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

To Apply: Complete This Form And Return To:
ADMINISTRATOR
ASHP GROUP INSURANCE PROGRAM
P.O. Box 10374 • Des Moines, IA 50306-8812

For resident 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

GROUP TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN SOCIETY OF HEALTH-SYSTEM PHARMACISTS

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 ASHP Group Life Insurance Plans? ❑ Yes ❑ No

If "yes," indicate which Plan(s) and provide details (amount of insurance): ❑ Term Life
Details:_____
(Person insured and amount of insurance)

Do you 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
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
	_____ 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 three 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 Society of Health-System Pharmacists, or a lawful married spouse of such member? ❑ Yes ❑ No

Membership # _____ Exp. Date _____
(Membership in ASHP is required for participation in this plan. Affiliate members are not eligible.)

3. Payment Option:

(Choose only one)

Total Premium Contribution Enclosed: $_____

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

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

❑ **OPTION 2: PERIODIC BILLING:** ❑ Annual ❑ Semiannual ❑ Quarterly ❑ Monthly A $2.00 billing fee will be included for modes other than Annual or EFT.

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a.Initial Insurance Amount: $ _____

❑ **Initial Child Insurance Amount: $1,000** ❑ Yes ❑ No

Note: Member coverage must be in force to request Child Coverage.

b. Increase Amount from $_____ to $_____

c. **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? ❑ Yes ❑ No

Residents of All Other States:

Is the insurance applied for intended to replace, discontinue or change an existing policy? ❑ Yes ❑ No

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

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

❑ Primary ❑ Secondary %: _____

Beneficiary Name:_____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #:_____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name:_____
Last First MI

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #:_____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

BE SURE TO COMPLETE ALL PAGES AND SIGN ➡

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 an operation or had any illness, disease or injury?	❑	❑
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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

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

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

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

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

7. Authorization:

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

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

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

7. Authorization: *(continued)*

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

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

Owner's Signature X _____ **Date** _____
(NECESSARY ONLY IF MEMBER PREVIOUSLY TRANSFERRED OWNERSHIP OF HIS/HER GROUP TERM LIFE INSURANCE)

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE IN FORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

2/20 ed.

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.

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 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, 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 **8/12 ed.**

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Group Term Life Insurance

Underwritten by New York Life Insurance Company

For American Society of Health-System Pharmacist

HELP SECURE YOUR FAMILY'S FUTURE

An adequate life insurance policy is added protection against the uncertainty of tomorrow. In the unfortunate event of your death, or that of your spouse, family members who are left may be forced to change educational plans, living arrangements, or lifestyle. With the loss of your earning power, what would happen to your loved ones?

Most ASHP members already have some life insurance protection. But statistics show they probably don't have enough protection. Many financial planners suggest you carry 5 to 9 times your annual salary in life insurance. Of course, life insurance needs vary according to your family and financial situation (living expenses, mortgage payments, college education for children.)

For example: in an average situation, a 34-year old with a family and a home, making $40,000 per year might consider a minimum of $200,000 of life insurance…and similarly, a 49-year old making $55,000 per year might consider carrying at least $275,000 of coverage.

WHO IS ELIGIBLE?

ASHP members, and lawful spouse of such members under age 60 are eligible to apply for coverage for themselves and unmarried dependent children ages 6 months through 22 years. In order to become insured, satisfactory evidence of insurability must be provided and the required premium must be paid when due.

A dependent child who is a member is eligible for member coverage only. If both member and spouse are covered only one may insure any eligible children.

This coverage is available only for residents of the United States* and Puerto Rico. This coverage is not available to residents of Canada.

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

WHAT YOU CAN CHOOSE

You choose the Benefit Option That's Best for You

Options of $25,000 to $1,000,000* (in multiples of $1,000)

FOR EACH UNMARRIED DEPENDENT CHILD $1,000

The total amount of coverage for an individual insured under this policy issued by New York Life Insurance Company may not exceed $1,000,000.

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

COVERAGE FEATURES

VALUABLE BENEFIT...

for the same specially-negotiated premium

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

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

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

You can request payment equal to 50% or $50,000 (whichever is less) of a qualified terminally ill person's in force coverage. The request must be made at least 12 months prior to that person's scheduled coverage termination age, and the amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

If a scheduled reduction will occur within 6 months of the date the advance payment is approved, the benefit payable will be the lesser of 50% or $50,000 of the reduced coverage. This benefit is not available for terminal illness due to attempted suicide or intentionally self-inflicted injury. Note: An insured will be eligible for only one terminal illness benefit during his/her lifetime.

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

Exclusions

Your ASHP Group Term Life Insurance Plan provides benefits for death from any cause (except suicide during the two years your coverage is in force) … at any time … in any place throughout the world. There are no wartime or aviation restrictions in the coverage.

If a person commits suicide, whether sane or insane, within two years from the date his insurance takes effect, the only benefit will be a refund of premiums paid. If a person's age, sex or any other data is misstated, the correct data will be used to determine if insurance is in force. If insurance is in force, the premium and/or benefits will be adjusted according to the facts.

Your Choice of Beneficiary

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

Premiums Are Waived If You're Totally Disabled

If you become totally disabled (as defined in your certificate) before age 60, and remain so disabled for 6 consecutive months or longer, your insurance will be continued as long as you remain totally disabled without additional premium contributions until coverage terminates when you reach age 80. The amount continued will be based on the options under which you and your dependents were insured at the time your disability began, subject to the scheduled decreases. You may be asked to provide evidence of your continued total disability from time to time.

Amounts at Later Ages

Coverage amounts will reduce to 50% at age 65, and further reduce to $5,000 at age 70. Premium does not decrease.

When Coverage Ends

Your insurance will continue automatically until your 80th birthday, as long as you pay your premium when due, the Group Policy remains in force and insurance does not end for your class or the amount of insurance for any covered person, less the amount of an Accelerated Death Benefit paid, equals zero or less. Dependent's insurance will continue until your insurance ends under the group policy, the group policy is changed to end dependents' life insurance except dependent insurance can continue if your coverage ended due to payment of an Accelerated Death Benefit in which the benefit amounts reduced to zero or less or the person ceases to be a dependent.

High Levels of Coverage

You may select from $25,000 up to $1,000,000 (in 1,000 or 5,000 increments) for yourself.

Children over 6 months of age through age 22 may receive $1,000 of coverage. You are automatically the beneficiary of your dependents' coverage.

EFFECTIVE DATE

You and your dependent children will become insured on the date specified by New York Life Insurance Company provided the initial premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you are performing the normal activities of a person in good health of like age [NC residents: a person of like age] on the date coverage is to become effective. If you are not performing your normal daily activities as required, you will not become insured until the day you are performing such activities provided such date is within three months of the date insurance would have been effective, and you are still eligible. (Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date as specified by New York Life Insurance Company.)

Pay Less If You're a Non-Smoker

If you qualify as a non-tobacco user, your premiums will be reduced.

Group Conversion Privilege

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

CERTIFICATE OF INSURANCE

This brochure contains only a brief description of some 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 the Trustee of the Qualified Association and Organization 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!

RENEWAL PAYMENTS AND CLAIMS

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

HOW TO APPLY

Consider Your Eligibility

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

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals. We also request that you provide the following information for everyone you are requesting coverage on as well as on any named beneficiary: full name, address, date of birth, Social Security number, and telephone number. Please call 1-800-503-9230 to complete this request. If you prefer enclose a separate piece of paper with this information together with your application.

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

This Group Term Life Insurance is medically underwritten based on the information provided by you on your Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested.

A physical exam, EKG, blood test or other medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the program.

Apply in Three Easy Steps

1. Refer to the Coverage description for benefits and premium costs as you fill out the application. Be sure to indicate whether you are requesting coverage for your spouse and children.
2. Make out your check for the total premium contribution due, payable to: Administrator, ASHP Insurance Program. If you choose the convenient Electronic Funds Transfer (EFT), be sure to include a voided check in addition to the check for the first payment due.
3. Mail the completed application with your check to the Administrator in the postage-paid envelope provided.

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

If you have questions about your eligibility or the features of this Plan, call a Customer Service Representative toll-free at 1-800-503-9230.

This Group Term Life Insurance Policy is Administered by:

AMBA
ASSOCIATION MEMBER BENEFITS ADVISORS

AMBA Administrators, Inc.
ASHP Group Insurance Program
P.O. Box 10374
Des Moines, IA 50306-8812

1-800-503-9230
www.ashpinsurance.com

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

This Group Term Life Insurance Policy is Underwritten by:

NEW YORK LIFE

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30850-0
on Policy Form GMR-FACE/G-30850-0

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

The ASHP 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 ASHP also receives a fee for the license of its name and logo for use in connection with this coverage.

YOUR COST

Current 2023 Quarterly Rates for Member and Spouse per $1,000 of Life Insurance

The cost of this life insurance is based upon your gender, amount of insurance requested, usage of tobacco/nicotine products, and attained age on the date coverage is issued. Cost increases as you grow older and enter a new age bracket. Premium contributions will vary depending upon the options chosen. All of your eligible children can be insured for $1,000 each for $0.71 quarterly.

For Benefit Amounts of $100,000 or Less

Age	Non-Smoker Male	Smoker Male	Non-Smoker Female	Smoker Female
Under 30	$0.23	$0.29	$0.18	$0.25
30-34	$0.36	$0.43	$0.24	$0.31
35-39	$0.45	$0.56	$0.33	$0.44
40-44	$0.68	$0.82	$0.48	$0.63
45-49	$0.98	$1.29	$0.71	$0.93
50-54	$1.61	$2.10	$1.15	$1.51
55-59	$2.44	$3.17	$1.96	$2.56
60-64*	$3.58	$4.67	$2.90	$3.80
65-69*	$5.92	$7.71	$4.74	$5.98
70-74*	$10.42	$13.60	$8.86	$11.03
75-79*	$15.57	$20.37	$13.10	$18.32

For Benefit Amounts Over $100,000

Age	Non-Smoker Male	Smoker Male	Non-Smoker Female	Smoker Female
Under 30	$0.20	$0.25	$0.16	$0.23
30-34	$0.31	$0.37	$0.22	$0.28
35-39	$0.39	$0.49	$0.30	$0.39
40-44	$0.60	$0.72	$0.44	$0.56
45-49	$0.86	$1.14	$0.63	$0.82
50-54	$1.41	$1.85	$1.02	$1.32
55-59*	$2.15	$2.79	$1.73	$2.25
60-64*	$3.15	$4.12	$2.55	$3.34
65-69*	$5.21	$6.79	$4.16	$5.26
70-74*	N/A	N/A	N/A	N/A
75-79*	N/A	N/A	N/A	N/A

*For renewal only.

Payment options include: Automatic monthly check withdrawal and semi-annual direct bill. If you select semi-annual direct bill, find the appropriate quarterly rate above and multiply by 2 to figure your premium. The rates shown will not be changed unless they are changed for all insureds in your classification.

A $2.00 billing fee will be included for Quarterly or Monthly billing modes. To avoid this fee, select the Annual mode or EFT (Electronic Funds Transfer).