under the influence of alcohol? Yes No

If "Yes", please provide complete details, including driver's license number:

5. Name and address of doctors or other practitioners consulted, or hospitals that would have records:

Additional Details:

Signature of Proposed Insured:

Joan A. Doe



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

BACK PAIN QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member (Last / First / MI)	

- During the past 5 years how often have you had pain or discomfort in your back? *YES*
- What area(s) of the back was involved?
 - Upper part of back (neck or cervical area)
 - Middle part of back (thoracic or dorsal area)
 - Lower –(lumbar or sacroiliac area)
- What was the date of back injury or onset of back condition? *7/1/06*
- What was the diagnosis? *BULGING DISK*
- During the past 5 years have you missed work as a result of a back problem? Yes No
If "Yes", how long were you out of work?
- Do you visit a chiropractor? Yes No
If "Yes", frequency:
- Does the pain radiate to other parts of the body? Yes No
If "Yes", where and please describe:
- During the past 5 years have you:
 - Undergone any x-rays or other investigations of your back: Yes No
If "Yes", please provide details:
 - Had or been advised to have treatment or surgery for any back complaints: Yes No
If "Yes", details:
 - Been hospitalized for any back complaint: Yes No
 - Had any restrictions of movement of your back: Yes No
If "Yes", details: *COULDN'T WALK*
 - Worn a back support, brace or belt? Yes No
If "Yes", how long?
- Names and addresses of doctors or other practitioners consulted, or hospitals that would have records: *DR. KILBARE, ANY ADDRESS, ANY CITY*

Name of Proposed Insured:

JOHN A. DOE

(PLEASE PRINT)

New York Life Insurance Company

– A Mutual Company Founded in 1845 –
51 Madison Avenue, New York, NY 10010



BLOOD DISORDER/AIDS QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/11/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. During the past five years have you tested positive for Hepatitis B and/or Hepatitis C? Yes No
- a) Are you a Hepatitis B carrier or do you have chronic Hepatitis B? Yes No
- b) Have you been immunized against the Hepatitis B virus? Yes No
- If "Yes", please give year of immunization: _____

2. During the past five years have you ever been medically diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

Signature of Proposed Insured: *John A. Doe*

New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

BLOOD PRESSURE QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. Date high blood pressure was first diagnosed? *11/1/06*
 2. What are your latest blood pressure readings (if known)?
Latest reading: *140/80* Date taken: *4/15/08*
Highest reading: *140/90* Date taken: *2/1/07*
Average reading: *140/75* Date taken: *4/1/08*
 3. Approximately how often is your blood pressure checked and by whom? *6 MONTHS BY DOCTOR*
 4. During the past 5 years have you had a cardiovascular work up? YES NO
If "Yes", Date: Results:
 5. Have you gained or lost weight in the past two years? YES NO
If "Yes", provide details.
 6. Do you smoke? YES NO
If "Yes", how much?
 7. During the past 5 years what medications have you taken for this condition (name of medications) *ASPIRIN*
 8. If the type of medication OR the dosage changed within the past year, please provide details. *NO*
 9. Name and address of doctor now treating you. *DR. KILBARE, ANY ADDRESS, ANY CITY*
- Signature of Proposed Insured: *John A Doe*

GQA-L/H-BP



New York Life Insurance Company
 – A Mutual Company Founded in 1845 –
 51 Madison Avenue, New York, NY 10010

BONE / JOINT DISORDER QUESTIONNAIRE

ABC Member: (Last / First / MI)	Date of interview
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What was the diagnosis? *JOINT PAIN*
2. During the past 5 years how often have you had pain or discomfort due to this condition?
 Weekly Monthly Other
3. Date of most recent episode: *4/15/08*
4. Longest duration of discomfort: *ONE WEEK*
5. Longest duration you have been free of pain? *THREE WEEKS*
6. Was there a definite diagnosis or tentative or suspected diagnosis: *NO*

Please check all affected areas: shoulder* elbows* ankles* back hands*
 knees* feet* wrists* neck hips*

*If only one side was affected, please specify right or left. *BOTH*

7. Are the joints inflamed, red, hot, swollen or tender?
 If "Yes", please describe. Yes No
8. Is joint movement restricted?
 If "Yes", please provide details. Yes No
9. Is walking or standing restricted?
 If "Yes", please provide details. Yes No
10. Do you require special devices such as walking aids, braces, etc?
 If "Yes", specify. Yes No
11. Are or were personal or occupational activities restricted/limited?
 If "Yes", please provide details. Yes No
12. Any fractures?

BONE / JOINT DISORDER QUESTIONNAIRE (Continued)

13. What medications are you currently taking? (Names(s)) *ASPIRIN*
14. During the past 5 years what medications have you taken for this condition?
(Names(s)) *ASPIRIN*
15. During the past 5 years please describe other treatment, including surgical, received or recommended for this condition: *NONE*
16. During the past 5 years have you lost any time from work due to the above? Yes No
If "Yes", please provide details.
17. During the past 5 years have you had a rheumatological assessment? Yes No
If "Yes", list tests performed, dates and results.
18. During the past 5 years have you been hospitalised? Yes No
If "Yes", hospital, dates, diagnosis, and procedures performed.
19. Please provide the name and address of the doctor(s) consulted, and specialty:
DR. KILDARE
ANY ADDRESS
ANY CITY

Signature of Proposed Insured:

John A. Doe



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

CANCER QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What part of your body had the tumor? *COLON*
2. What was the exact diagnosis? *COLON CANCER*
3. When was it diagnosed? (M/D/Y): *1/1/01*
4. What treatment was used for the tumor? Any radiation and/or chemotherapy or was surgery performed? *RADIATION*
5. What is the date of the last treatment? (M/D/Y) *3/1/01*
6. Is any further treatment required? Yes No
If "Yes", please describe:
7. Was any medication prescribed? *NO*
8. Any recurrence of the tumor? *NO*
9. What is the name, address and phone number of the doctor who treated you and the doctor you see for follow-up checkups?
DR. KILDARE
ANY ADDRESS
ANY CITY
(123) 456 - 0202

Signature of Proposed Insured: *John A. Doe*

GQA-L/H-CAN



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

COLON QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What condition were you treated for? *COLON CANCER*
2. Is your condition currently active? Yes No
If No: Date of Last Attack/Episode: (M/D/Y) *11/1/01*
3. What is/was the frequency of your attacks/episodes: *ONCE A MONTH*
4. What test(s) were done and when? *COLON SCREENING*
5. What did your doctor diagnose as a result of your tests(s)? *CANCER*
6. During the past 5 years have you lost weight due to this condition? *NO*
7. Describe treatment and medications: *RADIATION*
8. During the past 5 years was surgery recommended, contemplated or performed? Yes No
Describe:

9. Names and addresses of doctors or other practitioners consulted, or hospitals that would have records:

*DR. KILGARE
ANY ADDRESS
ANY CITY*

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

DIABETES QUESTIONNAIRE

ABC Member: (Last / First / MI)	Date of interview
Name of Proposed Insured –if other than Member: (Last / First / MI)	

- When were you diagnosed with diabetes? (M/Y) *7/06*
- Do you follow a diabetic diet and/or exercise program? Yes No
- Are you now taking medication or undergoing treatment? Yes No
- What medication are you currently taking? *NONE*
- How often do you have your blood sugars tested? *ANNUALLY*
- During the past 5 years have you had any diabetic comas or insulin reactions? Yes No
- During the past 5 years have you ever required emergency treatment for this condition? Yes No
- During the past 5 years have you ever been hospitalized for this condition? Yes No
- During the past 5 years have you had any problems with your skin, eyes, kidneys, heart, numbness or tingling sensation in the limbs, or circulation in your feet? Yes No
- Name, address and telephone number of the physician(s) who treated you for this condition
- What other medical conditions do you have? *NONE*

*DR. KILDARE
 ANY ADDRESS
 ANY CITY
 (123) 456-7890*

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company
 – A Mutual Company Founded in 1845 –
 51 Madison Avenue, New York, NY 10010

DRUG USE QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

- | | | Yes | No |
|---|---|--------------------------|-------------------------------------|
| 1. During the past 5 years have you used: | | | |
| a) Narcotics: | Heroin, Morphine, Codeine, Demerol, Methadone | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| b) Barbiturates: | Amytal, Phenobarbital, Seconal, Nembutal | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| c) Marijuana: | Hashish, Cannabis | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| d) Amphetamines: | Benzedrine, Dexedrine, Methedrine | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| e) Cocaine: | Crack | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| f) Hallucinogens: | LSD, PCP, Mescaline, Peyote, Psilocybin | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
| g) Other Drugs: | | <input type="checkbox"/> | <input checked="" type="checkbox"/> |
- If "Yes", give details:

Type: _____ Usual Quantity: _____
 Frequency Used: _____ Dates: _____

2. During the past 5 years have you ever received medical advice or treatment or entered and/or attended a rehabilitation program for any of the above: Yes No
 Describe:

3. Are you still using any of the above: Yes No

4. Have you been charged by the authorities in connection with the use of any of the above: Yes No

If "Yes", give details:

Date: _____ Offense: _____
 Penalty: _____ Discharge date: _____

5. Did any event precipitate use of these substances? Yes No
 Describe:

6. Name and address of doctors or other practitioners consulted, or hospitals that would have records: *NONE*

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company

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51 Madison Avenue, New York, NY 10010

FIBROMYALGIA QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>Doe, John A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured —if other than Member: (Last / First / MI)	

- When were you diagnosed with fibromyalgia? (M/Y) ~~NO~~ *(M/Y)*
- What laboratory tests or special studies were done and what were the results:
testing
- Are you now, or have you in the past, received medication or treatment? Yes No
If yes, details (including names, dosage, date treatment began/ended):
Drugs 3mg started 5/1/06 ended 5/1/07
- Has this changed in the last 12 months? Yes No
- During the last 5 years have you lost of time from work due to this condition, if so, when and how long? *NO*
- During the last 5 years have you been hospitalized for this condition? Yes No
- Current status: (full recovery, any residuals, any limitations) *full recovery*
- Date, names and address of doctors consulted regarding this condition: *DR. Smith*
1234 willow Drive, AR 12345
- Additional details:

Signature of Proposed Insured: *John Doe*



New York Life Insurance Company

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51 Madison Avenue, New York, NY 10010

GASTROINTESTINAL DISORDER DIGESTIVE QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What was the diagnosis? *UPSET STOMACH*
2. Date of first attack: *4/1/08* Date of last attack: *4/1/08* Frequency of attacks: *ONCE*
3. During the past 5 years have you undergone any special tests: *NO*
4. What treatment and/or medication did your doctor prescribe as a result of your tests
Medication - specify: *ASPIRIN*
5. During the past 5 years have you been hospitalized due to this condition - Dates: MM/DD/YY *NO*
6. During the past 5 years have you had any surgery due to this condition - Date and Type: *NO*
7. During the past 5 years have you had a colonoscopy or endoscopy Yes No
If "Yes", results:
8. During the past 5 years have you lost any weight: Yes No
9. During the past 5 years did you miss any time from work due to this condition (if so, when and for how long): *NO*
10. Are you currently taking any medication: Yes No
11. Is any surgery scheduled or recommended by a medical practitioner? Yes No
12. Names and addresses of doctors or other practitioners consulted, or hospitals that would have records: *N/A*

Additional Details:

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company
 – A Mutual Company Founded in 1845 –
 51 Madison Avenue, New York, NY 10010

New York Life Insurance Company
FINANCIAL QUESTIONNAIRE

SUPPLEMENT TO REQUEST FOR DISABILITY COVERAGE

Name of Proposed Insured: DOE John A
 Last Name First Name Middle Initial

Please use this space to amplify and extend answers to questions in you application dated _____

A. I currently practice as a Sole proprietor _____ Partner _____ Corporate Owner _____ Employee X

B. PERSONAL FINANCIAL INFORMATION OF THE PROPOSED INSURED

	Annualized Rate of Current Income Year <u>2008</u>	Actual Filed Most Recent Calendar Year Year <u>2007</u>	Actual Filed Two Calendar Years ago Year <u>2006</u>
EARNED INCOME	<u>55,000</u>	<u>52,000</u>	<u>50,000</u>
1. Salary or Wages from the Form W2	<u>55,000</u>	<u>52,000</u>	<u>50,000</u>
2. Sole Proprietor Net Profit from 1040 Schedule C	<u>0</u>	<u>0</u>	<u>0</u>
3. Share or Partnership or S Corp Non-passive income from 1040 Schedule E	<u>0</u>	<u>0</u>	<u>0</u>
4. Qualified Pension Plan contributions or Qualified Profit Sharing contributions or 401K contributions that would cease if the proposed insured were disabled	<u>0</u>	<u>0</u>	<u>0</u>
5. Bonus, Commission or other Earned Income from occupation (explain on reverse side)	<u>0</u>	<u>0</u>	<u>0</u>
6. Other Earned Income from any other full or part time work (explain on reverse side)	<u>0</u>	<u>0</u>	<u>0</u>
TOTAL EARNED INCOME (Must be completed)	<u>55,000</u>	<u>52,000</u>	<u>50,000</u>
C. UNEARNED INCOME including passive income. If none, check ()	<u>0</u>	<u>0</u>	<u>0</u>
D. ESTIMATED NET WORTH (Exclusive of Residence)	<u>90,000</u>	<u>80,000</u>	<u>78,000</u>

I understand that any insurance issued will be in consideration of the answers and statements provided on this form which supplements my request for group insurance and on any form(s) or documents signed by me and made part of the certificate of insurance, if issued. I also understand insurance may be invalidated if New York Life finds that I have not answered the questions on this truthfully and complete.

5/11/08
Date

John Doe
Signature



New York Life Insurance Company
 – A Mutual Company Founded in 1845 –
 51 Madison Avenue, New York, NY 10010

New York Life Insurance Company
FINANCIAL QUESTIONNAIRE

For Life Insurance Coverage

Name of Proposed Insured: DOE JOHN A
 Last Name First Name Middle Initial

1. Insurance Summary

Personal

	<u>Company</u>	<u>Amount</u>
A) Applied for or pending	<u>XYZ INSURANCE</u>	<u>\$ 100,000</u>
	_____	\$ _____
	_____	\$ _____
B) In Force- Other Coverage Not to be replaced	<u>NONE</u>	\$ _____
	_____	\$ _____
	_____	\$ _____
C) To be replaced	<u>NONE</u>	\$ _____
	_____	\$ _____
Total Amount in all Companies?	A + B - C	<u>\$ 100,000</u>

- 2. Annual Net Earned Income 55,000
- 3. Annual Unearned Income 0
- 4. Total Estimated Net Worth 75,000

5/1/08
 Date

John A. Doe
 Signature of Proposed Insured



FINANCIAL QUESTIONNAIRE
SUPPLEMENT TO REQUEST FOR DISABILITY COVERAGE
(Please complete both sides)

If any question does not apply, indicate "NA".

APPLICANT'S NAME: JOAN A. DOE

NAME OF GROUP PLAN/ POLICY NUMBER: XYZ 4456 (Please print)

Please complete the following questions:

- 1. If self-employed, complete the following: (If "no", go to question #4)
a. How long?
b. What percentage of the business do you own?
2. If self-employed, are you working jointly with your spouse? If "yes", complete the following:
a. How many other employees in the business?
b. How many employees are relatives?
3. Are you working out of your home? If "yes", is any work conducted outside the home? Please explain and/ or provide details including average number of days per week clients are seen
4. If not self- employed, how long are you employed at your current place of business? 20 YEARS
5. If less than one year, how long were you employed with your previous employer? N/A Please provide employer history (names/ addresses) for the last five years:
6. How many hours per week are you working? 40
7. Describe your duties: UNDERWRITE INSURANCE APPLICATIONS
8. Do you earn income from other occupations? NO
9. a. Do you intend to live outside of the U.S. or Canada? NO If "Yes", for how long? N/A
b. Have you lived outside of the U.S. or Canada in the past two years? NO If "Yes" please provide details

FINANCIAL QUESTIONNAIRE
 SUPPLEMENT TO REQUEST FOR DISABILITY COVERAGE *(continued)*

I. **TOTAL NET WORTH** (Assets minus Liabilities): \$ 80,000

TOTAL ANNUAL UNEARNED INCOME
 (As reported to IRS - e.g. Interest, Dividends, Royalties, Rental Income etc.) \$ 3,000

II. **IF EMPLOYED** - Annual Salary \$ 50,000

III. **SELF-EMPLOYED** - Complete all sources of income:

A. **SOLE PROPRIETOR or PARTNER**
 Gross earned income (share of partnership income)
 Past 12 months or fiscal year ending _____
 (Gross earnings before business expenses and taxes) \$ _____

Total business expenses for above period (your share) (Minus) \$ _____

Net earned income, before personal income tax \$ _____

B. **PROFESSIONAL CORPORATION**
 Annual salary drawn currently \$ _____
 Your share of S-Corp distribution, if any (Plus) \$ _____
 Your share of dividends (Plus) \$ _____
 Payment of bonus (Plus) \$ _____

▪ Was the bonus a one-time payment or annual payment ?
 Payment of commission (Plus) \$ _____

▪ Was the commission a one-time payment or annual payment ?
 Annual Cost of corporate-paid benefits (Plus)
 (e.g. Life or Health Insurance premiums, pension or
 profit sharing trust contributions paid on your behalf):
Total annual earned income \$ _____

IV. **DISABILITY INSURANCE IN FORCE** - INCLUDE ANY GROUP DISABILITY BENEFITS

<u>Company</u>	<u>Policy#</u>	<u>Benefit</u>	<u>Elimination Period</u>	<u>Maximum Benefit Period</u>
<u>N/A</u>				

V. **DISABILITY INSURANCE APPLIED FOR WITH ANOTHER OR COMPANIES:**
N/A

VI. Will coverage applied for with us replace any of the above? Yes _____ No X
 (If so, indicate which, and date it will be terminated) _____

I understand that any insurance issued will be in consideration of the answers and statements provided on this form which supplements my request for group insurance and on any other form(s) or documents signed by me and made part of the certificate of insurance, if issued. I also understand insurance may be invalidated if New York Life finds that I have not answered the questions on this form truthfully and completely.

Signature of Applicant John Doe Date 5/11/08

Signature of Accountant _____ Date _____
(Optional unless requested)



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

HAZARDOUS SPORTS AND AVIATION QUESTIONNAIRE

ABC Member: (Last / First / MI) <u>DOE JOHN A</u>	Date of interview <u>5/1/08</u>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

A) SCUBA Diving and/or Skin Diving

- What is your certification?
 Basic Open Water Advanced Specialty Dive Master Instructor
 Master Instructor Master Scuba Diver None
- How many dives have you done in the last 12 months? NONE
- How many dives do you plan in the next 12 months? NONE
- What is the average depth you dive? 60 ft.
- What is the maximum depth you have dived? 100 ft.
- Do you do any diving for work or as part of your job? Yes No
If “Yes”, please provide details. _____
- Do you do any specialty diving? Yes No If “Yes”, provide type: Wreck
 Cave Salvage Ice Other _____
- Do you ever dive alone? Yes No If “Yes”, please provide details. _____

B) Organized Auto racing/Motorcycle racing/Power Boat racing/Snowmobile racing/other type Vehicle racing

- What type of organized 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 Hill-Climb Ice Hydroplane Scramble Midget Offshore Speedway Other
If “Other”, please provide details. _____
- What is the length of track/course? _____ Miles.
- What type of vehicle do you race? (Top fuel, funny car, stock, super stock, etc.) _____.
- What is your best Elapsed Time (ET)? _____ (hrs/min/secs.)
- How many races have you done in the last 12 months? _____

HAZARDOUS SPORTS AND AVIATION (Continued)

Auto racing/Motorcycle racing/Power Boat racing/Snowmobile racing/other type Vehicle racing (continued)

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. _____

HAZARDOUS SPORTS AND AVIATION (Continued)

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 US? 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 _____
3. Are you instrument flight rated (IFR)? Yes No

4. How many total hours have you flown as a pilot? _____ hours.

HAZARDOUS SPORTS AND AVIATION (Continued)

Civilian (Continued)

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. Do you fly as a non-fare paying passenger for business (e.g., corporate jet)? Yes No
If "Yes", how many hours per year? _____.
8. Have you had any flying accidents? Yes No If "Yes", please provide full details.
9. Do you fly outside the United States? Yes No
If "Yes", please provide details. _____
10. Have you received any reprimands, fines, warnings, or had restrictions put on your flying?
 Yes No If "Yes", please provide full details. _____
11. Have you flown or intend to fly any experimental or home-built aircraft? Yes No
If "Yes", please provide full details. _____
12. Do you do crop-dusting, aerobatic, barnstorming or any unusual type flying?
 Yes No If "Yes", please provide details. _____.
13. 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 (e.g. 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 details.

HAZARDOUS SPORTS AND AVIATION (Continued)

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 give full details.

Signature of Proposed Insured: _____

John A. Doe



New York Life Insurance Company

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HEADACHE QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

- When did headaches first occur? *11/1/07* When was last attack? *3/1/08*
- How often do they occur? *5 TIMES PER YEAR*
- How long do they last: Intermittent: Continuous: Brief: Prolonged:
- Are there any associated symptoms or signs: (Yes or No)
 - vision, visual fields, double vision: *NO*
 - numbness, tingling: *NO*
 - muscle weakness: *NO*
 - nausea, vomiting: *NO*
 - dizziness, hearing loss: *NO*
 - unsteadiness of gait or limbs, staggering: *NO*
 - undue sleepiness: *NO*
 - kidney disorder: *NO*
 - seizures: *NO*
 - high blood pressure: *NO*
- Is there any relationship between headaches and:
 - nervous tension: *NO*
 - allergies: *NO*
 - medications: *NO*
 - menstrual cycle (women): *NO*
- During the last 5 years have any special diagnostic tests been done or recommended? *NO*
- What did your physician diagnose as a result of your test(s): *N/A*
- What treatments have been prescribed? *ASPIRIN*
- During the past 5 years what medications have you taken or are currently taking for this condition?
Dosage: *ASPIRIN*
- During the past 5 years have you missed any time missed from work due to headaches (if so, when and for how long)? *NO*
- Date, names and address of doctors consulted regarding this condition: *NONE*

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company
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HEART QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What condition(s) were you treated for? *HEART ATTACK*
2. When did you first experience this? *2 YEARS AGO*
3. What test(s) were done? *ELECTROCARDIOGRAM*
4. What were the results of the test(s)? *NEEDED SURGERY*
5. Was any treatment or medication prescribed? Yes No
If "yes" please describe: *BYPASS*
6. Are you still taking medication or under treatment? Yes No
If "No", date stopped:
7. During the past 5 years was surgery ever recommended? Yes No
8. During the past 5 years have you been hospitalized or required emergency treatment for this condition? Yes No
9. During the past 5 years have you ever had problems with fainting, dizziness, shortness of breath, heart rhythm disturbance or chest pain? Yes No
10. Names and addresses of doctors or other practitioners consulted, or hospitals who would have records:
*DR. KILMARE
ANY ADDRESS
ANY CITY*

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company

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51 Madison Avenue, New York, NY 10010

PSYCHIATRIC QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

- What specific condition/diagnosis were you treated for? *CONFUSION*
(a) date of onset? M/D/Y *4/1/06*
- When was it diagnosed by a professional? M/D/Y *8/1/06*
- Was treatment/medication prescribed? Yes No
If "Yes", details *ASPIRIN*
- Are you now taking medication or undergoing treatment? Yes No
If "Yes", provide name of medications. *ASPIRIN*
a.) Date last taken? *5/1/08*
- Most recent doctor visit? M/D/Y *4/15/08*
- Have you ever been hospitalized for this condition? *NO*
If "Yes", date (M/D/Y). and duration:
- How many days of work have you missed in the past 5 years due to this condition? *NONE*
- Does the condition cause any disability? Yes No
- Have you ever attempted suicide? Yes No
If "Yes", details:
- During the past 5 years have you been advised to have treatment for the use of alcohol?
 Yes No If "Yes", details:
- During the past 5 years have you been advised to have treatment for the use of drugs?
 Yes No If "Yes", details:
- Names and addresses of doctors or other practitioners consulted, or hospitals who would have records: *DR. KILLARE, ANY STREET, ANY CITY*

Signature of Proposed Insured *John A. Doe*



New York Life Insurance Company

– A Mutual Company Founded in 1845 –

51 Madison Avenue, New York, NY 10010

RESPIRATORY DISORDER QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

1. What condition(s) were you treated for? *DIFFICULT TO BREATHE*
2. Date of first attack or onset: *1/1/08* Date of last attack: *NO FURTHER ATTACKS*
3. Frequency of attacks in the past a) 12 months: b) 24 months: *ONCE SINCE 1/1/08*
Duration of attacks:
4. Severity: Mild Moderate Severe
5. What Treatment did your physician prescribe for this condition?: *REST*
Medication - Name: *ASPIRIN*
Hospitalization or Emergency room - Date and Duration: *N/A*
6. During the past 5 years have you missed work as a result of this condition: Yes No
Describe:
7. Have you undergone any tests for this condition? *NO*
Chest x-ray Date & Results:
Pulmonary Function Date & Results:
Other Date & Results:
8. Are you short of breath or do you wheeze between attacks: Yes No
If "Yes", does it happen: At Rest? On Exertion?
9. Have you ever coughed up: Blood Sputum *NO*
10. Do you smoke: Yes No
11. Is there a known allergic basis: Yes No
12. Are you still under any treatment: Yes No
13. Name and address of doctors or other practitioners consulted, or hospitals that would have records: *DR. KILDARE, ANY STREET, ANY CITY*

Additional Details:

Signature of Proposed Insured: *John A. Doe*



New York Life Insurance Company
 – A Mutual Company Founded in 1845 –
 51 Madison Avenue, New York, NY 10010

SEIZURE QUESTIONNAIRE

ABC Member: (Last / First / MI) <i>DOE JOHN A</i>	Date of interview <i>5/1/08</i>
Name of Proposed Insured –if other than Member: (Last / First / MI)	

- What was the diagnosis? *UNDETERMINED*
- When was the first episode? *6/1/07* Last episode? Number of attacks? *12/1/07 ONE*
- Has any cause for the seizures been determined? *NO*
Describe:
- How many episodes or seizures do you have in a year? *TWO*
- Are you now taking medication or treatment? Yes No
If "Yes", name of medication: *ASPIRIN*
- During the past 5 years have you had any special tests such as EEG's or CAT scans? Yes No
Result/Findings:
- Names and addresses of doctors or other practitioners consulted, or hospitals who would have records:
*DR. KILDARE
ANY STREET
ANY CITY*

Signature of Proposed Insured: *John Doe*

<i>SERFF Tracking Number:</i>	<i>FRCS-125641375</i>	<i>State:</i>	<i>Arkansas</i>
<i>Filing Company:</i>	<i>New York Life Insurance Company</i>	<i>State Tracking Number:</i>	<i>39040</i>
<i>Company Tracking Number:</i>	<i>4874</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>AC IR Application Filing</i>		
<i>Project Name/Number:</i>	<i>NYLASN/64/64</i>		

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: FRCS-125641375 State: Arkansas
Filing Company: New York Life Insurance Company State Tracking Number: 39040
Company Tracking Number: 4874
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: AC IR Application Filing
Project Name/Number: NYLASN/64/64

Supporting Document Schedules

Review Status: 05/09/2008

Satisfied -Name: Certification/Notice

Comments:

Attachments:
Autho.pdf
AR COC.pdf
AR RDB.pdf

Review Status: 05/09/2008

Satisfied -Name: Application

Comments:
Please see form schedule.

Review Status: 05/19/2008

Satisfied -Name: Statement of Variability

Comments:
There are 2 Explanation of Variability. There is a stand-alone document for the Enrollment form, and the Explanation of Variability for the Tele Supp for is attached as the last page of the form.

Attachment:
EXPLANATION OF VARIABLE for GMA-AC-IR 3 -1-2008.pdf

April 28, 2008

To: The Insurance Commissioner

Authorization

This letter, or a copy thereof, will authorize the consulting firm of First Consulting & Administration, Inc., Kansas City, Missouri, to represent this Company in matters before the Insurance Department.

This Authorization shall be valid until revoked by us.

New York Life Insurance Company

By:



Title:

Corporate Vice President - Contracts

STATE OF ARKANSAS

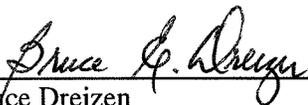
CERTIFICATION OF COMPLIANCE

Company Name: New York Life Insurance Company

Form Title(s): Enrollment Form, Supplement to Application, Alcohol Use Questionnaire, Back Pain Questionnaire, Blood Disorder/AIDS Questionnaire, Blood Pressure Questionnaire, Bone/Joint Disorder Questionnaire, Cancer Questionnaire, Colon Questionnaire, Diabetes Questionnaire, Drug Use Questionnaire, Fibromyalgia Questionnaire, Gastrointestinal Disorder Digestive Questionnaire, Financial Questionnaire, Financial Questionnaire for Life Insurance Coverage, Financial Questionnaire Supplement, Hazardous Sports and Aviation Questionnaire, Headache Questionnaire, Heart Questionnaire, Psychiatric Questionnaire, Respiratory Disorder Questionnaire, Seizure Questionnaire

Form Number(s): GMA-AC-IR, GMA-L/H-TELE-SUPP, GQA-L/H-AL, GQA-L/H-BCK, GQA-L/H-BD, GQA-L/H-BP, GQA-L/H-OS, GQA-L/H-CAN, GQA-L/H-COL, GQA-L/H-DIA, GQA-L/H-DU, GQA-L/H-FIBRO, GQA-L/H-GI, GQA-DI-FQ-06, GQA-L-FQ, GQA-DI-FQ2-06, GQA-L/H-HAZ, GQA-L/H-H, GQA-L/H-HRT, GQA-L/H-Psych, GQA-L/H-RD, GQA-L/H-SZ

I hereby certify that to the best of my knowledge and belief, the above form(s) and submission complies with Reg. 19, as well as the other laws and regulations of the State of Arkansas.



Bruce Dreizen
Corporate Vice President - Contracts

April 28, 2008

Date

STATE OF ARKANSAS
READABILITY CERTIFICATION

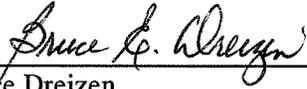
COMPANY NAME: New York Life Insurance Company

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
GMA-AC-IR	*
GMA-L/H-TELE-SUPP	*
GQA-L/H-AL	60
GQA-L/H-BCK	85.1
GQA-L/H-BD	61.1
GQA-L/H-BP	78.2
GQA-L/H-OS	70.1
GQA-L/H-CAN	57.3
GQA-L/H-COL	67.2
GQA-L/H-DIA	53.3
GQA-L/H-DU	*
GQA-L/H-FIBRO	76.7
GQA-L/H-GI	*
GQA-DI-FQ-06	*
GQA-L-FQ	*
GQA-DI-FQ2-06	65.9
GQA-L/H-HAZ	77.0
GQA-L/H-H	69.0
GQA-L/H-HRT	66.1
GQA-L/H-Psych	65.8

GQA-L/H-RD	66.7
GQA-L/H-SZ	67.6

*When scored with the policy, this form achieves a score of at least 50.



Bruce Dreizen
Corporate Vice President - Contracts

April 28, 2008

Date

EXPLANATION OF VARIABLE GMA – AC-IR Application

GENERAL-ALL

1. References to “Member” will appear as illustrated, the word “Employee” may replace or be added to Member, or a generic term such as “Applicant” may be substituted. References to “membership” will appear as illustrated or “employment” will replace or be added to such references.
2. References to “ABC” and “XYZ” are illustrative and will be replaced by the Policyholder and plan Administrator, if any.
3. The words “Request for Group Insurance from:” will appear as illustrated or may be replaced by ” Underwritten by:”
4. The bottom right code will be replaced by the applicable edition date of the initial application and may be changed to a different edition date if the application is subsequently revised, e.g. the addition of different or additional plan or to modify plans to include dependent insurance. Any reference to “G-xxxxxx” will be replaced by unique form number in order to allow New York Life to be able to differentiate particular policyholder or plan type.

GENERAL-PAPER

References to “below”, “above” and/or “on the reverse side” will appear as illustrated. Instructional wording may vary as sense demands in order to reflect the finalized format of the paper form.

GENERAL-INTERNET

1. Print outs of each and every screen used in the Internet application process will be available. Applicant will be able to view all answers before submitting.
2. For Internet applications, applicants will be instructed about the hardware or software requirements for access to and retention of electronic records, i.e. Adobe Acrobat 6.0.
3. Use of the Internet version of the form will be limited to those users who have access to specific websites either through membership in an association or through employment. The form will not be accessible to the general public. In no instance will the substantive content of the Internet version vary from the content of the paper version. The information contained in this electronic application for insurance is, for all intents and purposes, identical to the information that would be received via a paper application. In doing this New York Life will have substantially performed and/or complied with the requirements set forth under the Electronic Signatures and Records Act (ESRA) and the federal Electronic Signatures in Global and National Commerce Act (ESign).

EXPLANATION OF VARIABLE

GMA – AC-IR Application (Continued)

4. Internet forms may use “back”, “continue”, and/or “cancel” as prompts. The configuration of the form may be modified according to website format. Each question may appear as an individual prompt as follows:
 - Dialog box will require applicant interaction. It may display a message or “alert”. The message will usually only require an acknowledgement (by clicking “OK”), or may be used to confirm an action such as Save Information – Log Off or include a program termination notice.
 - A drop down/scroll down list may allow the applicant to chose one value from a list. Once the user has made a selection, such as state of residence or adding spouse insurance, the box will display the selected value.
 - Radio buttons will be used to allow the applicant to choose a defined set of options. e.g. male /female/, marital status or payment method. This button may not be passed even with a blank value. This might also be used in instances such as the New York Replacement wording where an applicant must acknowledge having read the Important Replacement Notice before being allowed to “Continue”, or in the Payment Option section where an applicant must chose which method of payment will be used.
 - Check boxes may be used to select options in instances of “Yes” or “No” answers.
 - Pop-ups may appear to advise the applicant about the next step in completing the application or may contain a menu of commands or options or instruction/information/tips for completing the form. The pop up will remain on the screen only until the applicant selects one of the commands. In no event will pop-ups contain substantive information not available on the paper version. Nor will they obscure information on the screen.

HEADING

1. The form heading will appear as illustrated or adapted to plan specifications i.e. the form will reference which type of insurance is being offered. Franchise Life Insurance may replace the reference to “Group”. “Enrollment Form” will appear as illustrated or synonymous terms such as “Application” or “Request Form” may be substituted.
2. The Administrator’s name, logo and address may be deleted or changed as required.
3. Depending on Administrator design, the applicant will be directed as to the ways an application may be submitted.
4. References to an “800” number or email address will appear as required.
5. For hardcopy version, an applicant will be instructed to type or print the application.

EXPLANATION OF VARIABLE

GMA – AC-IR Application (Continued)

MEMBER INFORMATION

1. The ID number may be deleted or replaced by another form of identification for the applicant.
2. The billing address will appear as shown or deleted if this is not within the scope of a particular Policyholder/Administrator's computer system capabilities or if the coverage is non-contributory.
3. The Social Security Number will appear as illustrated or deleted, depending upon the "privacy requirements" of a particular State.
4. "Home and Work Email address" and "Send correspondence to" will appear as shown or deleted if this is not within the scope of a particular Policyholder/Administrator's computer system capabilities.
5. Height and weight may be deleted if application is guaranteed issue.
6. "Marital Status" may include such terms as domestic partner, civil union or other term used to denote a legally recognized union similar to marriage. The question may be deleted depending on: (a) availability of dependent insurance; (b) state regulations; or (c) Policyholder decision.
7. Questions relating to military status will appear as illustrated or will be deleted based on plan design.
8. Spouse information such as "Maiden Name" and "Date of Employment or Membership" will appear as shown, modified or deleted, dependent on whether the applicant's eligibility is based on membership or employment.
9. "Residing outside of U.S. question" will appear as illustrated, changed for a Canadian group or may be deleted if the group is employer based and the applicant's eligibility is based on employment.

PAYMENT OPTION SELECTED

Will appear as illustrated or adjusted to accommodate a particular Policyholder/Administrator's billing method and/or computer system/website capabilities i.e. Electronic Fund Transfer. The option may be deleted if the coverage is non-contributory.

OCCUPATIONAL STATUS

Will appear as illustrated or modified; or deleted if not pertinent to plan offered.

EXPLANATION OF VARIABLE

GMA – AC-IR Application (Continued)

DEPENDENT INFORMATION

References to “Dependent Information” and “Spouse or Child amounts of insurance” will appear as shown, modified to provide only spouse coverage or may be deleted if Dependent Insurance is not available for a particular Policyholder. Dependent eligibility references and requirements will duplicate those of the Policy.

INSURANCE REQUESTED

1. Coverage Choices will be given depending on what coverage is available under the group policy.
2. References to “brochure” and “options” may be modified or deleted if another form of printed material is used or if there are not multiple options available. For Internet use, plan options, if applicable, will be shown via drop down list or similar web format.
3. The insurance requested area might be modified when the form is used only to solicit currently insured individuals. In such case the form will be modified to show that increased coverage is all that is requested and it may be separate for members and spouses or may be modified in instances when the form is used on a guaranteed issue basis.
4. For Life Insurance only: Insurance Replacement will appear as illustrated for compliance with New York’s Insurance Replacement mandates if New York residents are eligible or deleted if New York residents are not eligible. The Residents Of All Other States section will appear as illustrated or modified for compliance with the Insurance Replacement mandates of States other than New York. “Spouse/Child” references will appear as illustrated, modified to provide only spouse coverage or may be deleted if Dependent Insurance is not available for a particular Policyholder.
5. Notice regarding the applicant being contacted for further medical history will be deleted if the form is being used on a guaranteed issue basis.

BENEFICIARY DESIGNATION

The Beneficiary Designation will appear as illustrated or modified to reflect: (a) the availability of AD&D and/or Dependent Insurance; (b) the right to retain or revoke previous beneficiary designations if currently insured under the Policy; and/or (c) the automatic nature of the Dependent Life beneficiary designation and, if available, the right to name a different beneficiary.

EXPLANATION OF VARIABLE

GMA – AC-IR Application (Continued)

DECLARATION

“I understand that:” - will appear as illustrated or may provide for: (a) an effective date other than the first of the month following approval by New York Life, e.g. the date of approval or a date agreed to by the Policyholder and New York Life; (b) the availability of Dependent coverage or deleted depending on coverage(s) available; (c) a different time requirement for the payment of the initial contribution, appear but not less than 31 days; (d) the normal activities requirement may or may not appear as dictated by plan requirements; (e) a different dividend apportionment; and/or (f) the Policyholder’s name.

REQUEST FOR INSURANCE

1. “I request the” - will appear as illustrated for new insurance, or may be modified to request additional or continued insurance.
2. The statement, “I understand that New York Life has the right to require additional information” will appear as illustrated, or may be deleted if there is no need for additional information.

FRAUD NOTICE

The Fraud Notice will appear as illustrated or may be modified to provide for other State variations and based on the applicant’s residence in addition to those shown. The Internet version(s) of the fraud notice(s) will appear according to the applicant’s state of residence. The notice may appear as a drop down menu or other Internet formatting configuration.

AUTHORIZATION

1. The Authorization will appear as illustrated or may be deleted if the Authorization is not a part of the Enrollment form i.e. guarantee issue form, or may be modified to replace MIB with a similar information agency, to revise the AIDS reference and/or other references in the Authorization to comply with State mandates.
2. In all instances of web applications, use of electronic records will be voluntary.

SIGNATURE BLOCK

1. The signature block will appear as illustrated or may be modified if dependent insurance is not available. E signature will be an electronic symbol or process attached to or logically associated with the application and executed by the applicant. The signature block may be modified to accommodate e-signature format i.e. possibility of a member PIN number or use of membership ID number or completed through the use of an agent and signing with a digital pen/pad device. The applicant will be given the opportunity to “consent” to the use of an Electronic signature. In all instances, use of an electronic signature will be voluntary. In no instance will the applicant’s signature be transmitted to any other form.
2. Owner data will appear in the event the Owner is someone other than the applicant.