

1 Member Information (Continued)

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? If "Yes" please list: (Attach a separate sheet if necessary, sign and date)

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

2 Insurance Requested: (refer to brochure for eligibility, options, and coverage description)

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

Monthly Benefit: \$ _____ (from \$100 to \$15,000 per month in \$100 units)

Waiting Period (check one): 15 days 30 days

1) Average monthly amount of "Eligible Overhead Expenses" in preceding 6 months \$ _____

2) Practicing as: Corporation Partnership Individual

3) Average number of Employees: _____

4) What percent of the monthly "Eligible Expenses" are you responsible for: _____%

3 Statement of Health: Please initial 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 |
|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------|-----------------------|
| A. Are you now ill or taking any prescribed medications or receiving or contemplating any medical attention or surgical treatment? | <input type="radio"/> | <input type="radio"/> |
| B. 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: | <input type="radio"/> | <input type="radio"/> |
| 1. 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? | <input type="radio"/> | <input type="radio"/> |
| 2. other health or physical impairment including (in the past five years): | | |
| a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="radio"/> | <input type="radio"/> |
| b. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue? | <input type="radio"/> | <input type="radio"/> |
| c. Any other impairment? | <input type="radio"/> | <input type="radio"/> |
| C. During the past five years have you ever been counseled, treated, or hospitalized for the use of alcohol or drugs? | <input type="radio"/> | <input type="radio"/> |
| D. Are you now pregnant? | <input type="radio"/> | <input type="radio"/> |
| E. Are you now disabled, or have applied for or are applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance? | <input type="radio"/> | <input type="radio"/> |
| F. During the past two years, have you participated in, or do you plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or any type of organized motorcycle racing? | <input type="radio"/> | <input type="radio"/> |

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4 Fraud Notice: (Continued)

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: For 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.

AUTHORIZATION

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, 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 [my/our] protected health information to MIB, LLC; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how my 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 (PLEASE SIGN AND DATE IN INK)

X

Date: - -
MONTH DAY YEAR

Once completed and dated, this should be submitted at once to the AOA Group Insurance Office at the address below.

AOA Group Insurance Program • P.O. Box 26860 • Phoenix, AZ 85068-9961 • 1-866-331-0180

G-29336-3

Be Sure to Complete All Pages and Sign This Page