AMERICAN COLLEGE OF SURGEONS
Inspiring Quality: Highest Standards, Better Outcomes
100+years

Application for Insurance
American College of Surgeons Insurance Program

Complete this form and return to the ACS Insurance Plan Administrator:
AmWins Group Benefits Inc. ♦ P.O Box 153054 ♦
Irving, TX 75015-3054 ♦ Questions? Call 1-800-433-1672

Please print in ink or type all answers – initial and date any changes you make to this form

Request for Group Insurance From New York Life Insurance Company
51 Madison Avenue • New York, NY 10010

GROUP POLICY G-29000-0 G-29002-0 G-29002-1 G-29003-0 G-29004-0 G-29005-0 G-29006-0, G-29007-0	ACS ID NUMBER
SOCIAL SECURITY NO.	DATE OF BIRTH MM/ DD /YYYY

MEMBER'S FULL NAME (Last, First, MI)	❒ MALE ❒ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
BILLING ADDRESS (STREET) / CITY	STATE	ZIP CODE	
HOME ADDRESS (STREET) / CITY	STATE	ZIP CODE	
HOME PHONE ( ) / OFFICE PHONE ( ) / FAX NUMBER ( )	EMAIL ADDRESS		

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union* ☐ Domestic Partnership*
Maiden name_____ *Eligibility determined by State Law)

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: ❒ Yes ❒ No Country(ies)_____ For how long?_____
Spouse: ❒ Yes ❒ No Country(ies)_____ For how long?_____

BILLING INSTRUCTIONS (choose only one)

☐ **OPTION 1: AUTOMATIC PAYMENT:** I request and authorize ACS Insurance Program to make ☐ Monthly ☐ Quarterly ☐ Semiannual ☐ Annual withdrawals against the account specified on the attached ☐ Voided Check ☐ Statement Savings Account Deposit Slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.) I understand I will be notified in advance of the amount to be deducted initially and when it changes.

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

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

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

lawful Spouse and unmarried, dependent children as described in the brochure *If necessary attach a separate signed and dated sheet to provide additional dependent information*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	❒ MALE ❒ FEMALE	HEIGHT ft. in.	WEIGHT lbs.

Child (Name) 1.	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE	Child (Name) 3.	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE
Child (Name) 2.	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE	Child (Name) 4.	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE

BENEFICIARY DESIGNATION (*If necessary, attach separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect to: (a) all the insurance on my life under the Traditional Group Term Life and Accidental Death & Dismemberment Insurance Plan(s) being applied for under this application, and if I am already covered under the Plan(s), I hereby revoke any prior beneficiary designation; (b) ONLY the new insurance requested and issued as a result of this application for Group 10-Year/15-Year/20-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy

(If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other 10-, 15-. or 20-Year Term Life Insurance Certificate, contact the Trust Office at the number provided below). 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.

BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

BE SURE TO COMPLETE ALL PAGES AND SIGN PAGE 4

Application continued – see following page

Do Not Send Payment: Upon approval, you will be notified of the premium due

I HEREBY APPLY FOR THE COVERAGE CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION:

(Refer to www.acs-insurance.com, the brochure or your certificate for eligibility, options and coverage descriptions)

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

AGGREGATE LIFE INSURANCE MAXIMUM: The maximum amount a member may have under all life insurance plans combined is $4,000,000; spouse $2,000,000. Child(ren) may only be covered under one plan.

☐ **10-Year Level Term Life Insurance** (G-29004-0) (check one) ❒ New Application ❒ Additional Coverage

Member coverage available from $100,000 up to $4,000,000 in units of $50,000 …… $ _____

Spouse coverage available from $100,000 up to $2,000,000 in units of $25,000 …… $ _____
(Spouse coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children under age 25 may be covered for $10,000 ($100 from birth to 15 days).. ☐ $10,000 each

☐ **15-Year Level Term Life Insurance** (G-29006-0) (check one) ❒ New Application ❒ Additional Coverage

Member coverage available from $100,000 up to $4,000,000 in units of $50,000 …… $ _____

Spouse coverage available from $100,000 up to $2,000,000 in units of $25,000 …… $ _____
(Spouse coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children under age 25 may be covered for $10,000 ($100 from birth to 15 days).. ☐ $10,000 each

☐ **20-Year Level Term Life Insurance** (G-29005-0) (check one) ❒ New Application ❒ Additional Coverage

Member coverage available from $100,000 up to $4,000,000 in units of $50,000 …… $ _____

Spouse coverage available from $100,000 up to $2,000,000 in units of $25,000 …… $ _____
(Spouse coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children under age 25 may be covered for $10,000 ($100 from birth to 15 days).. ☐ $10,000 each

☐ **Traditional Group Life Insurance** (G-29000-0) (check one) ❒ New Application ❒ Additional Coverage

Member coverage available from $100,000 up to $4,000,000 in units of $50,000 …… $ _____

Optional Chronic Care Rider indicate the Amount of Life Insurance (up to $1Million) applicable to this rider ☐ None / $ _____

Spouse coverage available from $50,000 up to $2,000,000 in units of $25,000 (not to exceed member amount)$ _____

Optional Chronic Care Rider indicate the Amount of Life Insurance (up to $1Million) applicable to this rider ☐ None / $ _____
(Spouse coverage may not exceed your own coverage at time of application)

Child(ren) Unmarried dependent children under age 25 may be covered for $10,000 ($100 from birth to 15 days).. ☐ $10,000 each

LIFE INSURANCE QUESTIONS Must Be Completed if applying for Life Insurance

Do you have other life insurance in force? **Member:** ❒ Yes ❒ No **Spouse):** ❒ Yes ❒ No

If "Yes," total amount in all companies: Member: $_____ Spouse: $_____

Do you have other insurance applications pending? If "Yes," indicate amount and company:

Member: ❒ Yes ❒ No Amount $_____ Company_____

Spouse: ❒ Yes ❒ No Amount $_____ Company_____

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance

Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? **Member:** ❒ Yes ❒ No **Spouse:** ❒ Yes ❒ No

Residents of New York: I have read the Important Replacement Information on page 3. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Member:** ❒ Yes ❒ No **Spouse:** ❒ Yes ❒ No

BE SURE TO COMPLETE ALL PAGES AND SIGN PAGE 4

Application continued – see following page

COVERAGE SELECTION (CONTINUED)

☐ **Disability Income Insurance** (G-29002-0) (check one) ❒ New Application ❒ Additional Coverage

NOTE: Your Group ACS Long Term Disability, together with all other disability benefits you already carry, may not exceed 60% of your Average Monthly Income, or a total of $15,000, whichever is less.

Member Total Monthly Benefit Desired ($1,000 to $15,000 in $100 Units) ..... $ _____

Member WAITING PERIOD..... ☐ 30-day ☐ 60-day ☐ 90-day ☐ 180-day

Member Optional LTD Benefits - By checking the boxes below, I hereby apply for the following Optional Benefits

❒ Cost of Living Adjustment (COLA) Option

❒ Future Purchase Option (FPO) – ($500 to $7,500 in $500 units)..... $_____
NOTE: The FPO may not exceed Monthly Benefit in force and when combined may not exceed $15,000 plan maximum

Spouse Disability Insurance ..... ☐ $500 Monthly Benefit/30-day Waiting Period

Do you have in force or are you applying for any other disability income insurance? ❒ Yes ❒ No

If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above? ☐ Yes ☐ No If yes, indicate which, and date it will be terminated_____

☐ **Professional Overhead Expense Insurance** (G-29002-1) (check one) ❒ New Application ❒ Additional Coverage

MAXIMUM BENEFIT PERIOD: 24 Months **WAITING PERIOD**: 30-day

POE Monthly Benefit ($500 to $10,000 in $100 increments and $1,000 increments from $10,000 to $20,000)

Member Total Monthly Benefit Amount Desired..... $_____

NOTE: If you have partners, share office facilities, or are a member of a professional corporation, request a Monthly Benefit Amount equal to your share of expenses

1. What was your average monthly amount of eligible overhead expenses in the past 6 months? _____
2. If practicing as a partnership or corporation, for what percentage of these were you responsible? _____%

☐ **Accidental Death & Dismemberment Insurance** (G-29003-0) (check one) ❒ New Application ❒ Additional Coverage

Member coverage up to $500,000 Principal Sum in units of $50,000..... $ _____

Spouse Principal Sum Desired: $50,000 or $100,000..... $ _____
(Your spouse coverage may not exceed your own coverage at time of application)

☐ **Hospital Indemnity** (G-29007-0) ❒ New Application ❒ Please change my coverage

Daily Benefit amount available from $100 to $500 in $100 units ..... $ _____

Persons to be insured: ❒ Member Only ❒ Member plus One Dependent ❒ Member plus Two or More Dependents

THIS QUESTION MUST BE ANSWERED FOR HOSPITAL INDEMNITY COVERAGE TO BECOME EFFECTIVE:
Do you understand that the Hospital Indemnity Plan will not pay benefits for a confinement resulting from any condition which required medical care or treatment during the 12 months preceding an insured individual's effective date until: (a) such person has not consulted a doctor, received medical services or supplies or taken any medications for a continuous period of 12 months; or (b) after such person has been continuously insured under the Policy for 24 months? ❒ Yes ❒ No

MEDICAL HISTORY Please indicate the best contact number for a Service Provider to contact you and/or your spouse on behalf of New York Life Insurance Company for Medical History.
(Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)

Member	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile	**Spouse**	Contact #_____ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile

BE SURE TO COMPLETE ALL PAGES AND SIGN PAGE 4
Initial and date any changes you make to this form

Application continued – see following page

I request the group insurance shown on page(s) 2 and/or 3 of this application. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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, and on any supplemental forms, and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy. **I understand** that insurance will become effective on the first day of the month on or following the day approved by New York Life if: (a) I am alive on that date and the initial contribution is paid within 31 days after the date I am billed; (b) I and any approved dependents are actively performing the normal activities of a person in good health of like age on the effective (residents of NC "performing normal activities" is replaced by the requirement that health status remains the same as stated on the application); (c) for Disability and Overhead Insurance, I am actively working 30 or more hours per week on the date such insurance would take effect; and (d) for Hospital Indemnity Insurance any person proposed for insurance is not in a hospital or other medical institution on the approval date. Any person who is so confined will not become insured until the date he/she is no longer so confined, provided the person is still eligible for insurance.

HOSPITAL INDEMNITY INSURANCE IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, its subsidiaries, or the plan administrator about the physical and mental health of any persons proposed for insurance, including *significant history, findings, diagnosis and treatment, but excluding psychotherapy notes 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 representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked. 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 my/our protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated above including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

REVIEW THE ANSWERS ON THIS APPLICATION CAREFULLY. IF ANY OF YOUR ANSWERS ARE INCORRECT OR UNTRUE, EVEN IF UNINTENTIONAL, THE COMPANY MAY HAVE THE RIGHT TO DENY BENEFITS OR RESCIND YOUR COVERAGE IF THE MISREPRESENTATION IS DEEMED TO BE MATERIAL

IF I AM APPLYING FOR HOSPITAL INDEMNITY INSURANCE I HEREBY ATTEST THAT I AM PURCHASING THIS COVERAGE AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Member's Signature_____ Date_____

Spouse Signature _____ Date_____
(Necessary only if Spouse coverage is requested)

Application continued – see following page

Return completed form to the
ACS Insurance Plan Administrator:
AmWins Group Benefits Inc.
P.O Box 153054 ♦ Irving, TX 75015-3054
Questions? Call 1-800-433-1672

IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue, or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

FRAUD NOTICES – Please read before signing the application –

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.

RESIDENTS OF CA: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

FOR RESIDENTS OF D.C., WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

RESIDENTS OF FL: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

RESIDENTS OF KS: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of insurance fraud as determined by a court of law.

RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

RESIDENTS OF MD: Any person who knowingly or willfully presents a false and 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 (applicable to Accident and Health Insurance only)**:** 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 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.

Please retain a copy for your records

IMPORTANT NOTICE:

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

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, or a claim for benefits is submitted to a MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying New York Life in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, of the application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866- 692-6901 (TTY 866 346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. Information for consumers about MIB may be obtained on its website 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 person or prospective insured person.*

[2] ***CONFIDENTIAL ABUSE INFORMATION*** *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company 8.12ed