AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

NEW YORK LIFE

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

To Apply: Complete This Form And Return To:
ADMINISTRATOR
AAO GROUP INSURANCE PROGRAM
P.O. Box 14533 • Des Moines, IA 50306

For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS? Call: 1-888-424-2308
customerservice.service@getamba.com

GROUP TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

PLEASE PRINT IN INK OR TYPE ALL ANSWERS. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

(Please make any necessary corrections to your full name and street address if shown below.)

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: ☐☐☐–☐☐–☐☐☐☐

Home Phone: (____)_____

Work Phone: (____)_____

Fax: (____)_____

Email Address: _____
AMBA will not share your email information

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)
❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any AAO Group Life Insurance Plans? ❑ Yes ❑ No
If "yes," indicate which Plan(s) and provide details (person insured and amount of insurance):
❑ Term Life ❑ 10-Year Level Term Life
Details:_____
(Person insured and amount of insurance)

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?
Member: ❑ Yes, Country_____ For how long? _____ ❑ No
Spouse: ❑ Yes, Country_____ For how long? _____ ❑ No

		DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:	_____	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Spouse*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Child(ren)*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F

* See Plan Information/Plan Details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. Membership Affiliation:

Are you now a member of the American Academy of Ophthalmology? ❑ Yes ❑ No
Membership # _____ Exp. Date _____
(Membership in ACADEMY is required for participation in this plan. Affiliate members are not eligible.)

3. Payment Option*:

(Choose only one) Total Premium Contribution Enclosed: $_____

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the AAO Group Insurance Program to make ❑ monthly ❑ semiannual ❑ annual withdrawals against the account specified on the attached voided check and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Term Life Insurance Plan. (Enclose a VOIDED check.)

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

❑ **OPTION 2: PERIODIC BILLING:** ❑ Quarterly ($2.00 billing fee applies) ❑ Semiannual ($2.00 billing fee applies) ❑ Annual

* Select Annual Billing or EFT to avoid a $2.00 billing fee.

4. Insurance Requested: (Refer to the Plan Information/Plan Details for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a. Initial Member Insurance Amount: $ _____ Initial Spouse Insurance Amount: $ _____
Initial Child Insurance Amount: $2,500 each eligible child ❑
Note: Member coverage must be in force to request dependent coverage.

b. Increase Member Insurance Amount from $_____ to $_____
Increase Spouse* Insurance Amount from $_____ to $_____
*Spouse coverage cannot exceed 100% of member's coverage.

c. Do you have other life insurance in force? If "Yes," total amount in all companies:
Member: $ _____ Spouse: $_____

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

d. TOBACCO/NICOTINE USE: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?
Member: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT) Spouse: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT)

When did you last use tobacco or nicotine products? _____/_____ (MONTH/YEAR) When did you last use tobacco or nicotine products? _____/_____ (MONTH/YEAR)

e. 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 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

5. Beneficiary Designation: (Insert name, relationship and address)

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

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____ (Last First MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____ (Last First MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

6. Statement of Health: (Please initial and date any changes you make on this form.)

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

	YES	NO
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?	❑	❑
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❑	❑
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?	❑	❑
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?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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:

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

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" GIVE COMPLETE DETAILS BELOW.

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

Question Letter/No.	Name of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

7. Authorization:

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 plan 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.

7. Authorization: *(continued)*

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 indicated below and Fraud Notices indicated below, 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 X _____ **Date** _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X _____ **Date** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED; PLEASE SIGN AND DATE IN INK)

Owner's Signature X _____ **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 SPECIFIED BY NEW YORK LIFE.

4/14 ed.

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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.

FOR RESIDENTS OF CA: For your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

FOR RESIDENTS OF D.C., <u>WARNING:</u> 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 or 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: <u>WARNING</u>: 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: <u>WARNING</u>: 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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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 Term Life Insurance Plan

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 Plan 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 Plan 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 Plan 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.

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 **7/15 ed.**

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AMERICAN ACADEMY™
OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

Group Term Life Insurance

Underwritten by New York Life Insurance Company

For American Academy of Ophthalmology Members and Their Families

WHY YOU MAY NEED TO ORGANIZE YOUR FAMILY'S FINANCIAL SECURITY

Many families go without the life insurance coverage they really need because they think it is going to be too expensive.

But the simple fact is, life insurance doesn't have to be expensive. The Academy Group Term Life Insurance designed for and available to members of the American Academy of Ophthalmology has proven just that.

Feel free to compare the costs and benefits of this policy sponsored by your organization with any other now available. You'll probably find that this Group Term Life Insurance is one of your best choices in terms of quality, service, reliability, and value.

WHO IS ELIGIBLE?

American Academy of Ophthalmology (ACADEMY) members under age 65 are eligible to apply for coverage for themselves, their lawful spouses under age 60, and unmarried dependent children ages 14 days through 22 years (24 if a full-time student). In order to become insured, satisfactory evidence of insurability must be provided and the required premium contribution must be paid.

A dependent who is a member is eligible for either member or dependent coverage, but not both. If both member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

This coverage is available only for residents of the United States (excluding NC and territories) and Puerto Rico.

WHAT YOU CAN CHOOSE

FOR MEMBER

Options of $50,000 to $1,000,000 (in multiples of $10,000)*

FOR SPOUSE

Options of $50,000 to $1,000,000 (in multiples of $10,000)*
May not exceed member' coverage.

FOR EACH ELIGIBLE DEPENDENT CHILD

$2,500 ($500 at ages 14 days through 5 months)

***Coverage decreases starting at member's age 65. See "Amounts of Insurance at Member Ages 65 through 84."**

The total amount of coverage an individual may have under all group life insurance underwritten by New York Life Insurance Company may not exceed $2,000,000.

The total amount of coverage an individual may have under all group policies issued by New York Life Insurance Company to the Trustees of the Ophthalmologists Insurance Trust may not exceed the maximum benefit option for any insured person.

FEATURES VALUABLE BENEFIT...

with no increase in premium contributions

The Living Benefit or "accelerated death benefit" is designed to provide members with the option to have a portion of a terminally ill insured's life insurance benefit paid while he/she is still alive.

The money received under this feature can be used however you see fit. For example, it can help pay medical bills and other outstanding debts and financial obligations ... it can help you keep your savings and assets intact ... it can help you maintain your quality of living.

To qualify for this benefit, a person must be under age 69, and the person must be insured under this policy and be diagnosed as having a life expectancy of 12 months or less. Proof of terminal illness will consist of a statement from a doctor and any other medical information New York Life Insurance Company believes necessary to confirm the person's status.

You can request payment equal to 50% of a qualified terminally ill person's in force coverage. The request must be made at least 12 months prior to that person's scheduled coverage termination age, and the amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.) If a scheduled reduction will occur within one year of the date the advance payment will be made, the benefit payable will be 50% of the reduced coverage. (See "Amounts of Insurance After Age 64.") **Note:** An insured will be eligible for only one terminal illness benefit during his/her lifetime.

Please note that the receipt of this benefit may affect your eligibility for public assistance programs and may be taxable. You may wish to consult the appropriate social services agency and a qualified tax advisor about how this may affect your personal situation.

Volume Discounts for Member and Spouse

The more coverage you request, the more you can save! If you are insured for options $100,000 through $240,000, you'll receive a discount based on volume. If you are insured for options of $250,000 through $1,000,000, you'll receive another discount based on volume. If a program experience warrants, a premium credit or dividend maybe available. Premium credits cannot be promised or guaranteed.

Non-Smoker Discount

Reduced rates are available for qualified non-smokers.

Exclusions

Benefits for a covered person's death due to suicide, attempted suicide or intentionally self-inflicted injury during the first 24 months of coverage will be limited to a return of premium contributions.

Incontestability

The validity of any amount of your insurance which has been in force for two years during your lifetime will not be contested except for insurance eligibility provisions or nonpayment of premium contributions.

Your Choice of Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

When Coverage Ends

Insurance for you can remain in force to age 85, and for your insured dependents as long as they remain otherwise eligible, provided: (a) you continue to pay premium contributions when due; (b) you remain a member of the ACADEMY; and (c) the group policy is not terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong. Dependent coverage ends when your coverage ends. Upon your death, coverage for insured dependents may continue as described in the Certificate of Insurance.

Coverage for dependent children terminates upon their attainment of age 23 (25 if a full-time student).

Group Conversion Privilege

This policy provides conversion privileges under certain circumstances of involuntary termination as described in the Certificate of Insurance.

AMOUNTS OF INSURANCE AT MEMBER AGES 65 THROUGH 84

The amount of life insurance for you and your spouse is based on your age at last birthday and, depending upon the applicable option, may be reduced on the premium due date on or next following the day you attain a specified age, as follows:

- At age 65, options in excess of $250,000 reduce to $250,000;
- At age 70, options in excess of $100,000 reduce to $100,000;
- At age 75, options in excess of $50,000 reduce to $50,000;

All coverage terminated on the premium due date on or after a member turns 85. See the Group Conversion privilege.

Note: Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Ophthalmologists Insurance Trust.

EFFECTIVE DATE

Note: *Residents of NC: Any reference to "performing the normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application.* You and your dependents will become insured on the date specified by New York Life Insurance Company provided the initial premium contribution is paid within 31 days after the date you are billed (send no money now), satisfactory evidence of insurability has been submitted, and you and your dependents are performing the normal activities of a person in good health of like age on that date. Coverage for any person who is not performing his or her normal activities on the date coverage would otherwise become effective will not become effective until the date he or she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance. (Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date as specified by New York Life Insurance Company.)

CERTIFICATE OF INSURANCE

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustees of the Ophthalmologists Insurance Trust.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits.

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated, and you will be sent a full refund, no questions asked!

RENEWAL PAYMENTS AND CLAIMS

Once your application is approved, you will have a 31-day grace period for your payment of renewal premium contribution. When you want to submit a claim, call or write the Administrator for claim forms.

HOW TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing with ACADEMY. Please wait until your application for membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact ACADEMY directly.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your application may be used as the basis for invalidating your insurance.

The Group Term Life Insurance is medically underwritten based on the information provided by you on your Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the policy.

Apply in Two Easy Steps

1. Refer to the description for benefits and premium costs as you fill out the application. Be sure to indicate whether you are requesting coverage for your spouse and children.

   If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form or go to www.aaoinsure.mybenefitsolutions.com to download the form.

2. Mail your completed application to:

   AAO Group Insurance Program
   P.O. BOX 14533
   Des Moines, IA 50306

   Residents of Puerto Rico:
   Please send your completed application to:
   Global Insurance Agency, Inc.
   P.O. Box 9023918
   San Juan, PR 00902-3918

If you have questions about your eligibility or the features of this policy, call a Customer Service Representative toll-free at 1-800-424-9883.

This Group Term Life Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)
AAO Group Insurance Program
P.O. BOX 14533
Des Moines, IA 50306

Questions?
1-888-424-2308
www.aaoinsure.mybenefitsolutions.com

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

This Group Term Life Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29077-0
on Policy Form G-29077-0/GMR-FACE

The ACADEMY Insurance Trust incurs costs in connection with this sponsored policy. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. ACADEMY may also may receive a fee for the license of its name and logo for use in connection with this policy.

LI113P-24458

28233-HA8 11/22

YOUR COST

Current **2024** Quarterly Premium Contributions

The initial cost of insurance for you and your lawful spouse is based on your attained age when insurance becomes effective, the amount selected, and on the member's tobacco/nicotine use. The cost increases as you, the member, grow older. Premium contributions will vary depending upon the options chosen. The cost of coverage for all of your eligible dependent children under the $2,500 option is $0.95.

Non-Smoker Member Rates

Member's Age	$100,000 Option	$250,000 Option	$500,000 Option	$750,000 Option
Under 30	$11.00	$25.00	$50.00	$75.00
30–34	14.00	30.00	60.00	90.00
35–39	18.00	42.50	85.00	127.50
40–44	30.00	70.00	140.00	210.00
45–49	51.00	115.00	230.00	345.00
50–54	90.00	202.50	405.00	607.50
55–59	151.00	340.00	680.00	1,020.00
60–64†	269.00	605.00	1,210.00	1,815.00

Non-Smoker Spouse Rates

Member's Age	$100,000 Option	$250,000 Option	$500,000 Option	$750,000 Option
Under 30	$9.00	$20.00	$40.00	$60.00
30–34	11.00	22.50	45.00	67.50
35–39	15.00	35.00	70.00	105.00
40–44	24.00	55.00	110.00	165.00
45–49	41.00	92.50	185.00	277.50
50–54	72.00	162.50	325.00	487.50
55–59	121.00	272.50	545.00	817.50
60–64†	†	†	†	†

†Call the Administrator for renewal rates (at ages 65-84 for member coverage, 60-84 for spouse coverage). See section titled "Amounts of Insurance At Member Ages 65 through 84" for applicable benefit decreases. Coverage terminates at member age 85. See Group Conversion Privilege.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

The premium contributions shown reflect the current rates and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insurance under this group policy. For example, a class of insureds is a group of people all with the same issue age. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Ophthalmologists Insurance Trust.

YOUR COST

Current **2024** Quarterly Premium Contributions

The initial cost of insurance for you and your lawful spouse is based on your attained age when insurance becomes effective, the amount selected, and on the member's tobacco/nicotine use. The cost increases as you, the member, grow older. Premium contributions will vary depending upon the options chosen. The cost of coverage for all of your eligible dependent children under the $2,500 option is $0.95.

Smoker Member Rates

Member's Age	$100,000 Option	$250,000 Option	$500,000 Option	$750,000 Option
Under 30	$14.00	$30.00	$60.00	$90.00
30–34	18.00	40.00	80.00	120.00
35–39	25.00	57.50	115.00	172.50
40–44	43.00	97.50	195.00	292.50
45–49	76.00	170.00	340.00	510.00
50–54	135.00	305.00	610.00	915.00
55–59	224.00	505.00	1,010.00	1,515.00
60–64†	385.00	865.00	1,730.00	2,595.00

Smoker Spouse Rates

Member's Age	$100,000 Option	$250,000 Option	$500,000 Option	$750,000 Option
Under 30	$11.00	$22.50	$45.00	$67.50
30–34	14.00	32.50	65.00	97.50
35–39	20.00	45.00	90.00	135.00
40–44	35.00	77.50	155.00	232.50
45–49	60.00	137.50	275.00	412.50
50–54	108.00	245.00	490.00	735.00
55–59	179.00	402.50	805.00	1,207.50
60–64†	†	†	†	†

†Call the Administrator for renewal rates (at ages 65-84 for member coverage, 60-84 for spouse coverage). See section titled "Amounts of Insurance At Member Ages 65 through 84" for applicable benefit decreases. Coverage terminates at member age 85. See Group Conversion Privilege.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.

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How to Determine the Cost for Other Options

The rates shown are for qualified non-smokers requesting specified amounts of coverage. If you and/or your spouse do not qualify for non-smoker rates, or if you wish to apply for an amount not shown, please contact the Administrator for the applicable rates. If you wish to pay semi-annually or annually, multiply the rate shown by two or four, respectively.