GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

To Apply: Complete This Form and Return, with your initial premium payment,
To: **ADMINISTRATOR**
ASHP **GROUP INSURANCE PROGRAM**
PO BOX 10374 • Des Moines, IA 50306-8812

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

QUESTIONS? Call: 1-800-503-9230
customerservice.service@mercer.com

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:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address: _____
AMBA will not share your email information

Member's Date of Birth: _____ Sex: ❑ M ❑ F
MO. DAY YR.

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. Weight _____lbs.

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)

❑ Civil Union* ❑ Domestic Partner* *Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Do you intend to reside outside the U.S. in the next 12 months?
❑ YES, Countries:_____ For how long? _____ ❑ No

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the American Society of Health-System Pharmacists? ❑ Yes ❑ No Membership # _____

B. What is your occupation? _____

Main Duties: _____

C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you at "FULL-TIME WORK"? ❑ Yes ❑ No

D. Gross Annual Income from: Salary $_____ Self-Employment $_____ (Self-employment start date _____)
(Mo./Day/Yr.)

Bonus $ _____ Commissions $_____

Total $ _____

E. YOUR ANNUAL NET EARNED INCOME $_____

Is your ANNUAL NET EARNED INCOME more than 25% above or below your previous year? ❑ Yes ❑ No

If YES, what was your ANNUAL NET EARNED INCOME last year? $ _____

If YES, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? $ _____

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal service—before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes—for any twelve-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

Your ANNUAL NET EARNED INCOME must be at least $20,000 for you to be eligible for this coverage.

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

I request the following coverage: ❑ new ❑ additional

❑ Myself only ❑ Myself and lawful Spouse/Domestic Partner

If you are increasing or altering your present amount of coverage, indicate the new TOTAL AMOUNT in item A. below.

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you have or for which you're applying does not exceed 60% of your AVERAGE MONTHLY INCOME, as defined in the brochure.

I hereby apply for the coverage indicated below, based upon all my statements made in this application:

A. **Monthly Benefit Option:** $_____ (not to exceed 60% of your monthly income)

B. **Benefit Period:** ❑ Option 65/65 ❑ Option 5/5 (Spouses may only be covered for Option 5/5)

C. **Waiting Period:** ❑ 30-day ❑ 90-day

D. Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the ASHP Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check, and such bank to process the withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Insurance Plan. (Enclose a voided check.)

_____

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

❑ **Option 2:** Periodic Billing: ❑ Semiannual A $2.00 billing fee will be included for modes other than EFT.

E. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability?

❑ Yes ❑ No IF YES, PLEASE LIST

Company	Plan	Monthly Benefit	Benefit Period

F. Do you intend to discontinue any of the disability insurance listed in "e," above, if the coverage applied for is approved? ❑ Yes ❑ No

(If "YES," please indicate which coverage and the date it will be terminated.) _____

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

To the best of your knowledge and belief, please answer the following questions as they apply to you.

	YES	NO
1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment?.....	❑	❑
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:		
a. heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?.....	❑	❑
b. 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, chronic fatigue in the past five years?.....	❑	❑
(iii) Any other impairment?.....	❑	❑
3. During the past five years have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?.....	❑	❑
4. Are you now pregnant?.....	❑	❑
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?.....	❑	❑

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

6. During the past two years, have you participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?..... YES ☐ NO ☐

7. Driver's License No.:_____State in which issued: _____

8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... ☐ ☐

9. Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?..... ☐ ☐
If "Yes," please state when you last used tobacco or nicotine products and specify the product used:

_____ Mo/Yr _____ Product

10. Except for the residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?..... ☐ ☐
For residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?..... ☐ ☐

11. If you have answered any of the above Questions 1-10 "YES," give complete details below. (If you need more space, used a signed and dated separate sheet. Please avoid the use of terms such as "etc.", "various" or "miscellaneous.")

Question Letter/No.	Member or Spouse	Illness or Condition-Date of Onset-Duration-Treatment Operation-Degree or Recovery and Date:	Name and address of Physicians or other Practitioners and Hospital where confined or treated:

FRAUD NOTICE – *For residents of all states except those listed below:* 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 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 NY: Any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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 PR: 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.

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 attached and the Fraud Notices indicated above, including how our information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature _____ **Date** _____

(PLEASE SIGN AND DATE IN INK)

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.

6/18 ed.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income 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.**

ASHP Group Disability Income Insurance

Underwritten by New York Life Insurance Company

Sponsored by the American Society of Health-System Pharmacists

Provides you and your family with up to $4,000 in monthly benefits. All benefits are paid in addition to any other disability benefits you may receive.

Here's what the ASHP Group Disability Income Insurance has to offer:

Choose from $100 to $4,000 in monthly benefits (in $100 increments). Your monthly benefit, when combined with any other disability insurance you have or for which you're applying, may not exceed 60% of your AVERAGE MONTHLY INCOME.

Choose a **30-day or 90-day waiting period**. The waiting period is the number of consecutive days you must be total disabled before you can receive benefit payments.

Choose from two coverage options.

Option 65/65 provides you with benefits up to age 65 for a covered injury or sickness that results in total disability beginning prior to age 64.

Option 5/5 pays benefits up to a maximum of five years for a covered injury or sickness that results in total disability beginning prior to age 60. For a covered disability occurring on or after age 60, but prior to age 64, benefits will be paid up to age 65. *(Spouses are eligible for Option 5/5 only.)*

For both options, a total disability occurring on or after age 64, but prior to age 70, will pay benefits for up to 12 months.

All benefits will be **paid in addition** to any other disability benefits you might receive. Monthly benefits will be paid up to the maximum benefit period selected. Monthly benefits under either option will end on the date proof of continuing disability is not provided, you are no longer disabled, the maximum benefit period ends, or you die.

WHO IS ELIGIBLE?

Members of the ASHP can request coverage for themselves and their lawful spouses/domestic partners, provided both are under age 60, at FULL-TIME WORK they reside in the United States* (except territories) and Puerto Rico. However, members or spouses on full-time active duty in the armed forces are not eligible.

*Coverage is not available in all states at this time. Contact the Administrator about availability in your state.

IMPORTANT INFORMATION

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation on the basis of at least 30 hours per week at the place where such duties are normally performed.

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal services before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes for any 12-month period.

It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

AVERAGE MONTHLY INCOME, as of any date, is calculated using the time period that that produces the highest figure: 1. immediately preceding tax year; 2. immediately preceding two tax years, or 3.The entire period, if less than 12 months.

Total Disability

During the waiting period and next 60 months, Total Disability is defined as a disability due to sickness or injury which makes you completely unable to perform the material and substantial duties of your regular occupation or profession. After such 60 months, Total Disability is defined as your complete inability to perform the material duties of any gainful job for which you are reasonably fit by education, training or experience. To be considered Totally Disabled you must also be under the regular care of a physician other than yourself, and must not be engaged in any occupation for wage or profit.

Date Insurance Begins

Coverage begins on the first of the month following approval of your application by New York Life Insurance and receipt of your first premium. Each applicant must be at FULL-TIME WORK, as defined, on the date the insurance is to take effect. If you are not the insurance will take effect on the day you resume such work, provided you are still eligible.

Date Insurance Ends

Your insurance will end at the earliest of: the date the group policy ends; the date insurance ends for the insured's class; the end of the period for which the last premium was paid by insured; the date the covered person commences full-time active duty in the armed forces; the date the covered person ceases FULL-TIME WORK, as defined, for reasons other than total disability; the premium due date coinciding with or next following the date you cease to be an ASHP member; the premium due date coinciding with or next following the date you attain age 70; or with respect to spouses, the date the marriage ends by divorce or annulment.

Exclusions

No benefits are payable for disability due to: intentionally self-inflicted injury whether sane or insane, military service, a war or act of war, committing a crime or an attempt to do so, or pregnancy (except complications described in the Certificate of Insurance). No benefits are payable for any period of disability during which you are not under the direct care and treatment of a legally qualified physician, who is not yourself or an immediate member of your family.

IMPORTANT FEATURES

Cost-of-Living Benefit
This adjustment will be made every April 1 following each completed calendar year of Total Disability. It will be the lesser of: 2/3 of the previous year's CPI-U* percentage increase or 5% of the person's net monthly benefit. The increase will apply each year until: total disability ends; the end of the maximum benefit period; or the date the net monthly benefit amount payable is at least 25% higher than it would be in the absence of this provision.

* Consumer Price Index For All Urban Consumers, All Items, as published by the Labor Statistics.

Recurrent Disabilities Benefit
A recurrent Total Disability will be covered as a new disability with a new waiting period when it occurs following six or more continuous months of the insured's return to FULL-TIME WORK, or if it is due to unrelated causes.

Residual Disability Benefit
A potion of your monthly benefit will be paid to you when you suffer a covered illness or injury after you return to work following a period of total disability which has caused a continuous reduction of earnings of at least 25%. The insurance company has the right to require any proof needed to verify your earnings and continuation of residual disability.

Rehabilitation Benefit
If you become totally disabled, the insurance company will consider a rehabilitation program for you. Monthly benefits will continue when participating in an approved vocational rehabilitation program.

The maximum benefit period for rehabilitation is 24 months. Residual disability benefits will not be paid if you are receiving, or entitled to receive, rehabilitation benefits.

Survivor Benefits
Your eligible surviving spouse or dependent children, if the spouse is not living, will receive this benefit if you should die while you are receiving Total Disability benefits, if such benefits had been paid for six or more consecutive months. The benefit equals three times the last monthly benefit paid prior to death. If the person has no eligible survivors, it is not payable.

ADDITIONAL FEATURES

Possible Tax-Free Benefits
According to current tax laws, disability benefits you receive may be tax-free. Consult your personal tax advisor for details.

Premium-Free Disability
If you should become totally disabled prior to age 60 and receive benefit payments for six consecutive months, you will not be required to pay any premiums during the disability. When you stop receiving monthly benefits, premiums must again be paid when due.

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 receive a full refund — no questions asked!

Disability Insurance helps replace a portion of your income when you can't work
If you're like most people, your employer includes short-term disability insurance in your benefits package. While this type of coverage is ideal for minor injuries and illnesses that put you out of work for a brief period of time, what would you do if a major illness or injury struck and put you out of work for months or years?

That's where the ASHP Group Disability Income Insurance steps in. It pays you up to $4,000 per month in benefits (not to exceed 60% of your AVERAGE MONTHLY INCOME) after the waiting period when you are totally disabled due to covered injury or sickness.

Long-term disability insurance protection is so important. How could you and your family cope without the salary you rely on to pay the mortgage, car loan, education costs and even everyday living expenses?

CURRENT 2023 SEMI-ANNUAL PREMIUMS PER $100 OF COVERAGE				
	OPTION 5/5		OPTION 65/65	
AGE	Benefits begin on 31st day of total disability	Benefits begin on 91st day of total disability	Benefits begin on 31st day of total disability	Benefits begin on 91st day of total disability
Under 30	$3.20	$1.45	$7.79	$3.22
30-34	4.10	1.80	10.79	4.24
35-39	5.75	2.70	15.67	6.61
40-44	7.70	4.10	21.29	9.02
45-49	9.85	6.10	26.44	12.91
50-54	12.50	9.10	30.23	18.18
55-59	16.70	13.90	31.76	20.86
60-64*	23.96	14.67	23.97	14.67
65-69*	18.03	10.89	18.03	10.89

*For renewal only, you must be under age 60 to apply. Premiums are based on your age when insurance becomes effective and increase as you enter a new age category. To determine your premium multiply the number of $100 increments by the premium noted for the waiting period you select. Insurance terminates on the premium due date coinciding with or next following the date you attain age 70.

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

ABOUT YOUR REQUEST FOR COVERAGE

New York Life reserves the right to request medical information to determine an applicant's medical eligibility for coverage. Based on the age of the person proposed for insurance and the amount of coverage requested, a physical examination, EKG, blood test or other information may be required.

Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test are free of charge.

HOW TO APPLY

1. Complete the enclosed Application Form. It is extremely important that you answer fully the questions about medical history on this form. New York Life will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage. Please note that New York Life retains the right to request additional medical information and may contact you directly.
2. Make your check for the cost of insurance requested payable to: Administrator ASHP Group Insurance Program

If you choose the Electronic Funds Transfer (EFT) Option, be sure to include a voided check in addition to the check for the first payment due.

3. Mail the Application Form together with your check in the postage-paid envelope provided or to this address:
   ASHP Group Insurance Program
   P.O. BOX 10374
   Des Moines, IA 50306-8812

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

HOW TO FILE A CLAIM

To file a claim, write the Administrator for claim forms.

This Group Disability Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30970-0
on Policy Form GMR-FACE/G-30970-0

This Group Disability Insurance is Administered by:

AMBA Administrators, Inc.

ASHP Group Insurance Program
P.O. BOX 10374
Des Moines, IA 50306-8812

Any questions?
1-800-503-9230

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

ASHP incurs costs in connection with this sponsored Program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs.

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are as set forth in the group policy issued by New York Life Insurance Company to the American Society of Health-System Pharmacists.

10/22 ed.