AIATrust
Where smart architects manage risk

HBi

Complete the form and return to:
The AIA Trust Insurance Program
P.O. Box 1889, Sioux Falls, SD 57101

GROUP TERM LIFE INSURANCE PLAN APPLICATION

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

For Members of the American Institute of Architects

1 Member Information

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Member Name (First - M.I. - Last)

Address

City, State, Zip

Home Phone – – Height ft. in. Weight lb. Sex M F

Work Phone – – DOB MM/DD/YYYY SS# – –

Cell Phone – – Email For internal use only. Email will never be sold or shared.

Martial Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union (Eligibility determined by State Law)

☐ Domestic Partnership (Eligibility determined by State Law - submit a Declaration of Domestic Partnership form - not applicable in OR)

Maiden Name

Membership:

Are you now a member of AIA? ☐ Yes ☐ No **AIA Membership #**

Are you currently insured under any other AIA Plans? ☐ Yes ☐ No

If Yes, indicate which plan(s) and provide details below (person insured and amount of insurance):

PERSON(S) INSURED	AMOUNT OF INSURANCE	TYPE OF COVERAGE
	$	
	$	
	$	

RESIDENCY: In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member: ☐ Yes ☐ No	Country(ies):	If "Yes", for how long?
Spouse/Domestic Partner: ☐ Yes ☐ No	Country(ies):	If "Yes", for how long?

DEPENDENT INFORMATION:

Please complete for all persons proposed for insurance. If more than four children are proposed for insurance, attach a separate sheet. Please **sign and date** the additional sheet.

Spouse/Domestic Partner Name (First - M.I. - Last):	Social Security No: - -	Date of Birth: MM/DD/YYYY	☐Male ☐Female	Height: ft. in.	Weight: lb.

Child (Name):	Date of Birth:		Child (Name):	Date of Birth:	
1.	MM/DD/YYYY	☐Male ☐Female	2.	MM/DD/YYYY	☐Male ☐Female
3.	MM/DD/YYYY	☐Male ☐Female	4.	MM/DD/YYYY	☐Male ☐Female

Be sure to complete all pages, initial any changes and sign the last page.

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2 Insurance Requested: Refer to plan information for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☐ New Coverage ☐ Additional Coverage

NOTE: if you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

From $10,000 to $1,000,000, in $10,000 increments. Spouse/Domestic Partner Coverage from $5,000 to $500,000 in $5,000 increments not exceed member amount.

Group Term Life Insurance

☐ Member: Insurance Amount Requested $

☐ Spouse/Domestic Partner: Insurance Amount Requested $

☐ Child(ren): Children 15 days to 25 years are eligible for $5,000.

TOBACCO/NICOTINE USE: Have you or your spouse/domestic partner (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

Member: ☐ Yes ☐ No **Spouse/Domestic Partner:** ☐ Yes ☐ No

If "Yes," Please state when you last used tobacco or nicotine products and specify the product used.

Member: Product **Date:** MM/DD/YYYY

Spouse/Domestic Partner: Product **Date:** MM/DD/YYYY

FINANCIAL DATA:

Member Annual Earned Income $ Spouse/Domestic Partner Annual Earned Income $

CURRENT COVERAGE:

Member: Do you have other life insurance in force? ☐ Yes ☐ No If "Yes," total in all companies: $

Do you have other insurance applications pending? ☐ Yes ☐ No If "Yes," amount: $

Company:

Spouse/Domestic Partner: Do you have other life insurance in force? ☐ Yes ☐ No If "Yes," total in all companies: $

Do you have other insurance applications pending? ☐ Yes ☐ No If "Yes," amount: $

Company:

REPLACEMENT INFORMATION:

RESIDENTS OF ALL STATES EXECPT NEW YORK: Is the Life Insurance applied for intended to replace, discontinue or change an existing policy?

Member: ☐ Yes ☐ No **Spouse/Domestic Partner:** ☐ Yes ☐ No

RESIDENTS OF NEW YORK: I have read the important Replacement Information below. Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: ☐ Yes ☐ No **Spouse/Domestic Partner:** ☐ Yes ☐ No

IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK:
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.

3 Preferred Payment Mode

☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

Be sure to complete all pages, initial any changes and sign the last page.

CONTINUE ON PAGE 3

4 Beneficiary Designation: Insert name, address and relationship.

I make the following beneficiary designation with respect to all the insurance on my life under this AIA Trust Group Term Life Insurance Plan and If I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you want to name a different beneficiary for spouse/domestic partner coverage please contact the Administrator.) In naming more than one beneficiary, please note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 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.)

AIA Member's Primary Beneficiary is: ________ DOB MM/DD/YYYY

Address ________

City, State, Zip ________

Percent of Coverage: ____ % Relationship to AIA Member: ________ SS# ___-__-____

AIA Member's Secondary Beneficiary is: ________ DOB MM/DD/YYYY

Address ________

City, State, Zip ________

Percent of Coverage: ____ % Relationship to AIA Member: ________ SS# ___-__-____

5 Statement of Health: Please initial 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
1.	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?		
2.	Are you or any other person to be insured now ill or receiving medical attention or surgical treatment?		
3.	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 check-up, or been hospitalized or had an operation or had any illness, disease or injury?		
4.	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?		
5.	Is any person to be insured now pregnant?		
6.	During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or being treated for:		
	a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?		
	b. Arthritis, back trouble, bone or joint disorder?		
	c. Fainting spells, convulsions or epilepsy?		
	d. Sugar, blood, albumin or pus in urine?		
	e. Diabetes, kidney trouble, ulcers or digestive disorder?		
	f. Disorder of breast or reproductive organs or functions?		
	g. Nervous or mental disorder, emotional condition or psychiatric care?		
	h. Cancer, tumor or cyst?		
	i. Varicose veins, hemorrhoids or hernia?		
	j. Disorder of eyes, ears, nose or sinuses?		
	k. Thyroid, liver or respiratory disorder?		
	l. Alcoholism or drug habit?		
	m. Disorder of the blood?		
	n. 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?		

Be sure to complete all pages, initial any changes and sign the last page.

CONTINUE ON PAGE 4

5 Statement of Health: Please initial any changes you make on this form....*Continued*

If you have answered "YES" to any Questions, give complete details below. If needed attach a separate sheet.

Question Letter/#	Name(s) of Proposed Insured	Illness or Condition	Date of Onset	Duration	Treatment/ Operations	Degree of Recovery	Date
Name and Address of Physicians or Other Medical Care Practitioners or Hospitals Where Confined or Treated							

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Additional Details:

6 Fraud Notice:

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.

Be sure to complete all pages, initial any changes and sign the last page.
CONTINUE ON PAGE 5

6 Fraud Notice:...*Continued*

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: 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 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.

7 Authorization and Signature:

I understand that New York Life Insurance Company 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 authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company MIB, Inc. ("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.

A photo copy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

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 in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB, Inc.; and attest to having read the enclosed IMPORTANT NOTICE and Fraud Notices which are indicated above, including how our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature (PLEASE SIGN AND DATE IN INK)
X

Date
MM/DD/YYYY

Spouse's/Domestic Partner's Signature (NECESSARY ONLY IF COVERAGE IS REQUESTED)
X

Date
MM/DD/YYYY

Questions? Call 1-877-801-3727

Once completed and dated, this should be submitted at once to*:
The AIA Trust Insurance Program
P.O. Box 1889, Sioux Falls, SD 57101

***Residents of Puerto Rico - please send your completed application to**
Global Insurance Agency, Inc.
P.O. Box 9023919, San Juan, PR 00902-3918

Be sure to complete all pages, initial any changes and sign this page.

IMPORTANT NOTICE ON PAGE 6

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for AIA Group Term Life Insurance

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, Inc. ("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 applications 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, Inc., 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 website at www.mib.com.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean there is any insurance in force before the effective date is determined by New York Life.

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 person 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 as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company 8.12ed