GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

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 9023919 • San Juan, PR 00902-3919

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

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

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 Academy 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:_____

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 _____

3. Payment Option: (Choose only one)

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT)**: I request and authorize the AAO Group Insurance Program, Inc. to make ❑ quarterly ❑ semiannual ❑ annual withdrawals against the account specified on the attached and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group 10-Year Level Term Life Insurance Plan. (Enclose a VOIDED check.)

X _____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

❑ **OPTION 2: PERIODIC BILLING:** ❑ Quarterly ❑ Semiannual ❑ Annual

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a. Total* Member Insurance Amount Requested: $ _____

b. Total* Spouse Insurance Amount Requested: $** _____

c. Total Child Insurance Amount Requested: ❑ $2,500 each eligible child ❑ None

Note: Member coverage must be in force to request dependent coverage.

***Increased coverage requested in this application, if approved, will be issued in a separate, new Certificate of Insurance.**

****Spouse coverage cannot exceed 100% of Member's coverage.**

d. 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 _____

e. TOBACCO/NICOTINE USE: Have you and/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," _____ Spouse: ❑ Yes ❑ No If "Yes," _____

TYPE OF PRODUCT TYPE OF PRODUCT

When did you last use tobacco or nicotine product? _____/_____ When did you last use tobacco or nicotine products? _____/_____

MONTH/YEAR MONTH/YEAR

f. 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 only the insurance requested in this application for Group 10-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member – or owner of the coverage, if other than the member – as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other AAO Group 10-Year Term Life Insurance Certificate, 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 #: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #: _____

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?	❑	❑

g. Have you or your spouse (if proposed for insurance) had a parent, brother or sister who, prior to age 60, had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? [Note: This question is not applicable to MD residents.] ❑ ❑

h. Within the past two years have you or your spouse (if proposed for insurance) participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; hang gliding; parasailing; bungee jumping; organized motorcycle racing, or any type of organized motorized racing? ❑ ❑

i. Driver's License No.: Member _____ Spouse _____

State in which issued: Member _____ Spouse _____

Have you or your spouse (if proposed for insurance) had a driver's license suspended or revoked, or had any moving violations, within the last five years? ❑ ❑

6. Statement of Health: Continued...

YES NO

j. Except for residents of CT and MN, in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending?. . . . . ❑ ❑

For residents of CT and MN only, in the last seven years have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?. . . . . ❑ ❑

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:

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 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, representative 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 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)

Owner Information is required if owner is other than Applicant
(If Owner is a Trust, please submit a copy of the document with this application.)

Full Name: Last	First	Middle Initial	Relationship to Proposed Insured	Daytime Phone

Mailing Address Street	City	State	Zip Code

Tax ID#	Date of Birth	Social Security Number
	/ /	☐☐☐ – ☐☐ – ☐☐☐☐

Owner's Signature X _____ **Date** _____
(NECESSARY ONLY IF OTHER THAN MEMBER)

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.

5/13 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., 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 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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group 10-Year Level Term Life 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.**

Group 10-Year Level Term Life Insurance

AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

For American Academy of Ophthalmology Members and Their Families

Underwritten by New York Life Insurance Company

PREMIUMS AND BENEFIT OPTIONS REMAIN LEVEL FOR 10 YEARS – GUARANTEED!

Term coverage is the purest kind of life insurance, with no costly savings features. Here is term life insurance you can depend on for a full ten years, for premiums that will not go up and benefit options that will not go down. You can renew coverage up to age 75, subject to all termination of coverage provisions. Available to Academy members and spouses under age 65, the Group 10-Year Level Term Life Insurance helps you protect your family from the financial burdens of your or your spouse's premature death. Your renewal is guaranteed until age 75, provided you pay premiums when due, and the group policy remains in force. You can select a coverage amount to help meet your needs, from $100,000 up to $1,000,000 (in $50,000 units). The Policy features "Preferred" and "Select" Non-Smoker Rates and you can benefit from volume discounts when you apply for higher amounts of insurance. Plus, send no money until you are approved.

ELIGIBILITY

Members of the American Academy of Ophthalmology under age 65 may request coverage for themselves, their lawful spouse under age 65 and all unmarried dependent children ages 14 days through 22 years (24 if a fulltime student). In order to become insured, individuals must provide satisfactory evidence of insurability and the required premium must be paid.

A dependent who is also a member is eligible for either member or dependent coverage, but not both. If both the 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 (except territories), and Puerto Rico.

APPLY FOR UP TO $1,000,000 OF COVERAGE

Choose the amount of Group 10-Year Level Term Life Insurance you need to help protect you and your family for the next ten years – without the worry of premiums that could go up or benefits that could go down.

Amounts Of Insurance:
Members–$100,000 to $1,000,000 in $50,000 multiples.
Spouse–$100,000 to $1,000,000 in $50,000 multiples, not to exceed 100% of member's coverage.
Child(ren)–$2,500 ($500 at ages 14 days through five months)

The total amount of coverage an individual may have under all policies underwritten by New York Life Insurance Company may not exceed $2,000,000. In addition, the total amount of coverage an individual may have under all 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

Pay Less If You're a Qualified Non-Smoker
Non-smokers meeting the highest underwriting standards may qualify for the Policy's best rates. Other nonsmokers may qualify for higher, but still specially-negotiated rates.

Save with Volume Discounts on Higher Amounts of Insurance
If you or your spouse becomes insured for coverage amounts of $250,000 through $450,000, you'll receive a volume discount; and for amounts of $500,000 through $1,000,000 of coverage, you'll receive an even bigger discount.

Continuing Insurance After the 10-Year Term Ends
Premiums are guaranteed to remain level for the first ten years of coverage. At the end of the 10-year period, you may reapply for 10-year level term rates then in effect for a subsequent 10-year period, provided the insured person is under age 65 and otherwise eligible. If your application for a subsequent 10-year term of guaranteed rates is approved, your premium contribution will be based on the insured's person's age, health and tobacco/nicotine use at the time coverage becomes effective and will be guaranteed for a new 10-year term.

If you and your spouse are not approved for a subsequent 10-year term of guaranteed rates, or you do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis, under which premium contributions increase as the insured ages.

Help Keep Your Cost Manageable
Rates have been provided on an annual basis per $1,000 of coverage to make it easier for you to compare this coverage to other insurance offers on the market today. Two modes of payment are available to suit your budget: semiannual billing; and our semiannual or monthly Electronic Funds Transfer (EFT) option (your cost would be approximately one-half or one-twelfth, respectively, the amount you calculate from the rate chart.)

OTHER IMPORTANT INFORMATION

Valuable Living Benefit Provision "Accelerated Death Benefit"
The "Accelerated Death Benefit" option is available to help terminally ill insureds during a difficult, and often financially challenging time. Under this provision you may request one advance payment equal to 50% of your (or an insured dependent's) in force life insurance to be paid while the terminally ill person is still alive. The request must be made at least 24 months prior to the insured person's scheduled coverage termination age and the amount of insurance payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs...medical bills...outstanding debts...to help pay for experimental treatments...the cost of modifications to your home...or for a family vacation-the choice is yours.

To qualify, a terminally ill insured must provide New York Life Insurance Company with proof of terminal illness and anticipated life expectancy (12 months or less), as well as any other necessary

medical information requested. For additional details and limitations, please see the Certificate of Insurance.

Please note that receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult with the appropriate social services agency and seek the advice of a qualified tax advisor.

Exclusions
Coverage is payable for death by any cause except death from suicide during the first two years of coverage, whether sane or insane, for which the only benefit payable is the return of applicable premium contributions. The validity of any amount of your life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and non-payment of premium contributions.

You Name Your 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.

Ownership of Insurance
"Owner" means the person or entity with rights of ownership of this insurance as described in the Certificate of Insurance. If a transfer of ownership has been recorded by or on behalf of New York Life, or if initial ownership is by other than the member according to the information provided on the application,references throughout this Policy Information to "you" or "member" will mean "owner," as applicable.

Effective Date
***Note**: Residents of NC: Any reference to "performing 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.*

Insurance will take effect on the date your application is approved by New York Life Insurance Company provided the initial contribution is paid within 31 days after the date you are billed (send no money now) and any person to be insured is actively performing the normal activities of a person in good health of like age on the date of approval.

Any person who is not performing his/her normal daily activities as required will not become insured until the day he/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.

When Coverage Ends
Coverage will end when the insured person reaches age 75 (23 for children, or 25 for children who are full-time students) or earlier if: (a) premium contributions are not paid when due, (b) the group policy is terminated or modified by the Policyholder to end insurance for the group of insureds to which the member belongs, and (c) if the insured requests to terminate insurance. In addition, dependent child coverage will terminate when the child ceases to be an eligible dependent. Upon your death, coverage for your insured dependents may continue as described in the Certificate of Insurance.

Renewal Payments And Claims
Once this policy is approved, you will have a 31-day grace period for your payment of renewal premium contributions. When you want to submit a claim, call or write the Administrator for claim forms.

TO APPLY

Consider Your Eligibility
Before you request coverage, you must be a member in good standing of the Academy. Please wait until your application for membership is accepted before initiating your insurance requests. If you have any questions regarding membership, please call the Academy directly at 1-888-424-2308.

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 rescinding your insurance.

The Group 10-Year Level Term Life Insurance is medically underwritten based on the information provided by you on the 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 information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the Policy.

1. Truthfully complete and sign the application. Be sure to indicate whether you are requesting coverage for your dependents.
2. Do not send any money until New York Life Insurance Company has approved your application and notifies you of the premium contribution due, based on the information you have provided.

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.

3. 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 9023919
   San Juan, PR 00902-3919

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

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

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!

The Group 10-Year Level Term Life Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29206-0
on Policy Form G-29206-0/GMR-FACE

The Group 10-Year Level Term Life Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)

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

Any questions?
Phone:1-888-424-2308
Web: www.aaoinsure.com

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

The Ophthalmologists Insurance Trust incurs costs in connection with this sponsored program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The Academy also receives a fee for the license of its name and logo for use in connection with this coverage.

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YOUR COST

The cost of this life insurance is based upon the member or spouse's gender, amount of insurance requested, usage of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Premium contributions will vary based on the options chosen.

Only non-smokers meeting the highest underwriting standards will qualify for the "Preferred" rates shown. Other non-smokers may qualify for the higher "Select" or "Standard" rates. (Note: Smokers may only qualify for Standard Rates.) Upon approval of your application, you will be notified of the rate classification for each approved person.

Current 2026-2027 Annual Rates per $1,000 of **Insurance†** **Amounts $100,000*–$249,000††**						
	Male			**Female***		
Issue Age	**PREFERRED**	**SELECT**	**STANDARD**	**PREFERRED**	**SELECT**	**STANDARD**
20-23	0.83	0.94	2.28	0.74	0.85	1.94
24-25	0.83	0.94	2.29	0.74	0.85	1.94
26-27	0.83	0.94	2.30	0.74	0.85	1.94
28	0.83	0.94	2.32	0.74	0.85	1.96
29	0.83	0.94	2.34	0.74	0.85	1.96
30-34	0.83	0.94	2.35	0.74	0.85	1.99
35	0.83	0.94	2.42	0.74	0.85	2.03
36	0.84	0.97	2.53	0.76	0.88	2.12
37	0.86	1.01	2.69	0.80	0.91	2.28
38	0.91	1.04	2.86	0.84	0.96	2.46
39	0.96	1.10	3.10	0.88	1.02	2.69
40	1.01	1.16	3.34	0.92	1.07	2.88
41	1.06	1.24	3.65	0.98	1.15	3.10
42	1.13	1.33	4.01	1.04	1.22	3.31
43	1.20	1.42	4.42	1.13	1.32	3.58
44	1.27	1.54	4.86	1.20	1.40	3.83
45	1.39	1.66	5.32	1.26	1.50	4.12
46	1.51	1.79	5.84	1.34	1.57	4.42
47	1.64	1.94	6.41	1.40	1.67	4.74
48	1.76	2.11	7.01	1.48	1.76	5.09
49	1.93	2.29	7.63	1.56	1.86	5.44
50	2.10	2.51	8.26	1.66	1.99	5.80
51	2.28	2.72	8.87	1.76	2.10	6.17
52	2.45	2.95	9.46	1.90	2.23	6.55
53	2.64	3.22	10.08	2.03	2.36	6.95
54	2.88	3.49	10.78	2.17	2.52	7.36
55	3.11	3.80	11.58	2.32	2.70	7.78
56	3.38	4.13	12.48	2.45	2.88	8.15
57	3.65	4.48	13.43	2.59	3.06	8.51
58	3.98	4.85	14.51	2.72	3.29	8.89
59	4.36	5.30	15.78	2.90	3.52	9.38
60	4.79	5.84	17.26	3.12	3.82	10.03
61	5.28	6.44	18.88	3.41	4.16	10.86
62	5.81	7.15	20.63	3.73	4.54	11.86
63	6.43	7.94	22.69	4.12	4.99	13.00
64	7.16	8.84	25.21	4.54	5.47	14.27

†Payable via periodic billing (quarterly, semi-annually, or annually) or via the Monthly Pre-Authorized Check Payment as described previously.

††As previously noted, member an spouse benefits under this policy are available in $50,000 units.

*Male rates apply to all coverage issued to Montana residents, regardless of a person's sex.

The current annual premium for all eligible children is $3.80 for $2,500 ($500 for children ages 14 days through five months) of life insurance. Premiums are guaranteed to remain level for the first ten years of coverage. Then, if still eligible, you may reapply for the 10-year level term rates then in effect for a subsequent 10-year term. Rates for a subsequent term will be based on the insured person's age, health and tobacco/nicotine use at the time coverage becomes effective and will be guaranteed for a new 10-year term. If you and your spouse are not approved for a subsequent 10-year term of guaranteed rates, or you do not apply for a subsequent term, coverage will continue in force on a non-guaranteed rate basis, under which premium contributions increase as you age.

YOUR COST

The cost of this life insurance is based upon the member or spouse's gender, amount of insurance requested, usage of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Premium contributions will vary based on the options chosen.

Only non-smokers meeting the highest underwriting standards will qualify for the "Preferred" rates shown. Other non-smokers may qualify for the higher "Select" or "Standard" rates. (Note: Smokers may only qualify for Standard Rates.) Upon approval of your application, you will be notified of the rate classification for each approved person.

Current 2026-2027 Annual Rates per $1,000 of **Insurance†** **Amounts $250,000*–$499,000††**						
	Male			**Female***		
Issue Age	**PREFERRED**	**SELECT**	**STANDARD**	**PREFERRED**	**SELECT**	**STANDARD**
20-23	0.55	0.66	1.98	0.48	0.58	1.67
24-25	0.55	0.66	2.00	0.48	0.58	1.67
26-27	0.55	0.66	2.02	0.48	0.58	1.67
28	0.55	0.66	2.03	0.48	0.58	1.68
29	0.55	0.66	2.04	0.48	0.58	1.68
30-34	0.55	0.66	2.06	0.48	0.58	1.69
35	0.55	0.66	2.14	0.48	0.58	1.74
36	0.56	0.70	2.23	0.49	0.61	1.84
37	0.58	0.72	2.38	0.52	0.64	1.98
38	0.61	0.77	2.56	0.56	0.68	2.17
39	0.64	0.83	2.78	0.61	0.73	2.38
40	0.68	0.89	3.04	0.65	0.79	2.57
41	0.73	0.96	3.34	0.71	0.86	2.78
42	0.83	1.04	3.68	0.77	0.94	3.00
43	0.91	1.13	4.08	0.84	1.03	3.25
44	1.00	1.25	4.51	0.91	1.12	3.52
45	1.10	1.36	4.97	0.98	1.20	3.79
46	1.20	1.49	5.47	1.06	1.28	4.08
47	1.31	1.66	6.04	1.12	1.38	4.39
48	1.40	1.81	6.61	1.19	1.48	4.73
49	1.54	1.98	7.22	1.26	1.56	5.08
50	1.68	2.18	7.84	1.34	1.68	5.42
51	1.86	2.41	8.44	1.45	1.80	5.78
52	2.06	2.64	9.01	1.58	1.93	6.17
53	2.28	2.88	9.62	1.70	2.06	6.56
54	2.52	3.16	10.32	1.86	2.22	6.95
55	2.78	3.47	11.09	2.00	2.38	7.37
56	3.05	3.79	11.96	2.14	2.56	7.74
57	3.32	4.09	12.90	2.26	2.74	8.09
58	3.64	4.49	13.97	2.41	2.96	8.46
59	4.01	4.92	15.20	2.58	3.19	8.94
60	4.43	5.44	16.66	2.80	3.43	9.58
61	4.92	6.05	18.23	3.08	3.82	10.39
62	5.48	6.77	19.94	3.42	4.19	11.36
63	6.11	7.55	21.96	3.82	4.63	12.47
64	6.82	8.45	24.48	4.22	5.09	13.72

†Payable via periodic billing (quarterly, semi-annually, or annually) or via the Monthly Pre-Authorized Check Payment as described previously.

††As previously noted, member an spouse benefits under this policy are available in $50,000 units.

*Male rates apply to all coverage issued to Montana residents, regardless of a person's sex.

The current annual premium for all eligible children is $3.80 for $2,500 ($500 for children ages 14 days through five months) of life insurance. Premiums are guaranteed to remain level for the first ten years of coverage. Then, if still eligible, you may reapply for the 10-year level term rates then in effect for a subsequent 10-year term. Rates for a subsequent term will be based on the insured person's age, health and tobacco/nicotine use at the time coverage becomes effective and will be guaranteed for a new 10-year term. If you and your spouse are not approved for a subsequent 10-year term of guaranteed rates, or you do not apply for a subsequent term, coverage will continue in force on a non-guaranteed rate basis, under which premium contributions increase as you age.

YOUR COST

The cost of this life insurance is based upon the member or spouse's gender, amount of insurance requested, usage of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Premium contributions will vary based on the options chosen.

Only non-smokers meeting the highest underwriting standards will qualify for the "Preferred" rates shown. Other non-smokers may qualify for the higher "Select" or "Standard" rates. (Note: Smokers may only qualify for Standard Rates.) Upon approval of your application, you will be notified of the rate classification for each approved person.

Current 2026-2027 Annual Rates per $1,000 of **Insurance†**
Amounts $500,000*- $1,000,000††

	Male			Female*		
Issue Age	**PREFERRED**	**SELECT**	**STANDARD**	**PREFERRED**	**SELECT**	**STANDARD**
20-23	0.49	0.61	1.91	0.42	0.53	1.60
24-25	0.49	0.61	1.92	0.42	0.53	1.60
26-27	0.49	0.61	1.93	0.42	0.53	1.60
28	0.49	0.61	1.96	0.42	0.53	1.61
29	0.49	0.61	1.97	0.42	0.53	1.61
30-34	0.49	0.61	1.98	0.42	0.53	1.62
35	0.49	0.61	2.05	0.42	0.53	1.67
36	0.50	0.64	2.15	0.43	0.55	1.76
37	0.53	0.66	2.29	0.47	0.58	1.91
38	0.55	0.71	2.46	0.50	0.62	2.09
39	0.58	0.77	2.69	0.55	0.68	2.29
40	0.62	0.83	2.94	0.59	0.73	2.48
41	0.68	0.89	3.24	0.65	0.80	2.69
42	0.77	0.98	3.58	0.71	0.88	2.90
43	0.85	1.07	3.96	0.78	0.96	3.14
44	0.94	1.18	4.39	0.85	1.06	3.41
45	1.03	1.30	4.84	0.92	1.14	3.68
46	1.14	1.42	5.34	1.00	1.22	3.96
47	1.24	1.58	5.89	1.06	1.31	4.27
48	1.33	1.74	6.47	1.12	1.40	4.61
49	1.46	1.91	7.07	1.19	1.49	4.94
50	1.61	2.11	7.67	1.28	1.61	5.29
51	1.78	2.32	8.24	1.38	1.72	5.65
52	1.98	2.54	8.82	1.51	1.85	6.02
53	2.20	2.80	9.42	1.63	1.98	6.41
54	2.44	3.06	10.09	1.78	2.14	6.79
55	2.69	3.36	10.86	1.92	2.29	7.20
56	2.95	3.68	11.71	2.05	2.46	7.56
57	3.22	3.97	12.65	2.18	2.65	7.91
58	3.54	4.37	13.69	2.32	2.87	8.28
59	3.89	4.79	14.90	2.50	3.10	8.75
60	4.31	5.30	16.33	2.71	3.34	9.37
61	4.79	5.90	17.89	2.99	3.71	10.18
62	5.35	6.60	19.57	3.32	4.08	11.14
63	5.96	7.38	21.55	3.71	4.51	12.22
64	6.66	8.26	24.02	4.10	4.97	13.44

†Payable via periodic billing (quarterly, semi-annually, or annually) or via the Monthly Pre-Authorized Check Payment as described previously.

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