

SERFF Tracking Number: NYAA-128192533 State: Arkansas
Filing Company: New York Life Insurance Company State Tracking Number:
Company Tracking Number:
TOI: L04I Individual Life - Term Sub-TOI: L04I.213 Specified Age or Duration -
Fixed/Indeterminate Premium - Single Life
Product Name: Individual Level Benefit Term Life
Project Name/Number: /

Filing at a Glance

Company: New York Life Insurance Company

Product Name: Individual Level Benefit Term Life SERFF Tr Num: NYAA-128192533 State: Arkansas

TOI: L04I Individual Life - Term SERFF Status: Closed-Approved- Closed State Tr Num:

Sub-TOI: L04I.213 Specified Age or Duration - Fixed/Indeterminate Premium - Single Life Co Tr Num: State Status: Approved-Closed

Filing Type: Form

Reviewer(s): Linda Bird
Author: Gina Babka Disposition Date: 06/22/2012
Date Submitted: 06/08/2012 Disposition Status: Approved-Closed

Implementation Date Requested: On Approval
State Filing Description:

Implementation Date:

General Information

Project Name:

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode:

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/22/2012

State Status Changed: 06/22/2012

Deemer Date:

Created By: Gina Babka

Submitted By: Gina Babka

Corresponding Filing Tracking Number:

Filing Description:

Policy Form No. ITL1 – Individual Term Life Insurance Policy

Application AISL1, AISL1A, AISL1B, AISL1AB, AISL1BD, and AISL1D thru AISL5, AISL5A, AISL5B, AISL5AB, AISL5BD, and AISL5D - Life Insurance Applications

Application AISLW6 thru AISLW15 - Life Insurance Internet Applications

Reinstatement Applications RAIL1B, RAIL2B, RAIL3B and RAIL4B

Our Federal Employee Identification Number (FEIN) is 13-5582869

SERFF Tracking Number: NYAA-128192533 State: Arkansas
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Included in this filing are the above mentioned forms. This form is new and does not replace any existing form. The Policy Form provides Level Benefit Term Life Insurance to the applicants ages 30 to 74 inclusive for new issues. Premiums are guaranteed and increase at five year age intervals on an attained age basis: 30 to 34, 35 to 40, 40 to 44, 45 to 49, 50 to 54, 55 to 59, 60 to 64, 65 to 69, 70 to 74, and 75 to 79. Minimum coverage amounts of \$2,500 of insurance to a maximum of \$100,000 (increments of \$500 are available). At age 80 coverage ends with an option to convert to a whole life policy. Premiums are gender rated for this policy. This policy will be marketed on a national basis through: (1) direct mail; (2) TV commercials, (3) publications, and/or (4) the internet.

Medical Underwriting is based on the applicant's answers to health questions on the application and other information either provided by the applicant or for which the applicant gives us permission to obtain. Application forms AISL1, AISL1A, AISL1B, AISL1AB, AISL1D and AISL1BD thru AISL5, AISL5A, AISL5B, AISL5AB, AISL5D and AISL5BD will be the paper forms used for this product and the Whole Life product filed under NYAA-128192760 approved on 5/10/12. When offered over the internet an image of internet applications ISLW6 thru ISLW15 will appear as filed. All information provided by the applicant in prior screens will populate the image. These images will appear just prior to the applicant selecting the submit button confirming the agreement between both parties and confirming all information provided is correct. As the application image will appear populated with the applicant's information prior to submission we have not included screen shots for these applications.

As a direct response marketer, different applications may be are used in an effort to evaluate response rates. For this policy, the applications differ in their layout, agent question, payment options, health questions, and affirmation language. Health question and affirmation language versions are offered based on applicant age and coverage amount. When underwriting is required for reinstatement applications RAIL1B, RAIL2B, RAIL3B and RAIL4B will be used as appropriate in regards to the applicant's age and coverage amount. These reinstatement applications may also be used with form IGAL1 approved on 6/6/12 under SERFF filing NYAA-128161573 when needed.

Sincerely yours,

Maria Gabor
Compliance Services Consultant
Tel # (800) 595-3869, ext. 3746 (direct: 813-288-3746);
Fax # (813) 288-5773; or
E-mail address: Maria_Gabor@NYLAARP.newyorklife.com.
State Narrative:

Company and Contact

Filing Contact Information

Gina Babka, Compliance Consultant Gina_Babka@NYLAARP.newyorklife.com

SERFF Tracking Number: NYAA-128192533 State: Arkansas
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 TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
 Fixed/Indeterminate Premium - Single Life

Product Name: Individual Level Benefit Term Life
 Project Name/Number: /

5505 West Cypress Street 813-288-5717 [Phone]
 Tampa, FL 33607 813-288-5773 [FAX]

Filing Company Information

New York Life Insurance Company CoCode: 66915 State of Domicile: New York
 5505 West Cypress Street Suite 300 Group Code: 826 Company Type:
 Tampa, FL 33607 Group Name: State ID Number:
 (813) 288-5717 ext. [Phone] FEIN Number: 13-5582869

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? Yes
 Fee Explanation: 45 forms X \$50.00 = \$2,250.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
New York Life Insurance Company	\$2,250.00	06/08/2012	59921149

SERFF Tracking Number: NYAA-128192533

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State Tracking Number:

Company Tracking Number:

TOI: L041 Individual Life - Term

Sub-TOI: L041.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Individual Level Benefit Term Life

Project Name/Number: /

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/22/2012	06/22/2012

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Linda Bird	06/21/2012	06/21/2012	Gina Babka	06/22/2012	06/22/2012

SERFF Tracking Number: NYAA-128192533

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TOI: L041 Individual Life - Term

Sub-TOI: L041.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Individual Level Benefit Term Life

Project Name/Number: /

Disposition

Disposition Date: 06/22/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Product Name: Individual Level Benefit Term Life

Project Name/Number: /

Form	Life Insurance Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Life Insurance Internet Application	Yes
Form	Reinstatement Application	Yes
Form	Reinstatement Application	Yes
Form	Reinstatement Application	Yes
Form	Reinstatement Application	Yes

SERFF Tracking Number: NYAA-128192533 State: Arkansas
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TOI: L041 Individual Life - Term Sub-TOI: L041.213 Specified Age or Duration -
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Product Name: Individual Level Benefit Term Life
Project Name/Number: /

Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/21/2012
Submitted Date 06/21/2012
Respond By Date 07/23/2012

Dear Gina Babka,

This will acknowledge receipt of the captioned filing.

Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provision of this rule as well as all applicable requirements of this Department.

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,
Linda Bird

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Product Name: Individual Level Benefit Term Life
Project Name/Number: /

Response Letter

Response Letter Status Submitted to State
Response Letter Date 06/22/2012
Submitted Date 06/22/2012

Dear Linda Bird,

Comments:

Response 1

Comments: Thank you for the information. I apologize for the confusion, however, the disclosure and certification information are attached to the file as an additional document under the Flesch Certification section. Please let me know if additional information is needed.

Thank you for you time.

Maria Gabor

Related Objection 1

Comment:

Ark. Code Ann. 23-79-138 requires that certain information accompany every policy. Bulletin 15-2009 further address this issue.

Regulation 19s10B requires that all new or revised filings submitted must contain a certification that the submission meets the provision of this rule as well as all applicable requirements of this Department.

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Sincerely,

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Product Name: Individual Level Benefit Term Life
Project Name/Number: /
Gina Babka

SERFF Tracking Number: NYAA-128192533

State: Arkansas

Filing Company: New York Life Insurance Company

State Tracking Number:

Company Tracking Number:

TOI: L041 Individual Life - Term

Sub-TOI: L041.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Individual Level Benefit Term Life

Project Name/Number: /

Form Schedule

Lead Form Number:

Schedule Item Status	Form Number	Form Type Form Name	Action	Action Specific Data	Readability	Attachment
	ITL1	Policy/Contract/Fraternal Certificate Individual Term Life	Initial			ITL1 (National).pdf
	AISL1	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1.pdf
	AISL1A	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1A.pdf
	AISL1AB	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1AB.pdf
	AISL1B	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1B.pdf
	AISL1BD	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1BD.pdf
	AISL1D	Application/Enrollment Form Life Insurance	Initial		0.000	AISL1D.pdf
	AISL2	Application/Enrollment Form Life Insurance	Initial		0.000	AISL2.pdf
	AISL2A	Application/Enrollment Form Life Insurance	Initial		0.000	AISL2A.pdf
	AISL2AB	Application/Enrollment Form Life Insurance	Initial		0.000	AISL2AB.pdf

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Form	Application/ Life Insurance Enrollment Application	Initial	0.000	PDF File Name
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL2B	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL2B.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL2BD	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL2BD.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL2D	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL2D.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3A	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3A.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3AB	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3AB.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3B	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3B.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3BD	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3BD.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL3D	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL3D.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL4	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL4.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL4A	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL4A.pdf
Form	Application/ Life Insurance Enrollment Application	Initial	0.000	Form
AISL4AB	Application/ Life Insurance Enrollment Application	Initial	0.000	AISL4AB.pdf

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Product Name: Individual Level Benefit Term Life
 Project Name/Number: /

AISL4B	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL4B.pdf
AISL4BD	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL4BD.pdf
AISL4D	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL4D.pdf
AISL5	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5.pdf
AISL5A	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5A.pdf
AISL5AB	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5AB.pdf
AISL5B	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5B.pdf
AISL5BD	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5BD.pdf
AISL5D	Application/ Life Insurance Enrollment Application Form	Initial	0.000	AISL5D.pdf
AISLW6	Application/ Life Insurance Enrollment Internet Application Form	Initial	0.000	AISLW6.pdf
AISLW7	Application/ Life Insurance Enrollment Internet Application Form	Initial	0.000	AISLW7.pdf
AISLW8	Application/ Life Insurance Enrollment Internet Application Form	Initial	0.000	AISLW8.pdf
AISLW9	Application/ Life Insurance	Initial	0.000	AISLW9.pdf

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Item ID	Description	Initial	Value	File Name
AISLW10	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW10.pdf
AISLW11	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW11.pdf
AISLW12	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW12.pdf
AISLW13	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW13.pdf
AISLW14	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW14.pdf
AISLW15	Enrollment Internet Application Form Application/Life Insurance	Initial	0.000	AISLW15.pdf
RAIL1B	Enrollment Application Form Application/Reinstatement	Initial	0.000	Reinstatement Form RAIL1B Nat'l Non Compact.pdf
RAIL2B	Enrollment Application Form Application/Reinstatement	Initial	0.000	Reinstatement Form RAIL2B Nat'l Non Compact.pdf
RAIL3B	Enrollment Application Form Application/Reinstatement	Initial	0.000	Reinstatement Form RAIL3B Nat'l Non Compact.pdf
RAIL4B	Enrollment Application Form Application/Reinstatement	Initial	0.000	Reinstatement Form

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TOI: L041 Individual Life - Term

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Form

RAIL4B Nat'l
Non
Compact.pdf



NEW YORK LIFE INSURANCE COMPANY
 51 MADISON AVENUE, NEW YORK, NY 10010
 Administrative Office:
 5505 West Cypress Street, Tampa, Florida 33607
 1-800-[XXX-XXXX], [http://www.[nyldirect].com]

SIMPLIFIED TERM LIFE

The POLICY is a legal contract between the OWNER and New York Life Insurance Company.

DEFINED TERMS ARE ALL CAPITALIZED. PLEASE REFER TO THE DEFINITIONS SECTION.

WE certify that the INSURED becomes insured on the INSURANCE DATE stated below on the Policy Data if the initial PREMIUM is paid no later than 31 days after the INSURANCE DATE. Insurance is subject to: (a) the Suicide limitation; (b) the terms and conditions of the POLICY; and (c) OUR underwriting requirements.

POLICY DATA

POLICY NUMBER [123456]
OWNER [JOHN DOE]
INSURED [JOHN DOE]
ADDRESS [Main Street, USA]
DATE OF BIRTH [01/01/77]
AGE AT ISSUE [35]
SEX [Male]
INSURANCE DATE [4/1/12]
AMOUNT OF INSURANCE PREMIUM [\$10,000]
 [\$ 12.56 monthly – automatic PREMIUM payment(APP)]
 *See ‘POLICY PREMIUM’ for the complete schedule.
CLASS OF RISK [Standard]
BENEFICIARY [First Beneficiary MARY DOE, Wife]
 [Second Beneficiary JOHN AND MARY DOE, Children]
RIGHT TO EXAMINE THE POLICY FOR 30 DAYS The OWNER will have 30 days from the date of receipt to examine the POLICY. If the OWNER does not wish to keep the POLICY, it must be surrendered to OUR administrative office within this period. Upon such surrender, WE will return any PREMIUM paid and insurance will be void from the start.

This POLICY replaces all Policies and Policy Riders, if any, previously issued under the above Policy Number.

PREMIUM WILL INCREASE IN FIVE YEAR AGE BANDS. SEE PREMIUM ON POLICY PREMIUM SCHEDULE

This POLICY is eligible for dividends. However, dividends are not guaranteed and not expected to be paid.

[] []
 Secretary President

INDIVIDUAL LEVEL BENEFIT TERM LIFE INSURANCE POLICY

Renewable and Convertible To AGE 80
 Proceeds Payable at the INSURED’S Death

This POLICY is Participating

SCHEDULE

POLICY PREMIUM

The PREMIUM increases at five year AGE bands as follows: 30-34, 35-39, 40-44, 45-49, 50-54, 55-59, 60-64, 65-69, 70-74 and 75-79. The PREMIUM for each five year AGE band will be based on the INSURED's then current AGE. The PREMIUM for each AGE band is guaranteed not to change.

All PREMIUMS are payable in advance. PREMIUMS are payable at the Administrative Office.

Table 1- Annual Premiums for [Male Issue Age 35 with \$10,000] coverage

<u>Insured's Age</u>	<u>Annual Premium</u>	<u>Insured's Age</u>	<u>Annual Premium</u>
35	\$102.70	58	227.90
36	102.70	59	227.90
37	102.70	60	318.60
38	102.70	61	318.60
39	102.70	62	318.60
40	124.70	63	318.60
41	124.70	64	318.60
42	124.70	65	414.50
43	124.70	66	414.50
44	124.70	67	414.50
45	150.70	68	414.50
46	150.70	69	414.50
47	150.70	70	584.70
48	150.70	71	584.70
49	150.70	72	584.70
50	185.50	73	584.70
51	185.50	74	584.70
52	185.50	75	1013.80
53	185.50	76	1013.80
54	185.50	77	1013.80
55	227.90	78	1013.80
56	227.90	79	1013.80
57	227.90		

Non-Annual PREMIUM payments are determined as follows:

1. The annual amount determined above is divided equally among the scheduled number of payments in a Policy year.
2. An additional \$12 annual fee is added to non-APP monthly payments, translating to an additional \$1 per monthly payment.

TABLE OF VALUES

AGE AT ISSUE: [35]

GENDER: [Male]

At the Anniversary of the INSURANCE DATE	CASH VALUE Per \$1,000 of the Amount of Insurance	Length of Extended Term Insurance Available		At the Anniversary of the INSURANCE DATE	CASH VALUE Per \$1,000 of the Amount of Insurance	Length of Extended Term Insurance Available	
		Years	Days			Years	Days
[1	0.00	0	0	26	37.57	3	67
2	0.00	0	0	27	41.54	3	62
3	0.00	0	0	28	44.39	3	26
4	0.00	0	0	29	45.97	2	330
5	0.00	0	0	30	46.13	2	246
6	0.00	0	0	31	49.35	2	231
7	0.00	0	0	32	51.22	2	191
8	0.00	0	0	33	51.57	2	126
9	0.00	0	0	34	50.23	2	38
10	0.00	0	0	35	46.88	1	291
11	0.00	0	0	36	49.37	1	262
12	0.00	0	0	37	49.34	1	203
13	1.40	0	157	38	46.13	1	118
14	3.49	1	1	39	39.31	1	11
15	5.46	1	162	40	28.23	0	246
16	8.91	2	45	41	33.33	0	263
17	12.18	2	212	42	34.38	0	245
18	15.18	2	316	43	30.19	0	193
19	17.83	3	2	44	19.30	0	111
20	20.00	3	15	45	0.00	0	0]
21	23.63	3	95				
22	26.71	3	136				
23	29.29	3	137				
24	31.34	3	102				
25	32.73	3	36				

This table assumes that the required PREMIUMS have been paid to the Anniversary shown. CASH VALUES and Extended Term Insurance at times not shown will be furnished upon request.

This table assumes that the required PREMIUMS have been paid to the Anniversary shown. CASH VALUES and Paid-Up Insurance amounts at times not shown will be furnished upon request. At AGE 121, WE will send a notice to the OWNER stating that the CASH VALUE equals the Amount of Insurance.

All CASH VALUES in the Table of Values are based on the 2001 CSO Mortality Table, Age Last Birthday, Male/Female, Composite with a 4.50% interest rate per annum. Curtate functions are used.

The values and benefits in this POLICY are equal to, or greater than, the values required by the NAIC Standard Nonforfeiture Law. A detailed statement of the method of computing these values and benefits has been filed with the state in which this POLICY is delivered.

**TABLE OF
CONTENTS**

IMPORTANT NOTICE [5]

- Annual Dividends
- Assignments
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- Right To Continue Coverage To AGE 80
- Other Details

INDIVIDUAL LEVEL BENEFIT TERM LIFE INSURANCE [6]

- Death Benefit
- What Benefit Is Payable
- Beneficiary
- Ownership
- Request Procedure

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- Surrender for Cash
- Extended Term Insurance

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- Permanent Policy
- Notice Of Conversion Right

DEFINITIONS [8]

IMPORTANT NOTICE

ANNUAL DIVIDENDS	This POLICY is eligible to share in OUR divisible surplus. Each year WE determine the POLICY's share, if any. This share, if any, is payable in cash as a dividend on the POLICY anniversary, if all PREMIUMS due have been paid. Upon termination of the POLICY any dividends payable shall be paid to the OWNER. However, it is not expected that any dividends will be payable on this POLICY.
ASSIGNMENTS	While the INSURED is living, the OWNER may assign this POLICY, or any interest in it, by providing US with a completed assignment form. The assignment will take effect as of the date it was signed unless otherwise requested by the OWNER. All interest is then subject to that of the assignee. The OWNER still has the rights of ownership that have not been assigned. An assignee cannot change the OWNER or beneficiary of this POLICY. WE are not responsible for the validity of any assignment. Any assignment will be subject to any action WE take before WE record the assignment. Any amount payable to the assignee will be paid in a lump sum.
DEFERRAL OF PAYMENT	OUR general practice is to pay benefits as soon as reasonably possible. However, WE may defer the payment of the Surrender Benefit for up to six months after receipt of a request for payment. WE will pay interest, at the rate required by state law, compounded annually on the amount of any benefit so deferred. Interest will be paid from the date of deferral until the date the benefit is paid.
ENTIRE CONTRACT	The contract consists of the: (a) POLICY; (b) attached application; (c) any application for reinstatement; and (d) any attached riders or endorsements. Statements made by the applicant in the application, in the absence of fraud, are representations, not warranties.
GRACE PERIOD	This POLICY has a grace period of 31 days for the payment of any PREMIUM due once the insurance initially becomes effective. During the Grace Period the POLICY continues in force. If the INSURED dies during the Grace Period, the amount of any PREMIUM due or overdue may be deducted from any amount payable under the POLICY.
EXAMINATION	WE, at OUR own expense, have the right and opportunity to examine the medical records of the deceased in order to determine the cause of death.
INCONTESTABILITY	Except for nonpayment of PREMIUMS, WE cannot contest the validity of the insurance or reinstated insurance after it has been in force for two years during the INSURED's lifetime from: (1) the INSURANCE DATE, and (2) the date the insurance is reinstated, if applicable. To contest, WE will only rely upon material statements signed by the applicant in applying for or reinstating such insurance.
MISSTATEMENTS	If the AGE AT ISSUE or Sex is incorrect the amount payable under the POLICY will be the amount the most recent PREMIUMS would have purchased at the correct AGE AT ISSUE or Sex.
POLICY CHANGES	The POLICY can be changed at any time in writing by OUR Chairman, President, Secretary, or one of OUR Vice Presidents. The POLICY cannot be changed without the OWNER's consent. No agent of OURS is authorized to change this contract.
REINSTATEMENT	The OWNER can apply to reinstate the POLICY within 3 years after lapse. The OWNER must apply for on a form satisfactory to US and pay all overdue PREMIUMS during the INSURED'S lifetime. Reinstatement is subject to evidence of insurability. The reinstated coverage will have a new 2 year contestability period starting from the reinstatement date. Interest will be applied from each PREMIUM DUE DATE at 6% per year.
RIGHT TO CONTINUE COVERAGE TO AGE 80	The INSURED's coverage can continue to AGE 80. The PREMIUM for the continued coverage increases as described on the Policy Premium Schedule.
OTHER DETAILS	On all stated days and dates, insurance begins at 12:01 A.M. and insurance ends at midnight as applicable to the INSURED.

INDIVIDUAL LEVEL BENEFIT TERM LIFE INSURANCE

WE will pay a benefit for the INSURED's death in accordance with all of the following:

DEATH BENEFIT

The Death Benefit is payable when the INSURED dies and after WE receive satisfactory proof of the INSURED's death. OUR general practice is to pay Death Benefits as soon as reasonably possible. Death Benefit payments including any refund of unearned PREMIUMS will be made within 2 months after we receive due proof of the INSURED's death. WE will pay interest on Death Benefit payments as required by law. The Death Benefit payable includes any death benefit from riders, as applicable, and is payable in a lump sum.

WHAT BENEFIT IS PAYABLE

Except as stated below, the Death Benefit payable is the Amount of Insurance in force on the INSURED on the date of the INSURED's death. WE will adjust the Death Benefit by adding any unearned PREMIUMS paid or deducting any PREMIUM due but not paid.

SUICIDE

If the INSURED dies within the first two years insurance is in force and the death is due to, related to or occurs during: suicide, an attempt at suicide or an intentional self-inflicted injury; WE will only return the PREMIUMS paid for insurance.

BENEFICIARY

Beneficiary(ies) are classed as first, second and so on. Unless otherwise provided in the beneficiary designation, the benefits will be paid in equal shares to the first beneficiary(ies) who survives the INSURED by 15 days. If no first beneficiary(ies) so survives, payment will be made in equal shares to any second beneficiary(ies) who survives the INSURED by 15 days, and so on. Surviving beneficiary(ies) in the same class will have an equal share in the proceeds otherwise designated for a deceased beneficiary in that class. If no beneficiary is designated or no beneficiary survives the INSURED, the benefit will be payable to the INSURED's estate.

OWNERSHIP REQUEST PROCEDURE

The OWNER can transfer all or any part of incidents of ownership of the insurance as described below.

To: (a) designate a beneficiary or change a beneficiary designation; and/or (b) transfer ownership; WE must be given a completed, request from the OWNER on a form satisfactory to US. The request will take effect as of the date it was signed, unless the OWNER requests another date, subject to any payment made or any other action taken by US before OUR receipt. In the case of a transfer of ownership, any incidents of ownership so transferred, shall be transferred on the date the transfer becomes effective.

WHEN INSURANCE ENDS

The insurance will end on the earlier of:

1. prior to AGE 80, the last day of the INSURANCE PERIOD for which the last PREMIUM has been paid, except that insurance will not end if the PREMIUM is paid within the Grace Period; or
2. the day before the anniversary of the INSURANCE DATE on which the INSURED is AGE 80 but see the "Conversion Rights" section.

NON-FORFEITURE VALUES

OPTIONS WHEN INSURANCE ENDS	If insurance ends due to unpaid PREMIUM, and it has no CASH SURRENDER VALUE there are no options available. If insurance has CASH SURRENDER VALUE, and ends due to unpaid PREMIUM, the OWNER can elect to surrender the insurance for its CASH SURRENDER VALUE or the insurance will continue as Extended Term Insurance in accordance with the following provisions.
SURRENDER FOR CASH	<p>Subject to the Deferral Of Payment section on the Important Notice page(s), the OWNER can surrender all of the insurance for its CASH SURRENDER VALUE. To do so, the OWNER must: (a) make a request in a form satisfactory to US, no later than 3 months after the date insurance ends; and (b) give up the Policy. If surrender is requested within 30 days after a policy anniversary, the CASH VALUE will be no less the CASH VALUE as of such POLICY anniversary.</p> <p>All insurance will end on the date of surrender. The date of surrender is the date WE receive the OWNER's request for such surrender.</p>
EXTENDED TERM INSURANCE	<p>If the insurance has CASH SURRENDER VALUE when it ends and the OWNER has not elected to surrender the insurance for its CASH SURRENDER VALUE, the insurance will continue as Extended Term Insurance. No more PREMIUMS are due for this insurance. It is payable to the beneficiary when WE have proof that the INSURED died while this Extended Term Insurance was in effect.</p> <p>The amount of the Extended Term Insurance is the Amount of Insurance in force. Subject to the other conditions in the "What Benefit Is Payable" provision, the death benefit payable is the amount of Extended Term Insurance. The length of time the Extended Term Insurance will continue in force is the time stated in the Table of Values on the Schedule page. The length of time is calculated on the basis of: (a) the INSURED's AGE AT ISSUE; and (b) the period of time such insurance was continuously in force under the POLICY. The calculation is made by applying the CASH SURRENDER VALUE at the net single premium rate. After this Extended Term Insurance goes into effect, no benefits from riders will be provided.</p> <p>The OWNER can surrender the Extended Term Insurance for its CASH VALUE. At the time of surrender, the CASH VALUE will be equal to the net single premium for the time remaining for the Extended Term Insurance.</p>

CONVERSION RIGHTS

A conversion right is available to the OWNER up to the INSURED's AGE 80. The OWNER can convert all or any part of this term insurance to a permanent life insurance policy, without giving US the INSURED's medical evidence of insurability, in accordance with all of the following:

PERMANENT POLICY	<p><u>Available Prior to AGE 80</u> - The permanent life insurance policy requirements are as follows: (a) a completed, written application for the permanent life insurance policy must be given to US by the OWNER, on a form satisfactory to US; (b) the first premium for the permanent life insurance policy must be paid; (c) the premium for the permanent life insurance policy will be based upon the INSURED's class of risk and AGE; (d) the permanent life insurance policy will be a form that WE make available as a Conversion for this POLICY without extra benefits; (e) the permanent life insurance policy will take effect on the PREMIUM DUE DATE for which the OWNER requests the conversion; (f) the Incontestability and Suicide provisions of the permanent life insurance policy will be measured from the INSURANCE DATE of this POLICY.</p> <p><u>Available When the INSURED Reaches AGE 80</u> - The permanent life insurance policy requirements are as follows: (a) the maximum Amount of Insurance the OWNER is eligible to convert will continue during the 31 day period immediately after the date insurance would otherwise end (the "Conversion Period") without payment of the PREMIUM; (b) a completed, written application for the permanent life insurance policy must be given to US by the OWNER, on a form satisfactory to US; (c) the first premium for the permanent life insurance policy must be paid within the Conversion Period; (d) the premium for the permanent life insurance policy will be based upon the INSURED's class of risk and AGE; (e) the permanent life insurance policy will be a form that WE make available as a Conversion for this POLICY without extra benefits; (f) the application for a permanent life insurance policy must be received within the Conversion Period; (g) the permanent life insurance policy will take effect on the day after the Conversion Period Benefit ends; (h) the Incontestability and Suicide provisions of the permanent life insurance policy will be measured from the INSURANCE DATE of this POLICY.</p>
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DEFINITIONS

AGE	AGE means the INSURED's AGE AT ISSUE plus the number of complete years from the INSURANCE DATE.
AGE AT ISSUE	AGE AT ISSUE means the INSURED's attained age on the date that the application was signed.
CASH VALUE	CASH VALUE means the amount stated for selected years in the Table Of Values on the Schedule page(s). Straight line interpolation will determine the CASH VALUE at times between Anniversaries. The amount is calculated on the basis of the INSURED's AGE AT ISSUE; and the period of time such insurance was continuously in force under this POLICY.
INSURANCE DATE	INSURANCE DATE means the date that insurance takes effect, subject to the PREMIUM being paid.
INSURANCE PERIOD	INSURANCE PERIOD means the span of time from a PREMIUM DUE DATE through the day before the next PREMIUM DUE DATE, during which insurance continues, if the PREMIUM for such span of time is paid.
INSURED	INSURED means a person whose life became insured under this POLICY, as approved by US, and remains insured under this POLICY. An INSURED must be a legal resident of the fifty states of the United States of America, the District of Columbia, the Commonwealth of Puerto Rico, the United States Virgin Islands, or Guam, at issue.
OUR	OUR means New York Life Insurance Company.
OWNER	OWNER means the person who has all rights of ownership for the insurance. Unless otherwise stipulated, on the INSURANCE DATE the OWNER will be the INSURED.
POLICY	POLICY means this insurance contract, which provides insurance on the life of the INSURED. The POLICY is issued to the OWNER by US.
PREMIUM	PREMIUM means the applicable full periodic payment towards the insurance coverage, which must be paid for insurance to take effect on the INSURANCE DATE and/or for insurance to continue in force under the POLICY. PREMIUM is due on each PREMIUM DUE DATE.
PREMIUM DUE DATE	PREMIUM DUE DATE means the following dates by which the PREMIUM must be received: (a) initially the INSURANCE DATE; (b) thereafter, until AGE 80, based upon the mode of payment elected by the OWNER and approved by US, the annual, semiannual, quarterly or monthly reoccurrence of the INSURANCE DATE.
US	US means New York Life Insurance Company.
WE	WE means New York Life Insurance Company.

New York Life Insurance Company
51 Madison Avenue, New York, NY 10010

INDIVIDUAL LEVEL BENEFIT TERM LIFE INSURANCE POLICY

Renewable and Convertible To AGE 80
Proceeds Payable at the INSURED'S Death
This POLICY is Participating

APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth ____/____/____ (Required) Daytime Phone # () _____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth ____/____/____ (Required) Daytime Phone # () _____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

- 1. Please bill me later. [XXXXXXXXXXXX]
- 2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- 3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
- Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO
I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____/_____/_____
[Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____/_____/_____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$50,000 of [term] life insurance, please check here and complete application below.
- To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)
Date of Birth ____/____/____ (Required) Daytime Phone # (____) _____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
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SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)
Date of Birth ____/____/____ (Required) Daytime Phone # (____) _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (choose one option)

1. Please bill me later. [XXXXXXXXXXXX]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?.....	APPLICANT <input type="checkbox"/> YES <input type="checkbox"/> NO	SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.).....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____/_____/_____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____/_____/_____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$50,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
 [Primary Address] [Secondary Address]
 [City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____)
(Required)
 Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
 Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____)
(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually

[XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____ / ____ / ____
 [Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]

[Primary Address] [Secondary Address]

[City(.) State Zip + 4]

Social

Security No. [][][][] - [][][] - [][][][][]

(Required)

Male Female

Date of Birth []/[]/[] Daytime Phone # ([])

(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social

Security No. [][][][] - [][][] - [][][][][]

(Required)

Male Female

Email Address _____

Date of Birth []/[]/[] Daytime Phone # ([])

(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | | | |
|--|--|------------------|--|---------------|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | APPLICANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____ / /
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / /
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
[xxxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
[xxxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [xxxxxxxxxxxx]

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO
I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____ / ____ / ____
[Title(.) FirsnName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
[xxxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
[xxxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

1. Please bill me later. [xxxxxxxxxxxx]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter.
Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/____/____
[Applicant (Account Holder) Signature] Date

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
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Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

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X _____ / /
[Title(.) FirName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / /
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][]-[][][]-[][][][][] Male Female
(Required)
Date of Birth []/[]/[] (Required) Daytime Phone # ()
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name Social Security No. [][][][]-[][][]-[][][][][] Male Female
(Required)
Date of Birth []/[]/[] (Required) Daytime Phone # ()
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

- 1. Please bill me later. [XXXXXXXXXX]
- 2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- 3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____ / ____ / ____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?.....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.).....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

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I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / ____ / ____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [MonthXXXX 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix] Social Security No. [][][]-[][][]-[][][][][] Male Female
 [Primary Address] [Secondary Address] (Required)
 [City(.) State Zip + 4] Date of Birth ____/____/____ Daytime Phone # (____) _____
 Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
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SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name Social Security No. [][][]-[][][]-[][][][][] Male Female
 Email Address _____ Date of Birth ____/____/____ Daytime Phone # (____) _____
 (Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
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PAYMENT OPTIONS (choose one option)

1. Please bill me later. [XXXXXXXXXXXX]
2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|------------------|----------------|
| | APPLICANT | SPOUSE |
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | [] YES [] NO | [] YES [] NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | [] YES [] NO | [] YES [] NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... | [] YES [] NO | [] YES [] NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS

SPOUSE DETAILS

READ AND SIGN BELOW

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X _____/_____/_____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____/_____/_____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [MonthXXXX 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
 [Primary Address] [Secondary Address]
 [City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____)
(Required)
 Email Address _____

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
 Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____)
(Required)

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually

[XXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|--|--|
| | APPLICANT | SPOUSE |
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
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Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS

SPOUSE DETAILS

READ AND SIGN BELOW

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X _____ / ____ / ____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]

[Primary Address] [Secondary Address]

[City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)

Date of Birth []/[]/[] Daytime Phone # ()

Email Address _____

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)

Email Address _____

Date of Birth []/[]/[] Daytime Phone # ()

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Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXX]

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|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
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APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
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Email Address _____

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Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

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(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

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PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [xxxxxxxxxxx]

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

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| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

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SPOUSE DETAILS _____

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 [Title(.) FirName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

1. Please bill me later. [xxxxxxxxxxx]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter.
Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/____/____
[Applicant (Account Holder) Signature] Date

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|--|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered “Yes.” List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life (“NYL”). If material facts have been misstated here, benefits may be denied if the insured’s death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / ____ / ____
 [Title(.) FirName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth ____/____/____ Daytime Phone # () _____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth ____/____/____ Daytime Phone # () _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

- 1. Please bill me later. [XXXXXXXXXXXX]
- 2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- 3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.).....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

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X _____/_____/_____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____/_____/_____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$50,000 of [term] life insurance, please check here and complete application below.
- To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
Phone number (____)_____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix] Social Security No. [][][]-[][][]-[][][][][] Male Female
 [Primary Address] [Secondary Address] (Required)
 [City(.) State Zip + 4] Date of Birth ____/____/____ Daytime Phone # (____)
 (Required)
 Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name Social Security No. [][][]-[][][]-[][][][][] Male Female
 (Required)
 Email Address _____ Date of Birth ____/____/____ Daytime Phone # (____)
 (Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
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PAYMENT OPTIONS (choose one option)

1. Please bill me later. [XXXXXXXXXXXX]
2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.).....	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO
 I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____/_____/_____ X _____/_____/_____
 [Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

Choose one of the options below.

- To apply for up to \$50,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
 [Primary Address] [Secondary Address]
 [City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)
 Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
 Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|--|--|
| | APPLICANT | SPOUSE |
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
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APPLICATION

Request for Life Insurance • [Simplified Term Life]



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New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][]-[][][]-[][][][][] Male Female
Date of Birth ____/____/____ Daytime Phone # (____)_____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
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Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [][][][]-[][][]-[][][][][] Male Female
Date of Birth ____/____/____ Daytime Phone # (____)_____
(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]
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PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | | | |
|--|--|------------------|--|---------------|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | <input type="checkbox"/> YES <input type="checkbox"/> NO | APPLICANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
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[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

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APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

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[Primary Address] [Secondary Address]
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Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
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Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
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SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

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CONTINUE ON BACK

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| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
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APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

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[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

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Social Security No. [][][][] - [][][] - [][][][][] Male Female
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Date of Birth ____/____/____ Daytime Phone # (____) _____
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Email Address _____

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[xxxxxxxxxxxx]

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Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx]
[xxxxxxxxxxxx]

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PAYMENT OPTIONS (choose one option)

1. Please bill me later. [xxxxxxxxxxxx]

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Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/____/____
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CONTINUE ON BACK

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READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO
 I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured’s death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____ / ____ / ____
 [Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]

[Primary Address] [Secondary Address]

[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] (Required)

Male Female

Date of Birth []/[]/[] (Required) Daytime Phone # ()

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] (Required)

Male Female

Email Address _____ Date of Birth []/[]/[] (Required) Daytime Phone # ()

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

1. Please bill me later. [XXXXXXXXXX]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account.

[Applicant (Account Holder) Signature] _____ / / _____ Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO

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I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / / _____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / / _____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix] Social Security No. [][][]-[][][]-[][][][][] Male Female
 [Primary Address] [Secondary Address] (Required)
 [City(.) State Zip + 4] Date of Birth ____/____/____ Daytime Phone # (____) _____
 Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name Social Security No. [][][]-[][][]-[][][][][] Male Female
 Email Address _____ Date of Birth ____/____/____ Daytime Phone # (____) _____
 (Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
 Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
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PAYMENT OPTIONS (choose one option)

- Please bill me later. [XXXXXXXXXX]
- I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
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STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO
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X _____/_____/_____ X _____/_____/_____
 [Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
- To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
Phone number (____) _____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FName MI(.) LasName Suffix]
 [Primary Address] [Secondary Address]
 [City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)
 Email Address _____

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
 Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
 Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|--|--|
| | APPLICANT | SPOUSE |
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO

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X _____ / ____ / ____
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X _____ / ____ / ____
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]

[Primary Address] [Secondary Address]

[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth []/[]/[] Daytime Phone # ([] [] [] [])
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Email Address _____

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth []/[]/[] Daytime Phone # ([] [] [] [])
(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share

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PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | | | |
|--|--|------------------|--|---------------|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | <input type="checkbox"/> YES <input type="checkbox"/> NO | APPLICANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

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APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
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Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [xxxxxxxxxxx]

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|---|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) . | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

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 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
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PAYMENT OPTIONS (choose one option)

1. Please bill me later. [xxxxxxxxxxx]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter.
Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/____/____
[Applicant (Account Holder) Signature] Date

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|---|---|--|
| <p>1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?.....</p> <p>2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?</p> <p>3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) .</p> | <p>APPLICANT</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> | <p>SPOUSE</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> |
|---|---|--|

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SPOUSE DETAILS _____

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I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / ____ / ____
[Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXXX]

Please respond by: [MonthXXXX 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth []/[]/[] (Required) Daytime Phone # ()
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [][][][] - [][][] - [][][][][] Male Female
Date of Birth []/[]/[] (Required) Daytime Phone # ()

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]
Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

- 1. Please bill me later. [XXXXXXXXXXXX]
- 2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- 3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____ / /
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|--|---|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | APPLICANT <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | APPLICANT <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | APPLICANT <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO
I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life ("NYL"). If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. I authorize MIB, Inc., or any insurance company to release information about me to NYL, or its reinsurers, to determine my eligibility for life insurance. I authorize NYL, or its reinsurers, to make a brief report about me to MIB. **Note:** 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.

X _____ / /
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / /
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company

[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
 - To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
- Phone number (____)_____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
 [Primary Address] [Secondary Address]
 [City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____)_____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
 Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____)_____
(Required)

Coverage Amount Requested (please check only one coverage) \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (choose one option)

- Please bill me later. [XXXXXXXXXX]
- I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter. Make check payable to New York Life.
- I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)
I authorize New York Life to deduct premiums from my account. _____/_____/_____
[Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | |
|--|--|---|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | APPLICANT
<input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE
<input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life ("NYL"). If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. I authorize MIB, Inc., or any insurance company to release information about me to NYL, or its reinsurers, to determine my eligibility for life insurance. I authorize NYL, or its reinsurers, to make a brief report about me to MIB. **Note:** 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.

X _____/_____/_____
[Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____/_____/_____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION



Request for Life Insurance • [Simplified Term Life]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

Choose one of the options below.

- To apply for up to \$100,000 of [term] life insurance, please check here and complete application below.
- To talk to an agent about your life insurance or financial needs, please check here and provide your contact information.
Phone number (____)_____ Best day to call _____ morning afternoon evening

APPLICANT Please complete in ink.

[Title(.) FirstName MI(.) LastName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
Date of Birth ____/____/____ Daytime Phone # (____)
(Required)
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [][][]-[][][]-[][][][][] Male Female
(Required)
Date of Birth ____/____/____ Daytime Phone # (____)
(Required)

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print)	Relationship to You	Share	Beneficiary Name (please print)	Relationship to You	Share
---------------------------------	---------------------	-------	---------------------------------	---------------------	-------

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

	APPLICANT	SPOUSE
1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

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X _____ / ____ / ____
[Title(.) FirstName MI(.) LastName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / ____ / ____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [] [] [] [] - [] [] [] [] [] [] [] [] (Required) Male Female
Date of Birth ____/____/____ Daytime Phone # () _____
Email Address _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name
Email Address _____

Social Security No. [] [] [] [] - [] [] [] [] [] [] [] [] (Required) Male Female
Date of Birth ____/____/____ Daytime Phone # () _____

Coverage Amount Requested (please check only one coverage) [\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.) [XXXXXXXXXXXX]

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [XXXXXXXXXXXX]

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | | | | |
|--|--|------------------|--|---------------|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection? | <input type="checkbox"/> YES <input type="checkbox"/> NO | APPLICANT | <input type="checkbox"/> YES <input type="checkbox"/> NO | SPOUSE |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) | <input type="checkbox"/> YES <input type="checkbox"/> NO | | <input type="checkbox"/> YES <input type="checkbox"/> NO | |

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO

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X _____ / _____ / _____
[Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / _____ / _____
Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (send no money now)

I wish to be billed (please check one): Monthly Quarterly Semi-annually Annually [xxxxxxxxxxx]

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|---|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) . | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

Please supply full details for health questions answered “Yes.” List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

APPLICANT DETAILS _____

SPOUSE DETAILS _____

READ AND SIGN BELOW

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

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X _____ / /
 [Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / /
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



[XXXX-XXX-XXX]

Please respond by: [Monthxxxx 00, 0000]

New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

APPLICANT Please complete in ink.

[Title(.) FirsName MI(.) LasName Suffix]
[Primary Address] [Secondary Address]
[City(.) State Zip + 4]

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

SPOUSE/PARTNER (can apply even if applicant does not)

First Name (please print) Middle Last Name

Social Security No. [][][][] - [][][] - [][][][][] Male Female
(Required)

Date of Birth ____/____/____ Daytime Phone # (____) _____
(Required)

Email Address _____

Coverage Amount Requested (please check only one coverage) [\$xx,xxx \$xx,xxx \$xx,xxx \$xx,xxx \$xxx,xxx]
[xxxxxxxxxxx]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name (please print) Relationship to You Share Beneficiary Name (please print) Relationship to You Share

PAYMENT OPTIONS (choose one option)

1. Please bill me later. [xxxxxxxxxxx]

2. I prefer to send my first payment now.
Coverage will begin at the earliest possible date. You will be billed each month thereafter.
Make check payable to New York Life.

3. I want premiums to be deducted from my checking account each month. (Please enclose a voided check.)

I authorize New York Life to deduct premiums from my account. _____/____/____
[Applicant (Account Holder) Signature] Date

CONTINUE ON BACK

Complete and sign back before mailing

STATEMENT OF HEALTH (each applicant please check YES or NO for all 3 questions)

- | | APPLICANT | SPOUSE |
|---|--|--|
| 1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| 3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) . | <input type="checkbox"/> YES <input type="checkbox"/> NO | <input type="checkbox"/> YES <input type="checkbox"/> NO |

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APPLICANT DETAILS _____

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X _____ / /
 [Title(.) FirsName MI(.) LasName Suffix] Must Sign If Applying. (Please Do Not Print.) Date

X _____ / /
 Spouse/Partner Must Sign If Applying. (Please Do Not Print.) Date



APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name _____ Middle _____ Last Name _____

Social Security No. [][][] - [][] - [][][][][]
(Required)

Male
 Female

Address _____

Date of Birth ____/____/____
(Required)

City _____ State _____ Zip _____

Daytime Phone Number (____) _____

Email Address _____

Coverage Amount Requested

[\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name	Relationship to You	Share	Beneficiary Name	Relationship to You	Share
------------------	---------------------	-------	------------------	---------------------	-------

PAYMENT OPTIONS

- Send no money now. Payments will be billed monthly.
- I want premiums to be deducted from my checking account each month.

Account Holder: _____ Routing Number: _____ Account Number: _____

I authorize New York Life to deduct premiums from my account.

X _____ / /
AUTHORIZATION ELECTRONICALLY SIGNED [Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder? YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility? YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) YES NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS

READ AND SIGN

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO
I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

X _____ / /
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name _____ Middle _____ Last Name _____

Social Security No. [][][] - [][] - [][][][]
(Required)

Male
 Female

Address _____

Date of Birth ____/____/____
(Required)

City _____ State _____ Zip _____

Daytime Phone Number (____) _____

Email Address _____

Coverage Amount Requested

\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name _____	Relationship to You _____	Share _____	Beneficiary Name _____	Relationship to You _____	Share _____
------------------------	---------------------------	-------------	------------------------	---------------------------	-------------

PAYMENT OPTIONS

- Send no money now. Payments will be billed monthly.
- I want premiums to be deducted from my checking account each month.

Account Holder: _____ Routing Number: _____ Account Number: _____

I authorize New York Life to deduct premiums from my account.

X _____ / / _____

AUTHORIZATION ELECTRONICALLY SIGNED [Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... YES NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS

READ AND SIGN

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life ("NYL"). If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / / _____

APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXXX]

APPLICANT

First Name _____ Middle _____ Last Name _____ Social Security No. [][][]-[][]-[][][][] (Required) Male Female

Address _____ Date of Birth ____/____/____ (Required)

City _____ State _____ Zip _____ Daytime Phone Number (____) _____

Email Address _____

Coverage Amount Requested
 \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name	Relationship to You	Share	Beneficiary Name	Relationship to You	Share

PAYMENT OPTIONS

Send no money now. Payments will be billed monthly.

I want premiums to be deducted from my checking account each month.

Account Holder: _____ Routing Number: _____ Account Number: _____

I authorize New York Life to deduct premiums from my account.

_____ / / _____
AUTHORIZATION ELECTRONICALLY SIGNED [Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... YES NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS

READ AND SIGN

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

I understand that insurance will be effective on the date of the policy, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life. If material facts have been misstated here, benefits may be denied if the insured's death occurs within the first two years after the Insurance Date. I represent that, to the best of my knowledge and belief, the information on this application is true and complete. **Note:** 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.

_____ / / _____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

Social Security No. - - Male Female
(Required)

First Name _____ Middle _____ Last Name _____
 Date of Birth _____ / _____ / _____
(Required)

Address _____
 Daytime Phone Number (____) _____

City _____ State _____ Zip _____
 Email Address _____

Coverage Amount Requested

\$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name	Relationship to You	Share	Beneficiary Name	Relationship to You	Share
------------------	---------------------	-------	------------------	---------------------	-------

PAYMENT OPTIONS

- Send no money now. Payments will be billed monthly.
- I want premiums to be deducted from my checking account each month.

Account Holder: _____ Routing Number: _____ Account Number: _____

I authorize New York Life to deduct premiums from my account.

X _____ / / _____
AUTHORIZATION ELECTRONICALLY SIGNED [Applicant (Account Holder) Signature] Date

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... YES NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS

READ AND SIGN

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity?..... YES NO

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I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / / _____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

Social Security No. - - Male
 (Required) Female

First Name _____ Middle _____ Last Name _____
 Date of Birth ____/____/____ (Required)

Address _____
 City _____ State _____ Zip _____
 Daytime Phone Number (____) _____
 Email Address _____

Coverage Amount Requested

\$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name _____	Relationship to You _____	Share _____	Beneficiary Name _____	Relationship to You _____	Share _____
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PAYMENT OPTIONS

Send no money now. Payments will be billed monthly.

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... YES NO
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X _____ / ____ / ____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name _____ Middle _____ Last Name _____ Social Security No. [][][]-[][]-[][][][] (Required) Male Female
 Address _____ Date of Birth ____/____/____ (Required)
 City _____ State _____ Zip _____ Daytime Phone Number (____) _____
 Email Address _____

Coverage Amount Requested

[\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name _____	Relationship to You _____	Share _____	Beneficiary Name _____	Relationship to You _____	Share _____
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PAYMENT OPTIONS

Send no money now. Payments will be billed monthly.

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
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X _____ / ____ / ____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name Middle Last Name

Social Security No. [] [] [] - [] [] - [] [] [] []
(Required)

Male
 Female

Address

Date of Birth / /
(Required)

City State Zip

Daytime Phone Number ()

Email Address

Coverage Amount Requested

\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name	Relationship to You	Share	Beneficiary Name	Relationship to You	Share
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PAYMENT OPTIONS

Send no money now. Payments will be billed monthly.

STATEMENT OF HEALTH

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I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X _____ / /
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name _____ Middle _____ Last Name _____ Social Security No. [][][]-[][]-[][][][] (Required) Male Female

Address _____ Date of Birth ____/____/____ (Required)

City _____ State _____ Zip _____ Daytime Phone Number (____) _____

Email Address _____

Coverage Amount Requested

[\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name _____	Relationship to You _____	Share _____	Beneficiary Name _____	Relationship to You _____	Share _____
------------------------	---------------------------	-------------	------------------------	---------------------------	-------------

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STATEMENT OF HEALTH

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X _____ / ____ / ____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

First Name Middle Last Name

Social Security No. [] [] [] - [] [] - [] [] [] []
(Required)

Male
 Female

Address

Date of Birth ____ / ____ / ____
(Required)

City State Zip

Daytime Phone Number (____) _____

Email Address _____

Coverage Amount Requested

\$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XX,XXX \$XXX,XXX]

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name	Relationship to You	Share	Beneficiary Name	Relationship to You	Share

PAYMENT OPTIONS

Send no money now. Payments will be billed monthly.

STATEMENT OF HEALTH

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... YES NO
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Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS _____

READ AND SIGN

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X _____ / ____ / ____
APPLICATION ELECTRONICALLY SIGNED Date

APPLICATION

Request for Life Insurance • [Simplified Term Life]



New York Life Insurance Company
[51 Madison Avenue • New York, NY 10010]

[XXXX-XXX-XXX]

APPLICANT

Social Security No. - - Male
 (Required) Female

First Name _____ Middle _____ Last Name _____
 Date of Birth ____/____/____ (Required)

Address _____
 City _____ State _____ Zip _____
 Daytime Phone Number (____) _____
 Email Address _____

Coverage Amount Requested

\$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XX,XXX
 \$XXX,XXX

Beneficiary Designation (If more than one beneficiary is designated, proceeds will be divided equally unless you indicate a share.)

Beneficiary Name _____	Relationship to You _____	Share _____	Beneficiary Name _____	Relationship to You _____	Share _____
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PAYMENT OPTIONS

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STATEMENT OF HEALTH

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- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.)..... YES NO

Please supply full details for health questions answered "Yes." List date(s) of onset below, along with types of treatment, medicine and dosage.

APPLICANT DETAILS

READ AND SIGN

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? YES NO

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X _____ / ____ / ____
APPLICATION ELECTRONICALLY SIGNED Date

REINSTATEMENT APPLICATION FORM



REQUEST FOR INDIVIDUAL LIFE INSURANCE REINSTATEMENT

5505 West Cypress • Tampa, FL 33607-1707

Reply Required By:

Current + 14 days

[Mr. Sample C Sample
123 SP
Atlanta, GA 30303]

Insured _____
Policy No. _____
Amount of Insurance _____
Insurance Date _____
Amount Due _____
Telephone # _____

A COVERAGE AMOUNT REQUESTED

Same as previously requested.

B PAYMENT OPTIONS

Same as previously selected.

C BENEFICIARY DESIGNATION

Same as previously selected.

D STATEMENT OF HEALTH (Insured - Please Answer YES Or NO For All 3 Questions)

1. In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... YES NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
3. In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests)..... YES NO

For any "Yes" answer circle each condition or event above. List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

E READ AND SIGN

I understand that (a) premium payment for reinstatement of insurance does not mean there is any coverage in force, (b) reinstatement of this insurance will not take effect until the date the insurer approves this request, and the amount due is received within the lifetime of the insured, (c) if material facts have been misstated here, benefits may be denied if the insured's death occurs during the first two years from the date of reinstatement and (d) choice of billing method, beneficiary designations and frequency of payment will remain the same as previously selected. I represent to the best of my knowledge and belief, the information on this request is true and complete. **Note:** 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.

X

[Mr. Sample C. Sample] Must Sign (Please Do Not Print)

____/____/____
Month/ Date/ Year

RAIL1B

REINSTATEMENT APPLICATION FORM



REQUEST FOR INDIVIDUAL LIFE INSURANCE REINSTATEMENT

5505 West Cypress • Tampa, FL 33607-1707

Reply Required By:

Current + 14 days

[Mr. Sample C Sample
123 SP
Atlanta, GA 30303]

Insured _____
Policy No. _____
Amount of Insurance _____
Insurance Date _____
Amount Due _____
Telephone # _____

A COVERAGE AMOUNT REQUESTED

Same as previously requested.

B PAYMENT OPTIONS

Same as previously selected.

C BENEFICIARY DESIGNATION

Same as previously selected.

D STATEMENT OF HEALTH (Insured - Please Answer YES Or NO For All 3 Questions)

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune system disorder?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests)..... YES NO

For any "Yes" answer circle each condition or event above. List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

E READ AND SIGN

I understand that (a) premium payment for reinstatement of insurance does not mean there is any coverage in force, (b) reinstatement of this insurance will not take effect until the date the insurer approves this request, and the amount due is received within the lifetime of the insured, (c) if material facts have been misstated here, benefits may be denied if the insured's death occurs during the first two years from the date of reinstatement and (d) choice of billing method, beneficiary designations and frequency of payment will remain the same as previously selected. I represent to the best of my knowledge and belief, the information on this request is true and complete. **Note:** 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.

I authorize any physician, hospital, health care provider, pharmacy, pharmacy benefit manager or medical information retrieval service to release my medical information, my prescription drug history and other information to NYL, or its reinsurers, to determine my eligibility for life insurance. This information may be subject to further disclosure as required by law and may no longer be protected by the rules governing this authorization. I may revoke this authorization at any time by notifying NYL in writing, at the address on this form, except to the extent that NYL has collected information or taken action in reliance on it. This authorization may be used for 3 months from the date signed below unless revoked. This authorization must be signed and dated as a condition of obtaining this insurance. I or my authorized representative will receive a copy of this authorization.

X

[Mr. Sample C. Sample] Must Sign (Please Do Not Print)

_____/_____/_____
Month/ Date/ Year

REINSTATEMENT APPLICATION FORM



REQUEST FOR INDIVIDUAL LIFE INSURANCE REINSTATEMENT

5505 West Cypress • Tampa, FL 33607-1707

Reply Required By:

Current + 14 days

[Mr. Sample C Sample
123 SP
Atlanta, GA 30303]

Insured _____
Policy No. _____
Amount of Insurance _____
Insurance Date _____
Amount Due _____
Telephone # _____

A COVERAGE AMOUNT REQUESTED

Same as previously requested.

B PAYMENT OPTIONS

Same as previously selected.

C BENEFICIARY DESIGNATION

Same as previously selected.

D STATEMENT OF HEALTH (Insured - Please Answer YES Or NO For All 3 Questions)

- In the past 2 years, have you had treatment or medication for or been diagnosed by a doctor as having heart trouble, stroke, cancer, lung disease or disorder, diabetes, drug or alcohol abuse, liver or kidney disease, AIDS, AIDS Related Complex, immune system disorder or tested positive for exposure to HIV infection?..... YES NO
- In the past 2 years, for any condition, have you been admitted to or confined in a hospital, nursing home, extended care or special treatment facility?..... YES NO
- In the past 3 months, have you been advised by a doctor or had treatment, medication or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests)..... YES NO

For any "Yes" answer circle each condition or event above. List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

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5505 West Cypress • Tampa, FL 33607-1707

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X _____ / /
[Mr. Sample C. Sample] Must Sign (Please Do Not Print) Month/ Date/ Year

SERFF Tracking Number: NYAA-128192533

State: Arkansas

Filing Company: New York Life Insurance Company

State Tracking Number:

Company Tracking Number:

TOI: L041 Individual Life - Term

Sub-TOI: L041.213 Specified Age or Duration -

Fixed/Indeterminate Premium - Single Life

Product Name: Individual Level Benefit Term Life

Project Name/Number: /

Supporting Document Schedules

Item Status:

Status

Date:

Satisfied - Item: Flesch Certification

Comments:

Attachments:

General Readability Certification 6-4.pdf

Arkansas Certification.pdf

Item Status:

Status

Date:

Bypassed - Item: Application

Bypass Reason: All applications are new and have been added to the forms tab.

Comments:

Item Status:

Status

Date:

Satisfied - Item: Life & Annuity - Actuarial Memo

Comments:

Attachment:

AM_ITL1_AR.pdf

Item Status:

Status

Date:

Satisfied - Item: Statement of Variability

Comments:

Attachment:

Statement of Variability - AISL.pdf



The Company You Keep®

New York Life Insurance Corporation
5505 West Cypress Street Tampa, FL 33607

June 6, 2012

TO: Department of Insurance
Life & Health Division

RE: New York Life Insurance Corporation
Level Benefit Term Policy and Applications
Readability Certification

To Whom It May Concern:

The company has reviewed the enclosed policy forms and certifies that, to the best of its knowledge and belief, each form submitted meets your state's minimum statutory requirements relating to the readability of said forms.

A handwritten signature in black ink that reads "Michael Horan".

Michael Horan, Corporate Vice President

Arkansas Certification

I, Michael Horan, hereby certify that the submission of Policy ITL1 meets the provisions of this rule as well as all applicable requirements of the Arkansas Department of Insurance.

I also certify that each certificate holder is provided with a Guaranty Association Notice and contact information, including telephone number and address, for New York Life and the Arkansas Department Of Insurance.



Michael Horan, Vice President

June 8, 2012

GENERAL STATEMENT OF VARIABILITY
Policy Form ITL1 – Whatever Specific State

- Our 800 number will appear on the face page. At this time a dedicated number has not been secured.
- The website will also be included once the website is fully functional for customer service. At this time the url address is intended to be NYLDIRECT but has not been finalized.
- All “John Doe” information will vary for each individual. This includes all names, dates, and numbers.
- Pagination will be finalized once implemented onto our system and may change accordingly.
- Officer’s signatures will change as applicable.

GENERAL STATEMENT OF VARIABILITY
Application Forms

- Our address will either be “51 Madison Avenue” as shown or “5505 West Cypress St Tampa FL, 33607”.
- The Product name may appear as “Simplified Term Life” or “Simplified Whole Life” accordingly.
- The Date may appear as “Month, Day Year” or “MM/DD/YY”
- Multiple internal tracking codes may appear as shown. Additional codes may be needed. These codes assist in controlling the direct response distribution system.
- All “John Doe” information will vary for each individual. This includes all names, dates, and numbers. Personal titles may or may not appear (Mr., Mrs., Dr. etc.)
- The Coverage Amount section will offer up to six coverage amounts. These amounts will range from \$2,500 to \$100,000 and may include the option of “other” with a fill in line.
- The payment option for EFT may refer to “Applicant(Accountholder) Signature” as shown or “Accountholder Signature” or “Applicant Signature”
- The “talk to an Agent” section may or may not appear as either “term” or “whole”.