

**GROUP 10-YEAR LEVEL TERM LIFE APPLICATION
AMERICAN MARKETING ASSOCIATION INSURANCE PROGRAM**



Insurance Program
1-800-233-3938

COMPLETE THIS FORM AND RETURN

**TO:
NEBCO
P. O. Box 152501
Irving, TX 75015-2501**
*Please Print in Ink or Type All Answers.
Initial and date any changes you make.*



The Company You Keep.®
**Request for Group Insurance from
New York Life Insurance Co.
51 Madison Avenue
New York, NY 10010**

Member's full name: Last			First	MI	AMA Member Number	
What is your occupation?				Email Address		<input type="checkbox"/> Male <input type="checkbox"/> Female
Billing Address	Street	City		State	Zip Code	
Home Address	Street	City		State	Zip Code	
In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada? Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Country(ies): _____ For how long? _____ Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No Country(ies): _____ For how long? _____						
Date of Birth	Height		Weight		Social Security Number	
Mo. Day Yr.	Ft. Ins.	Lbs.				
Home Phone Number		Office Phone Number		Fax Number		
Area Code ()		Area Code ()		Area Code ()		
Marital Status:	Are you presently insured under the AMA Life Insurance Plan?			BILLING INSTRUCTIONS:		
<input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced <input type="checkbox"/> Single	<input type="checkbox"/> Yes <input type="checkbox"/> No Please provide details: _____			Please send premium statements <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annually <input type="checkbox"/> Annually		

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: <i>(Refer to brochure for eligibility and coverage description.)</i>	
<p>MEMBER COVERAGE AVAILABLE IN \$10,000 INCREMENTS FROM \$10,000 TO \$1,000,000.</p> <p>A. Plan Requested: <input type="checkbox"/> 10-Year Level Term Life Insurance</p> <p>B. Amount Requested: Total Member Amount Desired \$ _____</p> <p>One of the following must be checked: <input type="checkbox"/> Member Only ... <input type="checkbox"/> Member & Spouse* <input type="checkbox"/> Member & Children** ... <input type="checkbox"/> Member & Family**</p> <p>Total Spouse Amount Desired \$ _____</p>	<p>C. Smoking Status:</p> <p>Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months?</p> <p>Member: <input type="checkbox"/> Yes <input type="checkbox"/> No Spouse: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, when did you last use tobacco or nicotine products?</p> <p>Member: _____ mo/yr Spouse: _____ mo/yr</p>

* Spouse coverage available in \$10,000 increments from \$10,000 to \$1,000,000, not to exceed member's benefit.
 ** Dependent Children's coverage: age 15 days to 6 months - \$250, age 15 days to 23 years (age 26 if a full-time student) - \$3,000 for each child.
 - Member must apply for, or already have in force, a minimum of \$10,000 AMA Term Life Insurance in order to cover your spouse and/or dependent children. See plan details for definition of eligible dependents.

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS (i.e. lawful spouse and unmarried, dependent children under age 25):				
Full name (first, last, middle initial):	Date of Birth (mm/dd/yy)	Height (Ft., In.)	Weight (lbs.)	Sex M/F
Spouse:				
Child:				
Child:				

If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

D. INSURANCE REPLACEMENT

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

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: Yes No **Spouse:** Yes No

RESIDENTS OF OTHER STATES:

Is the Insurance applied for intended to replace, discontinue or change an existing policy?

Member: Yes No **Spouse:** Yes No

ALL RESIDENTS: IF ANY OF THE ABOVE ARE ANSWERED YES, PLEASE COMPLETE BELOW.

Do you have other life insurance in force? If "Yes," total amount in all companies:

Member: \$ _____ **Spouse:** \$ _____

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

Member: \$ _____ **Company** _____ **Spouse:** \$ _____ **Company** _____

BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to all the insurance on my life under this Group 10 Year Level Term Life Insurance Plan that I have selected and if I am already covered under this Plan, I hereby revoke any prior beneficiary designation.. The beneficiary for dependent coverage shall be the insured member – or owner of the coverage if other than the member – as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, please contact the Administrator). (1) In naming more than one beneficiary, please 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.)

Beneficiary: Primary Secondary % _____

Last Name First Name Middle Initial

Beneficiary's Relationship to Member

Social Security Number

Beneficiary: Primary Secondary % _____

Last Name First Name Middle Initial

Beneficiary's Relationship to Member

Social Security Number

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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 and all dependents to be insured.	YES	NO
a. Are you or any other person to be insured disabled or receiving any disability or worker's compensation benefits or on waiver or premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
b. Are you or any person to be insured now ill or receiving medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
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 check-up, or been hospitalized or had an operation or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
e. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
f. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or being treated for:	<input type="checkbox"/>	<input type="checkbox"/>
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>
2. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3. Fainting spells, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>
5. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
6. Disorder of breast or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>
7. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>
8. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
9. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
10. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
11. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
13. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
14. Other health or physical impairment including:	<input type="checkbox"/>	<input type="checkbox"/>
i. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
ii. Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
iii. Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>
g. (This question does not apply to residents of Maryland.) Have you or has your spouse had a parent, brother or sister who prior to age 60, was medically diagnosed by a physician as having, or being treated for, cancer, stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, or neuromuscular or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
h. Within the past two years have you or has your spouse participated in, or do either of you within the next two years plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, organized motorcycle racing, rodeo riding, snowmobiling, any type of motorized racing, hang-gliding, parasailing or bungee jumping?	<input type="checkbox"/>	<input type="checkbox"/>
i. Driver's License No.: Member: _____ Spouse: _____ State in which issued: Member: _____ Spouse: _____ Have you or your spouse had driver's license suspended or revoked, or had any moving violations, within the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
j. Except for residents of CT and MN , in the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction, or have an arrest pending? For residents of CT and MN only , in the last seven years, have you and/or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	<input type="checkbox"/>	<input type="checkbox"/>

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(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operation-Degree of Recovery and Date:	Name and Address of Physicians or other Medical Care Practitioners or Hospital where confined or treated:

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DECLARATION: I request the group insurance shown above. 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 that any material misstatements or failures to report information material to risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I UNDERSTAND that: (a) insurance will become effective on the date approved by New York Life if I and any approved dependents are performing the normal activities of a person in good health of like age (or with respect to North Carolina residents, performing the normal activities of a person of like age) on that date and the initial contribution is paid within 31 days after the date I am billed; and (b) any dividends apportioned to the group policy will be paid to the Group Policyholder of the Insurance Plan.

Fraud Warning Statements

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 AR and LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

FOR RESIDENTS OF 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.

FOR RESIDENTS OF D.C., the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by 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 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 denial of insurance benefits.

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 TN and 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 authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering my request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. New York Life may release information covered by this AUTHORIZATION to the Plan Administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. 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. A photocopy of this request form shall be as valid as the original. I acknowledge that if I or my authorized agent may request a copy of this signed AUTHORIZATION.

By signing and dating this application, I and my spouse (if proposed for insurance), request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest that to the best of my knowledge and belief, the statements made regarding my health are **true and complete**.

x _____ **DATE**

Member's Signature (Please sign and date in ink)

x _____ **DATE**

Spouse's Signature (Necessary only if spouse coverage is requested)

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



INSURANCE PROGRAM

1-800-233-3938

www.nebenefit.com/ama

IMPORTANT NOTICE:

How New York Life Underwrites Your Request For Group Level Term Life Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may make a brief report to MIB; however, we will not disclose our underwriting decision. 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.

MIB is a nonprofit organization of life insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or nonmedical information may be given to the Bureau, which may then be furnished to member companies.

If we cannot provide the coverage you request, 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 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 at P.O. Box 105, Essex Station, Boston, MA 02112, telephone (617) 426-3660. For Canadian residents, the address is 330 University Avenue, Suite 403, Toronto, Canada M5G 1R7, telephone (416) 597-0590 (TTY 866-346-3642).

For NM Residents: *PROTECTED PERSONS* have a right of access to certain CONFIDENTIAL ABUSE INFORMATION** 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 current address.*

** 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.*

*** 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.*

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean that there is any insurance in force before the effective date as determined by New York Life.