

**State:** Arkansas **Filing Company:** NYLIFE Insurance Company of Arizona  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2012 NB21 Application  
**Project Name/Number:** 2012 NB21 Application/211-500, et al.

## Filing at a Glance

Company: NYLIFE Insurance Company of Arizona  
Product Name: 2012 NB21 Application  
State: Arkansas  
TOI: L08 Life - Other  
Sub-TOI: L08.000 Life - Other  
Filing Type: Form  
Date Submitted: 09/17/2012  
SERFF Tr Num: NYLC-128688470  
SERFF Status: Closed-Approved-Closed  
State Tr Num:  
State Status: Approved-Closed  
Co Tr Num: 213-500, ET AL.

### Implementation

Date Requested:  
Author(s): Linda Lopinto, Robert Williams III, Ariana Castillo, Wanda Santos-Colletti, Barbara Micek  
Reviewer(s): Linda Bird (primary)  
Disposition Date: 09/24/2012  
Disposition Status: Approved-Closed  
Implementation Date:

State Filing Description:

**State:** Arkansas  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2012 NB21 Application  
**Project Name/Number:** 2012 NB21 Application/211-500, et al.

**Filing Company:** NYLIFE Insurance Company of Arizona

## General Information

Project Name: 2012 NB21 Application  
Project Number: 211-500, et al.  
Requested Filing Mode: Review & Approval  
Explanation for Combination/Other:  
Submission Type:  
Filing Status Changed: 09/24/2012  
State Status Changed: 09/24/2012  
Created By: Robert Williams III  
Corresponding Filing Tracking Number:

Status of Filing in Domicile:  
Date Approved in Domicile:  
Domicile Status Comments:  
Market Type:  
Overall Rate Impact:  
  
Deemer Date:  
Submitted By: Robert Williams III

### Filing Description:

Re: NYLIFE Insurance Company of Arizona (NYLAZ)  
FEIN #: 52-1530175  
NAIC: 82681353

Dear Director:

We are enclosing for your approval a new Part 1 application form for use when applying for whole life, term life, universal life, survivorship life and variable life products. We expect to introduce this new application in November 2012, or as soon thereafter as administratively possible.

Individual Life Insurance Application Part I, Form 213-500 is designed to replace form 211-500 approved 7/11/2011 under #49246.

Like the application this replaces, this new application includes a blank space at the end of each Company's Plan area for temporary use when new products are introduced before the application form can be updated and a section that will be completed only if Additional Insureds are to be covered under the policy. Additional copies of these questions will be available to ensure that we obtain necessary information for all Additional Insureds proposed for coverage.

### Differences Between the Enclosed New Form and the Application it Replaces

- The Plan section has been updated to include new products and riders that have been introduced since the previous application was approved.
- The Plan section has been updated to delete products and riders that are no longer being marketed.
- Minor text revisions have been made to Pages 1 and 2 of the application.
- Section G, Primary Insured's Beneficiary, has been revised.
- Section H, Current Health and Payment Information, has been revised.
- Section J, Personal Information, has been revised.
- Section K, Other Coverage, has been revised.
- Section N, Term Conversion, has been revised.
- Section P, The Non-Medical Health Questionnaire, has been revised.
- Additional Insured page has been revised.
- Additonal Insured Non-Medical Questionnaire has been revised.
- The Authorization section has been revised.

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Medical Questionnaire (Non-Medical-Application Part II), Form 213-510 and Medical Examiner's Report-Application Part II, Form 213-525 are designed to replace Form 211-510 and 211-525 approved 7/11/2011 under #49246. These forms have been revised for improved ease of use and underwriting.

Hazardous Sports and Aviation Supplement, Form 7663.101 is designed to replace form 7663.100 approved 10/23/2008 under #40595, and has been revised for improved ease of underwriting.

The Plan section has been bracketed in the event New York Life deletes or adds new products and riders. Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

Please note that this Part I Application form allows for the selection of the Asset Preserver policy, which is a universal life policy that allows for the acceleration of the death benefit for terminal illness and for chronic illness necessitating qualified long-term care service. Note that any underwriting questions or disclosures unique to that product appear in a separate supplement that was approved by the respective state insurance departments.

The enclosed Application is intended to fulfill multiple purposes. Because of that, it includes check boxes for reinstatements, term conversions, and amending the application, etc. There are questions in the term conversion section that are specific to the processing of term conversions for administrative purposes. Moreover, when additional coverage is applied for in conjunction with a term conversion, the entire application is completed for the additional insurance.

This application will be used in paper. The PDF submitted is the typeset version that will be printed by an outside vendor and stocked for use. It will also be made available on the company intranet for printing by the agents on their personal computers.

#### Additional Enclosures

- A certification that suitability questions and disclosures for variable life products will be included in separate forms.
- A readability certification applicable to the enclosed application forms.
- A certification that replacement questions are included in a separate form that was previously approved by the state insurance departments (applicable to all three companies).
- A Statement of variability regarding the bracketing of the Plan section.

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

Sincerely,

Linda E. LoPinto  
Corporate Vice President

## Company and Contact

### Filing Contact Information

Robert Williams III, Contract Consultant      Robert\_Williams\_III@nyl.com

**State:** Arkansas **Filing Company:** NYLIFE Insurance Company of Arizona  
**TOI/Sub-TOI:** L08 Life - Other/L08.000 Life - Other  
**Product Name:** 2012 NB21 Application  
**Project Name/Number:** 2012 NB21 Application/211-500, et al.

51 Madison Avenue 212-576-3449 [Phone]  
 Room 0154 212-447-4141 [FAX]  
 New York, NY 10010

**Filing Company Information**

NYLIFE Insurance Company of CoCode: 81353 State of Domicile: Arizona  
 Arizona Group Code: 826 Company Type: Life  
 51 Madison Ave Group Name: State ID Number:  
 New York, NY 10010 FEIN Number: 52-1530175  
 (212) 576-4809 ext. [Phone]

**Filing Fees**

Fee Required? Yes  
 Fee Amount: \$200.00  
 Retaliatory? No  
 Fee Explanation:  
 Per Company: No

Company	Amount	Date Processed	Transaction #
NYLIFE Insurance Company of Arizona	\$200.00	09/17/2012	62740590

State: Arkansas Filing Company: NYLIFE Insurance Company of Arizona  
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other  
Product Name: 2012 NB21 Application  
Project Name/Number: 2012 NB21 Application/211-500, et al.

## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	09/24/2012	09/24/2012

**SERFF Tracking #:**

NYLC-128688470

**State Tracking #:****Company Tracking #:**

213-500, ET AL.

**State:**

Arkansas

**Filing Company:**

NYLIFE Insurance Company of Arizona

**TOI/Sub-TOI:**

L08 Life - Other/L08.000 Life - Other

**Product Name:**

2012 NB21 Application

**Project Name/Number:**

2012 NB21 Application/211-500, et al.

## Disposition

Disposition Date: 09/24/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		No
Supporting Document	Memorandum of Variable Material		Yes
Form	Individual Life Insurance Application Part I		Yes
Form	Medical Questionnaire (Non-Medical – Application Part II)		Yes
Form	Medical Examiner's Report – Application Part II		Yes
Form	Hazardous Sports and Aviation Supplement		Yes

**State:** Arkansas  
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**Filing Company:** NYLIFE Insurance Company of Arizona

## Form Schedule

Lead Form Number: 213-500							
Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		213-500	AEF	Individual Life Insurance Application Part I	Revised: Replaced Form #: 211-500 Previous Filing #: 49246	0.000	213-500.pdf
2		213-510	AEF	Medical Questionnaire (Non-Medical – Application Part II)	Revised: Replaced Form #: 211-510 Previous Filing #: 49246	0.000	213-510.pdf
3		213-525	AEF	Medical Examiner's Report – Application Part II	Revised: Replaced Form #: 211-525 Previous Filing #: 49246	0.000	213-525.pdf
4		7663.101	AEF	Hazardous Sports and Aviation Supplement	Revised: Replaced Form #: 7663.100 Previous Filing #: 40595		7663.101.pdf

### Form Type Legend:

<b>ADV</b>	Advertising	<b>AEF</b>	Application/Enrollment Form
<b>CER</b>	Certificate	<b>CERA</b>	Certificate Amendment, Insert Page, Endorsement or Rider
<b>DDP</b>	Data/Declaration Pages	<b>FND</b>	Funding Agreement (Annuity, Individual and Group)
<b>MTX</b>	Matrix	<b>NOC</b>	Notice of Coverage
<b>OTH</b>	Other	<b>OUT</b>	Outline of Coverage
<b>PJK</b>	Policy Jacket	<b>POL</b>	Policy/Contract/Fraternal Certificate
<b>POLA</b>	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	<b>SCH</b>	Schedule Pages



INDIVIDUAL LIFE INSURANCE APPLICATION (PART I) TO:



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

- New Application, Paid Change Request, Additional Offer Program, Amend Application, Attained Age Term Conversion, Add Rider, Reinstatement, Original Age Term Conversion, Reinstate OPP, Exercising a rider: PPO, SPO, SPPO, GIR, GIR Face Increase, IER

A. Primary Insured

Form section A containing fields for First Name, Middle Name, Last Name, Suffix, Gender, Date of Birth, Residence, Social Security No., Tax ID No., Driver's License No., State, Country, Zip Code, Country of Citizenship, Country of Birth, State of Birth, How Long Living in the USA, Immigration Visa or Work Authorization, Employer Name, Street, City, State, Country, Zip Code.

If age 18 or over, has Primary Insured used tobacco, nicotine or any nicotine substitution product in any form in the last five years? Yes No
If "Yes", provide type and date of last use (Month) (Year)

B. Contact Information

Form section B containing fields for Contact Primary Insured at, Home Phone Number, Business Phone Number, Best Time to Call, Time zone, E-mail Address, Special Instructions.

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

Form section containing fields for Who acted as interpreter? Agent Other, First Name, Last Name, Relationship to Primary Insured.

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

C. Owner (if not Primary Insured)

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

Form section C containing fields for Type, Owner/Custodian, First Name, Middle Name, Last Name, Suffix, Gender, Date of Birth, Residence, Telephone Number, E-mail Address, Social Security No., Tax ID No., Exempt, Applied for, Relationship to Primary Insured, Country of Citizenship, Immigration Visa or Work Authorization, Trust, Name of Trust, Date of Trust, State where Trust established, Name of Trustee(s), Relationship of Trustee(s) to Primary Insured, Beneficiary(ies) of Trust, Relationship of Trust Beneficiary(ies) to Primary Insured, Uniform Transfers to Minors (UTMA/UGMA), Name of Minor, First, Middle, Last, Suffix, Minor's Date of Birth, UTMA/UGMA for the state of, Minor's Social Security No., Tax ID No., Exempt, Applied for.



**C. Owner (continued)**

<b>Successor Owner</b> <input type="checkbox"/> Primary Insured				Relationship to Primary Insured
First Name	Middle Name	Last Name	Suffix	

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

Residence: Street (P.O. Box Not Permitted) City State Country Zip Code

Telephone Number ( ) E-mail Address  Social Security No. or  Tax ID No.  Exempt  Applied for

Relationship to Primary Insured Country of Citizenship  U.S. or \_\_\_\_\_

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

**D. Applicant (if not Primary Insured)**

Same as Owner

**If Primary Insured is under age 18 years, complete the following questions.**

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

Are all other children in the family insured or to be insured for an amount at least equal to that on the Primary Insured?  Yes  No (If "No", provide details in Section Q)

First Name	Middle Name	Last Name	Suffix	Date of Birth (mm/dd/yyyy)
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<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax ID No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for	Relationship to Primary Insured
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Residence: Street (P.O. Box Not Permitted) City State Country Zip Code

**E. Payer (if not Primary Insured)**

Same as  Owner  Applicant

First Name	Middle Name	Last Name	Suffix	<input type="checkbox"/> Social Security No. or <input type="checkbox"/> Tax ID No. <input type="checkbox"/> Exempt <input type="checkbox"/> Applied for
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Residence: Street (P.O. Box Not Permitted) City State Country Zip Code Relationship to Primary Insured

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

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

(All modes not available on every plan or product)

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

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

NYL-A-Plan # \_\_\_\_\_  List Bill # \_\_\_\_\_  MainStay # \_\_\_\_\_

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

**Policy Transfers/Premium Financing**

- Does the Proposed Insured, Applicant or Owner plan to transfer any right, title, or ownership interest in the policy being applied for to a third party, or has any of these parties ever transferred any rights, title or ownership in any life insurance policy to a third party? .....  Yes  No
  - Is any part of the premium for this policy being financed by a third party, or has the Proposed Insured, Applicant or Owner been offered any inducement, fee or compensation, including "free life insurance," as an inducement to purchase life insurance? .....  Yes  No
  - Has the Proposed Insured, Applicant or Owner, within the past twelve months, authorized any third party to have a life settlement or viatical company review their personal medical status? .....  Yes  No
- If "Yes" to #1, #2 or #3, provide details in Section Q.

**Qualified Plans:**  401(k)  401(a)  412(e)(3)  Keogh  457  Profit Sharing  Defined Benefit  Pension Option  \_\_\_\_\_

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

**Split Dollar:**  Endorsement Split Dollar

**Premium Notices**

Send Premium notice to Owner's other US address:

Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

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

Name \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_



**G. Primary Insured's Beneficiary**

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

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

Class	Full Name (First, Middle, Last)	Date of Birth (mm/dd/yyyy)	Social Security No./ Tax ID No.	Relationship to Primary Insured	Share
_____	_____	_____	_____	_____	_____
Address & Phone # _____				<input type="checkbox"/> Same as Primary Insured	
_____	_____	_____	_____	_____	_____
Address & Phone # _____				<input type="checkbox"/> Same as Primary Insured	
_____	_____	_____	_____	_____	_____
Address & Phone # _____				<input type="checkbox"/> Same as Primary Insured	
_____	_____	_____	_____	_____	_____
Address & Phone # _____				<input type="checkbox"/> Same as Primary Insured	
_____	_____	_____	_____	_____	_____
Address & Phone # _____				<input type="checkbox"/> Same as Primary Insured	

**Trust**

Name of Trust \_\_\_\_\_ Date of Trust \_\_\_\_\_ State where Trust established \_\_\_\_\_

Name, Address & Phone # of Trustee(s) \_\_\_\_\_

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

Relationship of Trust Beneficiary(ies) to Primary Insured \_\_\_\_\_

**Uniform Transfers to Minors (UTMA/UGMA)**

Name, Address & Phone # of Custodian \_\_\_\_\_ as custodian for

Name of Minor \_\_\_\_\_ UTMA/UGMA for the state of \_\_\_\_\_

Minor's Date of Birth (dd/mm/yyyy) \_\_\_\_\_ Minor's Social Security Number \_\_\_\_\_

**H. Current Health and Payment Information**

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

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

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

**Total amount paid \$ \_\_\_\_\_ If amendment, amount previously paid \$ \_\_\_\_\_**

**4. Complete the following questions for any Proposed Insureds actual age 24 months old or younger (except for children under CI Rider and Family Protection Plan):**

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

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



I. Coverage Information

NYLIC		RIDERS					DIVIDEND OPTION	
<input type="checkbox"/> Whole Life <input type="checkbox"/> Custom Whole Life Premium Pay Years _____ <input type="checkbox"/> Modified Premium Whole Life Face Amount \$ _____ or Premium \$ _____ <input type="checkbox"/> Automatic Premium Loan	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> DOT \$ _____ <input type="checkbox"/> LBR \$ _____	<input type="checkbox"/> OPP <input type="checkbox"/> COM <input type="checkbox"/> WP <input type="checkbox"/> Scheduled Bill \$ _____ <input type="checkbox"/> Unscheduled (Lump Sum) \$ _____	<input type="checkbox"/> CPB <input type="checkbox"/> CI <input type="checkbox"/> PPO <input type="checkbox"/> PPB \$ _____	<input type="checkbox"/> LCTR__ PI \$ _____ <input type="checkbox"/> LCTR__ OCI 1 \$ _____ <input type="checkbox"/> LCTR__ OCI 2 \$ _____	<input type="checkbox"/> YCTR PI \$ _____ <input type="checkbox"/> YCTR/OCI \$ _____ <input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Pd Up Ad <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash		
<input type="checkbox"/> Survivorship Whole Life Face Amount \$ _____ <input type="checkbox"/> Automatic Premium Loan <input type="checkbox"/> _____	2nd to Die <input type="checkbox"/> DOT \$ _____ <input type="checkbox"/> LTR \$ _____	<input type="checkbox"/> EPR \$ _____ <input type="checkbox"/> _____ \$ _____	1st to Die <input type="checkbox"/> LFD \$ _____	<input type="checkbox"/> OPP <input type="checkbox"/> COM <input type="checkbox"/> WP <input type="checkbox"/> Scheduled Bill \$ _____ <input type="checkbox"/> Unscheduled (Lump Sum) \$ _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Pd Up Ad <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash		
<input type="checkbox"/> Yearly Convertible Term Face Amount \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____	<input type="checkbox"/> CI # units _____	<input type="checkbox"/> YCTR PI \$ _____ <input type="checkbox"/> YCTR/OCI \$ _____	<input type="checkbox"/> LBR <input type="checkbox"/> PPO \$ _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash		
<input type="checkbox"/> Level Premium Convertible Term _____ Year Guaranteed Level Premium Face Amount \$ _____	<input type="checkbox"/> WP <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> LBR \$ _____	<input type="checkbox"/> LCTR__ PI \$ _____ <input type="checkbox"/> LCTR__ OCI 1 \$ _____	<input type="checkbox"/> LCTR__ OCI 2 \$ _____	<input type="checkbox"/> YCTR PI \$ _____ <input type="checkbox"/> YCTR/OCI \$ _____	<input type="checkbox"/> CI # units _____ <input type="checkbox"/> ECPO (LCT 11-20 only) \$ _____	<input type="checkbox"/> PPO \$ _____	(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash	
<input type="checkbox"/> Family Protection Face Amount \$ _____ (Insured 1) Face Amount \$ _____ (Insured 2)	<input type="checkbox"/> WP (Insured 1) <input type="checkbox"/> WP (Insured 2) <input type="checkbox"/> _____	<input type="checkbox"/> LBR					(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash	
<input type="checkbox"/> One Year Non-Renewable Term Face Amount \$ _____						(Select one) <input type="checkbox"/> Accum <input type="checkbox"/> Prem <input type="checkbox"/> Cash		
<input type="checkbox"/> _____ Face Amount \$ _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____	<input type="checkbox"/> OPP <input type="checkbox"/> COM <input type="checkbox"/> WP \$ _____ <input type="checkbox"/> Unscheduled (Lump Sum) _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____			

NYLAZ

<input type="checkbox"/> _____ Face Amount \$ _____	<input type="checkbox"/> _____ \$ _____	<input type="checkbox"/> _____ \$ _____
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NYLIAC		RIDERS				
<input type="checkbox"/> Universal Life IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> MDW <input type="checkbox"/> ADB \$ _____ <input type="checkbox"/> GIR \$ _____ <input type="checkbox"/> LBR	<input type="checkbox"/> CI # units _____	<input type="checkbox"/> OCI 1 \$ _____ <input type="checkbox"/> OCI 2 \$ _____	<input type="checkbox"/> LPBR <input type="checkbox"/> _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____	
<input type="checkbox"/> Survivorship Universal Life IRC Sec. 7702 Option: <input type="checkbox"/> CVAT <input type="checkbox"/> GPT Face Amount \$ _____ Life Insurance Option: <input type="checkbox"/> Level (1) <input type="checkbox"/> Increasing (2) <input type="checkbox"/> Face Amount plus Adjusted Premium (3) Planned Premium \$ _____ Initial Premium \$ _____	<input type="checkbox"/> FTD \$ _____	<input type="checkbox"/> 10 YLTR \$ _____	<input type="checkbox"/> EPR \$ _____	<input type="checkbox"/> _____ \$ _____ <input type="checkbox"/> _____		



I. Coverage Information

NYLIAC

RIDERS

Custom UL Guarantee  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option  
 Level  \_\_\_\_\_  
 IRC Sec. 7702 Option  
 CVAT  \_\_\_\_\_  
 Planned Premium \$ \_\_\_\_\_  
 Planned Premium Paying Period \_\_\_\_\_  
 Add'l 1st Year Premium \$ \_\_\_\_\_

MDW  LBR  
  
 \_\_\_\_\_  \_\_\_\_\_  
 \$ \_\_\_\_\_

ROP  
 Maximum ROP Benefit Amount \$ \_\_\_\_\_  
 ROP Percentage \_\_\_\_\_%  
 ROP Benefit Interest Rate \_\_\_\_\_%

Custom SUL Guarantee  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option  
 Level  \_\_\_\_\_  
 IRC Sec. 7702 Option  
 CVAT  \_\_\_\_\_  
 Planned Premium \$ \_\_\_\_\_  
 Planned Premium Paying Period \_\_\_\_\_  
 Add'l 1st Year Premium \$ \_\_\_\_\_

LBR  FTD  
 \$ \_\_\_\_\_  
  
 EPR  10YLTR  
 \$ \_\_\_\_\_ \$ \_\_\_\_\_  
  
 \_\_\_\_\_  \_\_\_\_\_  
 \$ \_\_\_\_\_

ROP  
 Maximum ROP Benefit Amount \$ \_\_\_\_\_  
 ROP Percentage \_\_\_\_\_%  
 ROP Benefit Interest Rate \_\_\_\_\_%

Nautilus Advantage Universal Life  
 IRC Sec. 7702 Option  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level(1)  Increasing(2)  
 Face Amount plus Adjusted Premiums (3)  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_

MDW  CI  OCI 1  LPBR  \_\_\_\_\_  
 ADB # units \_\_\_\_\_ \$ \_\_\_\_\_  \_\_\_\_\_ \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  OCI 2 \_\_\_\_\_  
 GIR \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  
 LBR

Nautilus Advantage Survivorship  
 Universal Life  
 IRC Sec. 7702 Option  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level(1)  Increasing(2)  
 Face Amount plus Adjusted Premiums (3)  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_

FTD  10 YLTR  EPR  \_\_\_\_\_  
 \$ \_\_\_\_\_ \$ \_\_\_\_\_ \$ \_\_\_\_\_  
  
 \_\_\_\_\_

Instant Legacy - SPUL  
 Single Premium \$ \_\_\_\_\_

Submit completed Simplified Medical Questionnaire - Part II  
 Do not complete section P "Non-medical Health Questionnaire" for Instant Legacy.

Variable Universal Life Accumulator  
 IRC Sec. 7702 Option:  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level (1)  Increasing (2)  
 Face Amount plus Adjusted Premium (3)  
 \_\_\_\_\_  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_

MDW  ADB  OCI 1  
 \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 LER  CI  OCI 2  
 GIR # units \_\_\_\_\_ \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  GMDB  WSP  
 \_\_\_\_\_  \_\_\_\_\_  
 LBR  GMAB  \_\_\_\_\_



NYLIAC

RIDERS

Survivorship Variable Universal Life Accumulator  
 IRC Sec. 7702 Option:  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level (1)  Increasing (2)  
 Face Amount plus Adjusted Premium (3)  
 \_\_\_\_\_  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_

1st to Die  GMDB (Younger Insured's Age 100)  \_\_\_\_\_  
 FTD  \_\_\_\_\_ \$ \_\_\_\_\_  
 \$ \_\_\_\_\_  LER  
 EPR  GMAB  
 \$ \_\_\_\_\_

Lifetime Wealth Variable Universal Life  
 IRC Sec. 7702 Option:  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level (1)  Increasing (2)  
 Face Amount plus Adjusted Premium (3)  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_  
 Investment Adviser  None  
 \_\_\_\_\_ a

MDW  ADB  GMDB  OCI 1  
 LER  CI  GMAB \$ \_\_\_\_\_  
 \$ \_\_\_\_\_ # Units \_\_\_\_\_  PAIR\*  OCI 2  
 LBR  WSP \$ \_\_\_\_\_  
 \_\_\_\_\_

\*The Pre-Approved Increase Rider (PAIR) is optional for Attained Age Term Conversion and must be selected if desired. The PAIR rider is automatically included on all new issues.

Asset Preserver  
 Face Amount \$ \_\_\_\_\_ or  
 Single Premium \$ \_\_\_\_\_  
 \*Benefit Payment Option:  
 Base Only  Base Plus EOB \_\_\_\_\_  
 Inflation Option \_\_\_\_\_

Submit completed Asset Preserver Application Supplement  
 \_\_\_\_\_  
 \$ \_\_\_\_\_  
 \*Not all Benefit Payment Options available in all states.

Legacy Creator - SPVUL  
 Single Premium \$ \_\_\_\_\_

LBR  \_\_\_\_\_  
 \_\_\_\_\_ \$ \_\_\_\_\_  
 Submit completed Simplified Medical Questionnaire - Part II  
 Do not complete section P "Non-medical Health Questionnaire" for Legacy Creator.

Executive Benefits  
 CorpExec VUL \_\_\_\_\_  CEUL  
 BOLI \_\_\_\_\_  
 CorpExec Accumulator  
 \_\_\_\_\_  
 IRC Sec. 7702 Option:  CVAT  GPT  
 Face Amount \$ \_\_\_\_\_  
 Life Insurance Option:  
 Level (1)  Increasing (2)  
 Face Amount plus Adjusted Premium (3) (if applicable)  
 \_\_\_\_\_  
 Unisex Issue:  Yes  No

LTR (CorpExec VUL only)  
 STR (CorpExec VUL, CEUL, CorpExec Accumulator)  
 OLP (CorpExec Accumulator Only)  
 \_\_\_\_\_  \_\_\_\_\_  
 \$ \_\_\_\_\_ \$ \_\_\_\_\_  
 Premium Paid at Issue: \$ \_\_\_\_\_ Billing Frequency:  Annual  Semi-Annual  Quarterly  Single  
 Planned Premium in Year 1: \$ \_\_\_\_\_  
 Planned Premium in Years 2-10:  
 Year 2: \$ \_\_\_\_\_ Year 5: \$ \_\_\_\_\_ Year 8: \$ \_\_\_\_\_  
 Year 3: \$ \_\_\_\_\_ Year 6: \$ \_\_\_\_\_ Year 9: \$ \_\_\_\_\_  
 Year 4: \$ \_\_\_\_\_ Year 7: \$ \_\_\_\_\_ Year 10: \$ \_\_\_\_\_

\_\_\_\_\_  
 Face Amount \$ \_\_\_\_\_ or  
 Planned Premium \$ \_\_\_\_\_  
 Initial Premium \$ \_\_\_\_\_  
 IRC Sec. 7702 Option  
 CVAT  \_\_\_\_\_  
 Planned Premium \$ \_\_\_\_\_  
 Planned Premium Paying Period \_\_\_\_\_  
 Add'l 1st Year Premium \$ \_\_\_\_\_

\_\_\_\_\_  \_\_\_\_\_  
 \$ \_\_\_\_\_ \$ \_\_\_\_\_

**Alternate and Additional Policy Requests** (Complete plan, face amount, rider(s), rider amount, and dividend option requests below. If changes to other sections are being requested, provide instructions below or in Section Q.)

Alternate  Additional Plan: \_\_\_\_\_ Face Amount: \$ \_\_\_\_\_  
 Rider: \_\_\_\_\_ Rider Amount: \$ \_\_\_\_\_  
 Amount Paid: \_\_\_\_\_ Dividend Option: \_\_\_\_\_  
 (Additional Only) CWL Premium Pay Years: \_\_\_\_\_

Instructions: \_\_\_\_\_



**J. Personal Information**

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

(a) had their driver's license suspended or revoked? .....  Yes  No  
If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage and give details below including reason, driver's license # (if other than previously stated), State of license, and month and year of occurrence.

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

(b) been declined for issue, reinstatement or renewal of any type of life or health insurance? .....  Yes  No  
If "Yes", indicate name or maiden name (if applicable) of person(s) applying for coverage, give company name (including New York Life), reason and date.

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

**2. In the last 10 years, has the Primary Insured or any other Proposed Insured(s)**

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

b) If "Yes" to a conviction, is the Primary Insured or any other Proposed Insured(s) currently on parole or probation as a result of such conviction? .....  Yes  No

(If "Yes" to 2a or 2b, indicate name or maiden name (if applicable) of person(s) applying for coverage, and give details below, including reason, State, County, month and year of occurrence.)

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

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

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

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

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

(a)  motorcycle  snowmobile and/or  all terrain vehicle (ATV) riding? Check all that apply. If "Yes", provide the following details:

Insured's Name \_\_\_\_\_ Annual mileage \_\_\_\_\_ Vehicle used for \_\_\_\_\_

Safety helmet used?  Yes  No Safety course completed?  Yes  No

(b) or any of the following: If "Yes", check all that apply and complete Form Series 7663.

- SCUBA or skin diving  auto racing  motorcycle racing  power boat racing  snowmobile racing  all terrain vehicle (ATV) racing
- or  any other type of vehicle racing  sky diving  rock/mountain climbing  helicopter skiing  cave exploration  hot air ballooning
- rodeo riding  flying as civilian pilot  flying as a military pilot  ultralight or  hang-gliding

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

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

**If "Pending" is checked off above, what is the total amount of pending coverage, excluding New York Life, that will be placed in all companies for each insured? \$ \_\_\_\_\_** Use Section Q for Additional Details.

**L. Financial Information**

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



M. Business and Creditor Insurance

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

1. Will an employer, including a partnership, be the owner and beneficiary of the insurance applied for on the life of an employee or partner? Yes No ("Employer" includes related parties, such as an affiliate of the business.) If "Yes", the Proposed Insured must acknowledge the following statement by initialing the space provided below.

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

Proposed Insured's initials here: \_\_\_\_\_

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

2. (a) If BUY/SELL, what is the net income \$ \_\_\_\_\_ and market value \$ \_\_\_\_\_ of the business? (b) Does insured(s) have ownership in the business? If "Yes", list all owners and percent of ownership for each (for survivorship policy, list each insured and provide ownership percentage for each). \_\_\_\_\_ Yes No

(c) Are all owners being insured? Provide details and amounts. \_\_\_\_\_ Yes No

3. (a) If KEY EMPLOYEE, provide reason why employee is key to the organization, and length of time employed. \_\_\_\_\_

(b) Are all Key Employees being insured? Provide details and amounts. \_\_\_\_\_ Yes No

4. If CREDITOR COVERAGE, what is the loan amount \$ \_\_\_\_\_, term \_\_\_\_\_ (years) \_\_\_\_\_ (months), and purpose? \_\_\_\_\_

Purpose \_\_\_\_\_ If creditor requires collateral assignment, include completed collateral assignment with application.

N. Term Conversion

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

1. Policy Number \_\_\_\_\_ Term Policy Term Rider These term coverages can be attained age converted (AATC): OCI DOT AD105 and after TL AD 85 and prior Conversion of Spouse Conversion of Child 1YT (Div. Opt.)

Amount to be Converted: Term Policy \$ \_\_\_\_\_ Term Rider \$ \_\_\_\_\_ Amount Remaining In Force: Term Policy \$ \_\_\_\_\_ Term Rider \$ \_\_\_\_\_ (If no amount entered, remainder will be terminated)

If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) PTIS rider without underwriting (less than 5 years from original issue date and meets amount rules) New rider with underwriting required (Provide details in Section Q)

Is a reduction in rating being requested? \_\_\_\_\_ Yes No

If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) \_\_\_\_\_ Yes No

If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy does not include this benefit, complete Sections J and P of this application.

2. Policy Number \_\_\_\_\_ Term Policy Term Rider These term coverages can be attained age converted (AATC): OCI DOT AD105 and after TL AD 85 and prior Conversion of Spouse Conversion of Child 1YT (Div. Opt.)

Amount to be Converted: Term Policy \$ \_\_\_\_\_ Term Rider \$ \_\_\_\_\_ Amount Remaining In Force: Term Policy \$ \_\_\_\_\_ Term Rider \$ \_\_\_\_\_ (If no amount entered, remainder will be terminated)

If there is an amount remaining in force that qualifies under the PTIS (Point in Scale) Program to be carried over to a term rider on the new base plan, are any of the following riders being applied for? New rider without underwriting (less than 5 years from original issue and meets minimum amount rules) PTIS rider without underwriting (5 years or more from original issue date or does not meet minimum amount rules) PTIS rider without underwriting (less than 5 years from original issue date and meets amount rules) New rider with underwriting required (Provide details in Section Q)

Is a reduction in rating being requested? \_\_\_\_\_ Yes No

If Waiver of Premium or MDW is being applied for, does the Primary Insured have a disability which prevents him/her from being actively at work? (If "Yes", provide details and dates in Section Q.) \_\_\_\_\_ Yes No

If you are applying for Waiver of Premium or MDW on the Primary Insured and the existing policy does not include this benefit, complete Sections J and P of this application.

For Attained Age Term Conversions the following apply:

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

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

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

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

O. Guaranteed Insurability Option Date (PPO and GIR)

Scheduled Option Date: Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Date of marriage birth adoption Mo. \_\_\_\_\_ Day \_\_\_\_\_ Year \_\_\_\_\_

Proof of event is required.



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

**P. Non-Medical Health Questionnaire**

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Height \_\_\_\_\_ft. \_\_\_\_\_in. Weight \_\_\_\_\_lbs.

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

- In the last 5 years, has the Proposed Insured consulted his or her primary physician, or other member of the medical profession, or been seen at a medical facility?  Yes  No Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone number ( \_\_\_\_\_ ) \_\_\_\_\_-\_\_\_\_\_  
 Date of last visit: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ Reason for visit: \_\_\_\_\_  
 Treatment or medication provided: (Provide details, name and dosage) \_\_\_\_\_
- List all medications prescribed in the last 2 years: (Include reason, dosage and frequency) \_\_\_\_\_

- In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
  - Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse?  Yes  No
  - Elevated blood sugar or diabetes?  Yes  No
  - Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder?  Yes  No
  - Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma?  Yes  No
  - Multiple sclerosis; epilepsy, seizures; intellectual disability; memory loss or other neurological disorder?  Yes  No
  - Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder?  Yes  No
  - Stroke, transient ischemic attack (TIA) or other circulatory disorder?  Yes  No
  - Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA?  Yes  No
  - Colitis; blood in stool; intestinal polyps or other intestinal disorder?  Yes  No
  - Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder?  Yes  No
  - Any psychiatric or mental health condition (include counseling or hospitalization)?  Yes  No
  - Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use?  Yes  No
- In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?  Yes  No
- In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply)  Yes  No
- In the last two (2) years, other than as already stated, has the Proposed Insured:
  - Had any surgery or been recommended to have surgery?  Yes  No
  - Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy)  Yes  No
  - Been unable to work, unable to attend school or been disabled for 30 days or more?  Yes  No
- Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship; medical condition; age at onset of illness; current age, if alive, or age at death. If cancer indicated, provide type or location.)  Yes  No
- In the last 12 months, has the Proposed Insured had a change in weight greater than 10 pounds?  Yes  No
  - If "Yes", please provide how many pounds lost \_\_\_\_\_ or how many pounds gained \_\_\_\_\_ and check off all that apply:  
 Diet  Exercise  Surgery  Pregnancy  Unknown
- Complete the following questions if the Proposed Insured is actual age 70 or over:
  - Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home?  Yes  No
  - Does the Proposed Insured live in a facility that provides him or her with personal care?  Yes  No
  - Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation?  Yes  No
  - Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply)  Yes  No

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

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







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

**Additional Insured Non-Medical Health Questionnaire**

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_ Height \_\_\_\_\_ft. \_\_\_\_\_in. Weight \_\_\_\_\_lbs.

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

1. In the last 5 years, has the Proposed Insured consulted his or her primary physician, or other member of the medical profession, or been seen at a medical facility?  Yes  No Name \_\_\_\_\_  
Address \_\_\_\_\_ Phone number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
Date of last visit: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Reason for visit: \_\_\_\_\_  
Treatment or medication provided: (Provide details, name and dosage) \_\_\_\_\_

2. List all medications prescribed in the last 2 years: (Include reason, dosage and frequency) \_\_\_\_\_

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse? .....  Yes  No
  - b. Elevated blood sugar or diabetes? .....  Yes  No
  - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? .....  Yes  No
  - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma? .....  Yes  No
  - e. Multiple sclerosis; epilepsy, seizures; intellectual disability; memory loss or other neurological disorder? .....  Yes  No
  - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder? .....  Yes  No
  - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? .....  Yes  No
  - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? .....  Yes  No
  - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? .....  Yes  No
  - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder? .....  Yes  No
  - k. Any psychiatric or mental health condition (include counseling or hospitalization)? .....  Yes  No
  - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? .....  Yes  No

4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? .....  Yes  No

5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) .....  Yes  No

6. In the last two (2) years, other than as already stated, has the Proposed Insured:
- a. Had any surgery or been recommended to have surgery? .....  Yes  No
  - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) .....  Yes  No
  - c. Been unable to work, unable to attend school or been disabled for 30 days or more? .....  Yes  No

7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship; medical condition; age at onset of illness; current age, if alive, or age at death. If cancer indicated, provide type or location.) .....  Yes  No

8. a. In the last 12 months, has the Proposed Insured had a change in weight greater than 10 pounds? .....  Yes  No  
b. If "Yes", please provide how many pounds lost \_\_\_\_\_ or how many pounds gained \_\_\_\_\_ and check off all that apply:  
Diet  Exercise  Surgery  Pregnancy  Unknown

9. Complete the following questions if the Proposed Insured is actual age 70 or over:
- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? .....  Yes  No
  - b. Does the Proposed Insured live in a facility that provides him or her with personal care? .....  Yes  No
  - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? .....  Yes  No
  - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) .....  Yes  No

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

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



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

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

### Complete information below:

Primary Insured's Name: \_\_\_\_\_

Policy Number \_\_\_\_\_

### Indicate Type:

- Single Check-O-Matic       Check-O-Matic OPP
- Multiple Check-O-Matic      Previous Case Reference Number or Policy Number \_\_\_\_\_
- Add to Check-O-Matic      Previous Case Reference Number or Policy Number \_\_\_\_\_
- Concurrent Insured's Name \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

### ELECTRONIC FUNDS TRANSFER (EFT)

Check here to pay your initial premium payment via EFT. This initial payment will be processed on or after the date the form is signed. **PLEASE NOTE: One Time EFT payments are not available for Variable Products.** To have your payment(s) withdrawn directly from your bank account, via an Electronic Funds Transfer (EFT), please provide the following information or attach a VOID check/deposit slip with the following information. Please Check One:  Checking Account     Savings Account

**IMPORTANT: Please print all information clearly.**

Accountholder's Name _____ (List all names on The account) _____  Accountholder's Address _____	Check Number → 0123 01-23456789
Bank Name _____ Bank City/State _____ Bank Route/Transit Number _____	Sample DOLLARS Bank Account Number: When looking at this area on your check, if the check number (from the upper right corner) is included, please omit it when writing in the spaces below.
FOR	

## 3rd Party Payer Information

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

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 First Name                      Middle Initial                      Last Name

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

Relationship to the Policyowner: \_\_\_\_\_ Social Security Number/Tax ID Number \_\_\_\_\_

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

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

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

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

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## Statement of Agreement

### Those Persons Who Sign This Application Agree That:

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

### Fraud Warnings:

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

**FOR DISTRICT OF COLUMBIA: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

## Illustration

### Do not complete this section if:

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

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

- An illustration was not shown or given to me.
- An illustration was shown or given to me, but the policy applied for is different from the illustration.
- An illustration was displayed to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished. The illustration on the screen included the following personal and policy information:
- Type of Policy \_\_\_\_\_ Proposed Insured \_\_\_\_\_
- Initial Death Benefit \_\_\_\_\_ Rating/Class \_\_\_\_\_
- Dividend Option \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

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

CUSTOMER COPY

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## Statement of Agreement

### Those Persons Who Sign This Application Agree That:

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

### Fraud Warnings:

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**FOR DISTRICT OF COLUMBIA: WARNING:** It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

## Illustration

### Do not complete this section if:

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

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

- An illustration was not shown or given to me.
- An illustration was shown or given to me, but the policy applied for is different from the illustration.
- An illustration was displayed to me on a screen. The displayed illustration matches the policy applied for, but no printed copy of the illustration was furnished. The illustration on the screen included the following personal and policy information:
- Type of Policy \_\_\_\_\_ Proposed Insured \_\_\_\_\_
- Initial Death Benefit \_\_\_\_\_ Rating/Class \_\_\_\_\_
- Dividend Option \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

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



### Tax Certification

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

#### ACKNOWLEDGEMENT

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

#### AUTHORIZATION

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

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

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

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

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

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

**RELEASE OF INFORMATION TO OTHERS** The Insurer may give data about me that affects my insurability to: its subsidiaries; its affiliates; its parent company; its agents and their staffs; its reinsurers; and the Insurer and its reinsurers may give such data, including a brief report of my protected health information and data about any life insurance policy(ies) Insurer issues on me, to MIB, Inc. However, this will not be done in connection with information relating to testing for the AIDS virus.

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

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

#### Signatures

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

\_\_\_\_\_ Signed at \_\_\_\_\_ On \_\_\_\_\_  
Signature of the Primary Insured (Parent or Guardian if under 14 years 6 months) (City, State) (mm/dd/yyyy)

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

\_\_\_\_\_  \_\_\_\_\_  
Signature of Applicant if Other than Primary Insured or Owner Signature of Other Insured

\_\_\_\_\_  \_\_\_\_\_  
Signature of Other Insured Signature of Other Insured

\_\_\_\_\_  
Other Required Signature

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

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

\_\_\_\_\_  
Signature of Agent/Witness Countersigned Code #



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

### Medical Questionnaire (Non-Medical – Application Part II)

First Name \_\_\_\_\_ Middle Name \_\_\_\_\_ Last Name \_\_\_\_\_  
 Male  Female Date of Birth (mm/dd/yyyy) \_\_\_\_\_ Height \_\_\_\_\_ft. \_\_\_\_\_in.  
 Weight \_\_\_\_\_lbs.

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

1. In the last 5 years, has the Proposed Insured consulted his or her primary physician, or other member of the medical profession, or been seen at a medical facility?  Yes  No Name \_\_\_\_\_  
 Address \_\_\_\_\_ Phone number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_  
 Date of last visit: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Reason for visit: \_\_\_\_\_  
 Treatment or medication provided: (Provide details, name and dosage) \_\_\_\_\_

2. List all medications prescribed in the last 2 years: (Include reason, dosage and frequency) \_\_\_\_\_

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)
- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse?.....  Yes  No
  - b. Elevated blood sugar or diabetes?.....  Yes  No
  - c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder?.....  Yes  No
  - d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma?.....  Yes  No
  - e. Multiple sclerosis; epilepsy, seizures; intellectual disability; memory loss or other neurological disorder?.....  Yes  No
  - f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder?.....  Yes  No
  - g. Stroke, transient ischemic attack (TIA) or other circulatory disorder?.....  Yes  No
  - h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA?.....  Yes  No
  - i. Colitis; blood in stool; intestinal polyps or other intestinal disorder?.....  Yes  No
  - j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder?.....  Yes  No
  - k. Any psychiatric or mental health condition (include counseling or hospitalization)?.....  Yes  No
  - l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use?.....  Yes  No
4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)?.....  Yes  No
5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply).....  Yes  No
6. In the last two (2) years, other than as already stated, has the Proposed Insured:
- a. Had any surgery or been recommended to have surgery?.....  Yes  No
  - b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy).....  Yes  No
  - c. Been unable to work, unable to attend school or been disabled for 30 days or more?.....  Yes  No
7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship; medical condition; age at onset of illness; current age, if alive, or age at death. If cancer indicated, provide type or location.).....  Yes  No
8. a. In the last 12 months, has the Proposed Insured had a change in weight greater than 10 pounds?.....  Yes  No  
 b. If "Yes", please provide how many pounds lost \_\_\_\_\_ or how many pounds gained \_\_\_\_\_ and check off all that apply:  
 Diet  Exercise  Surgery  Pregnancy  Unknown
9. Complete the following questions if the Proposed Insured is actual age 70 or over:
- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home?.....  Yes  No
  - b. Does the Proposed Insured live in a facility that provides him or her with personal care?.....  Yes  No
  - c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation?.....  Yes  No
  - d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply).....  Yes  No

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

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

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

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



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### Medical Examiner's Report – Application Part II

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

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

1. In the last 5 years, has the Proposed Insured consulted his or her primary physician, or other member of the medical profession, or been seen at a medical facility?

Yes  No Name \_\_\_\_\_

Address \_\_\_\_\_ Phone number ( \_\_\_\_\_ ) \_\_\_\_\_ - \_\_\_\_\_

Date of last visit: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Reason for visit: \_\_\_\_\_

Treatment or medication provided: (Provide details, name and dosage) \_\_\_\_\_

2. List all medications prescribed in the last 2 years: (Include reason, dosage and frequency) \_\_\_\_\_

3. In the last ten (10) years, has the Proposed Insured been diagnosed, treated, tested positive for or been given medical advice by a member of the medical profession for: (If "Yes", circle all conditions that apply)

- a. Elevated blood pressure, chest discomfort, heart disorder, angina, murmur or irregular pulse?.....  Yes  No
- b. Elevated blood sugar or diabetes? .....  Yes  No
- c. Asthma, shortness of breath, chronic bronchitis (COPD), emphysema, lung disorder or any type of sleep disorder? .....  Yes  No
- d. Cancer, tumor, melanoma, leukemia, Hodgkins or any other lymphoma?.....  Yes  No
- e. Multiple sclerosis; epilepsy, seizures; intellectual disability; memory loss or other neurological disorder? .....  Yes  No
- f. Pancreatitis; hepatitis; cirrhosis, liver disorder, anemia or other blood disorder?.....  Yes  No
- g. Stroke, transient ischemic attack (TIA) or other circulatory disorder? .....  Yes  No
- h. Kidney disorder; protein or blood in the urine, urinary tract disorder or elevated PSA? .....  Yes  No
- i. Colitis; blood in stool; intestinal polyps or other intestinal disorder? .....  Yes  No
- j. Muscle weakness; bone or back disorder; arthritis; lupus or other connective tissue disorder?.....  Yes  No
- k. Any psychiatric or mental health condition (include counseling or hospitalization)? .....  Yes  No
- l. Drug or alcohol use, used cocaine or other controlled substances (other than as prescribed by a physician), or been counseled or hospitalized for drug or alcohol use? .....  Yes  No

4. In the last ten (10) years, has the Proposed Insured been diagnosed by a member of the medical profession or tested positive for Human Immunodeficiency Virus (AIDS virus) or Acquired Immune Deficiency Syndrome (AIDS)? .....  Yes  No

5. In the last two (2) years, has the Proposed Insured been treated by a member of the medical profession for any of the following symptoms, for which a final medical professional diagnosis is not yet known: chest pain or pressure; blood in urine; rectal bleeding; blood in stool; loss of consciousness; recurrent shortness of breath; or cough, fever, or headache lasting five or more days? (If "Yes", circle all that apply) .....  Yes  No

6. In the last two (2) years, other than as already stated, has the Proposed Insured:

- a. Had any surgery or been recommended to have surgery?.....  Yes  No
- b. Had any diagnostic tests (excluding HIV tests) or been recommended to have any diagnostic test other than already stated? (Such as but not limited to an X-ray, CT scan, stress test, MRI or ultrasound other than for pregnancy) .....  Yes  No
- c. Been unable to work, unable to attend school or been disabled for 30 days or more? .....  Yes  No

7. Among Proposed Insured's natural parents, brothers or sisters, has anyone been diagnosed or treated by a member of the medical profession for angina, heart disorder, stroke, diabetes or cancer? (If "Yes", provide the following details: relationship; medical condition; age at onset of illness; current age, if alive, or age at death. If cancer indicated, provide type or location.).....  Yes  No

8. a. In the last 12 months, has the Proposed Insured had a change in weight greater than 10 pounds? .....  Yes  No  
 b. If "Yes", please provide how many pounds lost \_\_\_\_\_ or how many pounds gained \_\_\_\_\_ and check off all that apply:  
 Diet  Exercise  Surgery  Pregnancy  Unknown

9. Complete the following questions if the Proposed Insured is actual age 70 or over:

- a. Within the last 2 years, has the Proposed Insured been unable to participate in normal activities or been confined at home? .....  Yes  No
- b. Does the Proposed Insured live in a facility that provides him or her with personal care? .....  Yes  No
- c. Has the Proposed Insured been hospitalized or evaluated, counseled or treated by a member of the medical profession for memory problems or disorientation? .....  Yes  No
- d. Within the last 2 years, has the Proposed Insured had a fall resulting in a fracture, or been bed-ridden for 2 weeks or more, or has the Proposed Insured required assistance in walking, eating, bathing, toileting, or dressing? (Circle all that apply) .....  Yes  No

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





H A Z 0 1



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

## HAZARDOUS SPORTS AND AVIATION SUPPLEMENT

First Name	Middle Name	Last Name	Date of Birth (mm/dd/yyyy)	Policy No./Tracking No.
------------	-------------	-----------	----------------------------	-------------------------

**A) SCUBA Diving and/or Skin Diving**

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

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

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

**C) Sky Diving**

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

**D) Rock/Mountain Climbing**

1. What type(s) of climbing do you do?  Indoor/Rock Gym  Bouldering  Top roping  Traditional "Trad"  Sport Climbing  Ice Climbing  
(Check all that apply)  Alpine  Expedition  Other \_\_\_\_\_
2. What is the most difficult class of technical climbing that you do?  YDS 5.0-5.5  YDS 5.6-5.9  YDS 5.10-5.14  Artificial Aid/YDS 6.0/A1-5
3. a. How many years have you been climbing? \_\_\_\_\_ b. How many climbs have you done in the last 12 months? \_\_\_\_\_
4. How many climbs do you plan to do in the next 12 months? \_\_\_\_\_
5. a. What is the maximum vertical length of your climbs? \_\_\_\_\_ b. Do you ever climb multi-pitch routes?  Yes  No
6. What is the longest time commitment grade of your climbs? Please specify number of hours or days. \_\_\_\_\_
7. Do you always wear a helmet when you climb?  Yes  No If "No", please provide details. \_\_\_\_\_
8. Do you ever self-belay?  Yes  No If "Yes", please provide details. \_\_\_\_\_
9. a. What is the maximum altitude/highest peak that you climb to? \_\_\_\_\_ b. Have you ever experienced altitude sickness?  Yes  No
10. Do you ever climb outside the lower 48 states?  Yes  No If "Yes", please provide details. \_\_\_\_\_
11. Do you ever free-solo, highball or climb alone (without another person present)?  Yes  No
12. Do you participate in a rescue service or local rescue team?  Yes  No If "Yes", please provide details. \_\_\_\_\_
13. Do you teach, coach, or are you certified by or a member of any climbing organizations or clubs?  Yes  No If "Yes", please provide details. \_\_\_\_\_

**E) Helicopter Skiing**

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



**F) Cave Exploration (Spelunkers)**

1. How many times have you gone caving in the last 12 months? \_\_\_\_\_
2. How many times do you plan on caving in the next 12 months? \_\_\_\_\_
3. Have you engaged in any underwater activities during caving?  Yes  No If "Yes", please provide details. \_\_\_\_\_

**G) Hot Air Ballooning**

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

**H) Rodeo Riding**

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

**Aviation Supplement Section**

**A) Civilian**

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

**B) Military**

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

**C) Ultralight/Lighter than Air**

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

**D) Hang-Gliding**

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

**Signatures**

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

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

Date: \_\_\_\_\_

GO Code \_\_\_\_\_ Agent Code \_\_\_\_\_

X \_\_\_\_\_  
Signature of Agent/Witness

Agent Last Name (Print) \_\_\_\_\_

SERFF Tracking #:

NYLC-128688470

State Tracking #:

Company Tracking #:

213-500, ET AL.

State:

Arkansas

Filing Company:

NYLIFE Insurance Company of Arizona

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

2012 NB21 Application

Project Name/Number:

2012 NB21 Application/211-500, et al.

## Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:			
Attachment(s):			
NYLAZ Readability Cert.pdf			

		Item Status:	Status Date:
Satisfied - Item:	Memorandum of Variable Material		
Comments:			
Attachment(s):			
Statement of Variability - General.pdf			

**NEW YORK LIFE INSURANCE COMPANY OF ARIZONA**  
**READABILITY CERTIFICATION**

**I certify that the forms listed on the attached page(s) meet the standards of your State's Readability Laws.**

**NEW YORK LIFE INSURANCE COMPANY OF ARIZONA**

*Linda E. LoPinto*

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**Signature**

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**Linda E. LoPinto**

**Name**

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**Corporate Vice President**

**Title**

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**September 14, 2012**

**Date**

**NEW YORK LIFE INSURANCE COMPANY OF ARIZONA**

**Flesch Scores for forms submitted with this filing are:**

<b><u>Form No.</u></b>	<b><u>Flesch Score</u></b>
213-500	51
213-510	68
213-525	71
7663.101	86

**New York Life Insurance Company  
New York Life Insurance and Annuity Corporation  
(09/12/12) Memorandum of Variable Material for:  
Life Application Number 213-500**

Variable material is bracketed in the Part 1 Application – Plan section:

The Plan section language has been bracketed in the event New York Life deletes or adds new products or riders.

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.