Group Decreasing Term Life Insurance Application

4S

Insurance Benefit for AFA Members & their Families

To enroll, complete this form and return to:

Forrest T. Jones & Company®*
Group Insurance Administrator
P.O. Box 418131
Kansas City, MO 64141-8131
** Forrest T. Jones Consulting Company in Arizona*

Underwritten by:

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

Questions? Call 800.291.8480 or email CustomerService@AFAInsure.com

Please print in ink or type; initial and date any changes.

Membership Affiliation

Are you currently a member of the Air & Space Forces Association and/or AFA Veteran Benefits Association? ☐ Yes ☐ No

(Membership in AFA/AFAVBA is required for participation in this policy. Affiliate members are not eligible.)

Membership Number: _____ Expiration Date: _____
(MM / DD/ Y YYY)

Personal Information

Name: _____
(FIRST NAME / MIDDLE INITIAL / LAST NAME)

Address: _____

City: _____ State: _____ ZIP: _____

Cell Phone: _____ Alternate Phone: _____

Email: _____ Sex: ☐ Male ☐ Female Height _____ Weight _____

Social Security Number: _____ Date of Birth: _____
(MM / DD / YYYY)

Marital status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union† ☐ Domestic Partner†

† Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Are you presently insured under any Air Force Association Group Life Insurance policies? ☐ Yes ☐ No

If "Yes," indicate which policy(ies) and provide details (person insured and amount of insurance):

☐ Term Life ☐ Decreasing Term Life ☐ 10-Year Level Term Life

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

Member: ☐ Yes ☐ No If yes, how long? _____ Country _____

Spouse: ☐ Yes ☐ No If yes, how long? _____ Country _____

Select Coverage:

Member Only: ☐

Family Plan: ☐ The Family Plan provides converage for the member, the member's spouse and dependent children for one member-only rate. See enclosed fact sheet for additional details.

If the Family Plan is chosen, please provide the following information on your spouse and dependent children proposed for coverage:

	FIRST NAME / MI / LAST NAME	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
Spouse:*					☐ M ☐ F
Child(ren):*					☐ M ☐ F
					☐ M ☐ F
					☐ M ☐ F

**See policy information/policy details for definition of eligible dependents. If more than four children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.*

Tobacco / Nicotine Use

Have you or your spouse (if applying for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? ☐ Yes ☐ No If "yes," please state when you last used tobacco or nicotine products and specify the product used.

Member: (Mo/Yr) ____/_____ Product _____ Spouse: (Mo/Yr) ____/_____ Product _____

Insurance Requested: (Refer to the enclosed fact sheet for eligibility, options, and coverage description.)

I hereby apply for the following coverages

a. **Select** ☐ Member Only ☐ Family Plan
High Option Plus ☐ Member Only ☐ Family Plan
High Option ☐ Member Only ☐ Family Plan
Standard ☐ Member Only ☐ Family Plan

Note: Member's age determines to coverage amount.

b. **Increase Member Insurance Amount from $_____ to $_____**
Increase Spouse Insurance Amount from $_____ to $_____
Spouse's benefit amount is based on the benefit amount you choose.

c. **Do you have other life insurance in force?** ☐ Yes ☐ No
If "Yes," total amount in all companies: Member $_____ Spouse $_____

Do you have other insurance applications pending? ☐ Yes ☐ No
If "Yes," indicate amount and company:
Member $ _____ Company _____
Spouse $ _____ Company _____

d. **Insurance Replacement**

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

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

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

Beneficiary Designation:

If you are applying for Initial Coverage under this policy, please complete a separate Group Term Life Insurance Beneficiary Designation Form for the member and spouse (if applying).

If you are increasing coverage under this policy, the death benefit will be paid to current beneficiary(ies) on file, or if no one is designated, benefits will default to beneficiary designations as indicated in the certificate of insurance.

Statement of Health:

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

A. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits, or on waiver of premium for life or health insurance? ☐ Yes ☐ No

B. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No

C. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination or checkup, or been hospitalized or had an operation or had any illness, disease or injury? ☐ Yes ☐ No

D. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ Yes ☐ No

E. Is any person to be insured now pregnant? ☐ Yes ☐ No

F. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ☐ Yes ☐ No
2. Arthritis, back trouble, bone or joint disorder? ☐ Yes ☐ No
3. Fainting spells, convulsions or epilepsy? ☐ Yes ☐ No
4. Sugar, blood, albumin or pus in urine? ☐ Yes ☐ No
5. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ Yes ☐ No
6. Disorder of the breasts or reproductive organs or functions? ☐ Yes ☐ No
7. Nervous or mental disorder, emotional condition or psychiatric care? ☐ Yes ☐ No
8. Cancer, tumor or cyst? ☐ Yes ☐ No
9. Varicose veins, hemorrhoids or hernia? ☐ Yes ☐ No
10. Disorder of eyes, ears, nose or sinuses? ☐ Yes ☐ No
11. Thyroid, liver or respiratory disorder? ☐ Yes ☐ No
12. Alcoholism or drug habit? ☐ Yes ☐ No
13. Disorder of the blood? ☐ Yes ☐ No
14. Other health or physical impairment including:
    a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
    b. Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past five years? ☐ Yes ☐ No
    c. Any other impairment? ☐ Yes ☐ No

If you answered "YES" to any question, give complete details below.

Question Letter/No.	Name of Proposed Insured	Illness or Condition / Date of Onset Duration / Treatment / Operation Degree of Recovery & Date	Name & Address of Physician or Other Practitioners/Hospital Where Confined or Treated

(If you need more space, use a signed and dated separate sheet. Please avoid the use of such terms as "etc.," "various" or "miscellaneous.")

Authorization

Sign and date

I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, LLC ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries or the Policy Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC; and attest to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature: _____ Date: _____

Spouse's Signature: _____ Date: _____
(*Necessary only if Spouse Coverage is requested)*

Owner's Signature: _____ Date: _____
(*Necessary only if Member previously transferred ownership of his/her Group Term Life Insurance)*

Payment of a Premium Contribution for insurance does not mean there is any coverage in force before the Effective Date as speicified by New York Life

Payment Method (select one)

A. ☐ **Automatic Withdrawal:** ☐ Checking Account *(include VOIDED check)*
☐ Savings Account *(include Deposit slip)*

I authorize my bank to deduct my insurance premium from the financial account indicated above on a monthly basis. If I wish to discontinue this authorization, or my account number changes, I will notify the policy administrator in writing.

Signature: (as it appears on account) X_____

B. ☐ **Credit Card Billing:** ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

☐ MasterCard ☐ VISA Card Number:_____ Expiration Date: _____/_____
MM YYYY

Print Name: (as it appears on card) _____

I authorize charges against this credit card for the purpose of collecting insurance premium payments due under this policy. If I wish to discontinue this authorization, or my credit card changes, I will notify the policy administrator in writing.

Signature: _____

C. ☐ **Direct Bill:** ☐ Monthly ☐ Quarterly ☐ Semiannually ☐ Annually

Send no premium now.

Mail your application to: Group Insurance Administrator, P.O. Box 418131, Kansas City, MO 64141-8131

Fraud Notices

FRAUD NOTICE—For residents of all states except those listed below and New York: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. **RESIDENTS OF CO,** the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

RESIDENTS OF CA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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

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

RESIDENTS OF KS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

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

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

RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

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

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

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

IMPORTANT NOTICE:

How New York Life Obtains Information And Underwrites Your Request For The Group Decreasing Life Insurance Policy

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, LLC ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Policy Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other application for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Policy Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Policy Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, LLC, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901 (TTY 866 346-3642). Information for consumers about MIB may be obtained on its Web site at www.mib.com.

For NM Residents: *PROTECTED PERSONS[1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION[2] we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1] *PROTECTED PERSON means a victim of domestic abuse; who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured person.*

[2] *CONFIDENTIAL ABUSE INFORMATION means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured family member, employer or associate of a victim of domestic abuse or a person with whom the applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company **8/12 ed.**

Group Term Life Insurance Beneficiary Designation Form

Insurance Benefit for AFA Members & their Families

Complete this form and return to:

Forrest T. Jones & Company®*
Group Insurance Administrator
P.O. Box 418131 I Kansas City, MO 64141-8131
** Forrest T. Jones Consulting Company in Arizona*

Questions? Call 800.291.8480 or email CustomerService@AFAInsure.com

Underwritten by:

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

Please print all answers in blue or black ink or type.

Insured's Name: ______________________ ☐ Member ☐ Spouse

Important: *In order to expedite claim payments, and in accordance with state insurance regulations, please provide the Identifying Information requested below for your beneficiary(ies). All states have unclaimed property laws requiring life insurance benefits to be transferred to the state if a beneficiary cannot be located. To avoid having benefits intended for your beneficiary(ies) being transferred to the state, please provide the Identifying Information to help us locate the beneficiary(ies) at time of claim.*

I hereby designate the person or persons below as beneficiary for the insurance specified above, revoking any other beneficiary designation.

Class/Share* (Sample designations and important Information on the Reverse side.)

☐ Primary
☐ Contigent
________%
☐ Per Stirpes

Beneficiary Name: ______________________ Relationship to Insured: ______________
(FIRST NAME / MIDDLE INITIAL / LAST NAME)
Address: ______________ City: ______________ State: ________ ZIP: ________
Date of Birth: ______________ Social Security No: ______________ Phone: ______________
(MM/DD/YYYY)
☐ Address & Phone same as Insured Member

☐ Primary
☐ Contigent
________%
☐ Per Stirpes

Beneficiary Name: ______________________ Relationship to Insured: ______________
(FIRST NAME / MIDDLE INITIAL / LAST NAME)
Address: ______________ City: ______________ State: ________ ZIP: ________
Date of Birth: ______________ Social Security No: ______________ Phone: ______________
(MM/DD/YYYY)
☐ Address & Phone same as Insured Member

☐ Primary
☐ Contigent
________%
☐ Per Stirpes

Beneficiary Name: ______________________ Relationship to Insured: ______________
(FIRST NAME / MIDDLE INITIAL / LAST NAME)
Address: ______________ City: ______________ State: ________ ZIP: ________
Date of Birth: ______________ Social Security No: ______________ Phone: ______________
(MM/DD/YYYY)
☐ Address & Phone same as Insured Member

If there is not enough room on this form, please attach a separate page with your dated signature including the names, addresses, Social Security Numbers (or Canada Social Insurance Numbers), dates of birth, and primary phone numbers of all beneficiaries.

AUTHORIZING SIGNATURE (Insured Member or previously designated non-insured Owner)

Signature______________________ Date ______________

Name (please print) ______________________

RECORDED ON BEHALF OF NEW YORK LIFE, subject to the terms and conditions of the group policy.

By______________________ Date ______________

* If no class (primary or contingent) for a beneficiary is indicated, the beneficiary will be considered primary. For each class of beneficiaries, all shares (percentages) must add up to 100%. Unless shares are stated otherwise, benefits will be distributed equally among all surviving beneficiaries in the same class (primary or contingent). If a primary beneficiary dies before the insured, that portion of the benefits will be equally distributed to the surviving primary beneficiaries; if no primary beneficiaries survive the insured, benefits will be paid to the surviving contingent beneficiary(ies) in the next class. If no contingent beneficiaries survive the insured, benefits will be distributed as provided in the Group Policy.

SAMPLES OF BENEFICIARY DESIGNATIONS

Below are examples of some common beneficiary designations that may be helpful as you complete this form.

1. Specific unequal shares (NOTE: Insert "Per Stirpes" after % to have any Benefits due any deceased beneficiary payable to his/her descendents)

Class/Share*

■ Primary
☐ Contigent
60 %
■ Per Stirpes

Beneficiary Name: John J. Smith (FIRST NAME / MIDDLE INITIAL / LAST NAME) Relationship to Insured: Brother

Address: 15 Bay Ridge Boulevard City: Smithville State: AK ZIP: 99999-0000

Date of Birth: 11/15/1974 (MM/DD/YYYY) Social Security No: 123-45-6789 Phone: (987) 654-3210

☐ Address & Phone same as Insured Member

■ Primary
☐ Contigent
40 %
■ Per Stirpes

Beneficiary Name: Antoinette Dubois Jones (FIRST NAME / MIDDLE INITIAL / LAST NAME) Relationship to Insured: Sister

Address: 2201Southwest Third Ave. City: Ocean City State: KS ZIP: 11111-2222

Date of Birth: 05/07/1979 (MM/DD/YYYY) Social Security No: 987-65-4321 Phone: (000) 873-4389

☐ Address & Phone same as Insured Member

2. Trust as Beneficiary:

"John Smith and Mary Jones as Trustees of the Jones Family Trust under the Trust document dated December 1, 2012." [Please provide Identifying Information for all Trustees.]

3. Minor Beneficiary - Uniform Transfers/Gifts to Minors Act (UTMA/UGMA) Designation:

"[Name of Adult] as Custodian for [Name of Minor] under [Insured Member's or Minor's State of Residence] Uniform Transfers/Gifts to Minors Act." [Please provide Identifying Information for the minor and adult Custodian.]

NOTICE REGARDING DESIGNATING A MINOR BENEFICIARY

Unless a UTMA/UGMA designation is used, or there is an existing court appointed guardian of the minor's estate who can make financial decisions for the minor, a claims payment to a minor may be delayed until a surviving parent, relative, or other interested party obtains a court appointment as financial guardian of the minor's estate, for the purpose of receiving the proceeds on behalf of the child.

NOTICE REGARDING TESTAMENTARY TRUST UNDER LAST WILL AND TESTAMENT AS BENEFICIARY

The following is understood and agreed when naming a Testamentary Trust under the Last Will and Testament as beneficiary of a specified decedent (Insured Member or non-insured owner).

Proceeds shall be paid to the named contingent beneficiary if the decedent dies intestate (without a Last Will and Testament), or with a Last Will and Testament but (1) it does not create a Trust and name a Trustee or (2) no court proceeding has been started to probate the Last Will and Testament or no Trustee qualifies and claims the proceeds within 12 months (18 in Mississippi, New York, Texas; 6 months in Florida and North Carolina) after the decedent's death. If the named contingent beneficiary is not living, and no further beneficiary is named, payment shall be made in accordance with the Group Policy.

New York Life is not obligated to inquire about the terms of any Trust affecting this policy or its proceeds, and shall not be held responsible for knowing the terms of any such Trust.

Payment to and receipt by said Trustee(s) or any successor Trustee(s), or payment to and receipt by the contingent beneficiary or insured's estate shall constitute a full discharge and releases the New York Life Insurance Company to the extent of such payment. The full discharge and release of the New York Life Insurance Company's obligation for payment applies to all persons and fiduciaries having any interest in such proceeds.

NOTICE REGARDING NON-INSURED OWNER

A non-insured owner who wishes to name a person other than themselves as beneficiary should do so only after receiving advice from their Counsel as to the possible tax consequences in light of existing decisional law to the effect that, when the proceeds are paid to someone other than the non-insured owner, the proceeds constitute a taxable gift from the owner to the beneficiary at the time of the insured's death.

***Per Stirpes** means that any interest in a life insurance policy that a deceased beneficiary would have, if living, will be shared equally by all living children of that deceased beneficiary.