GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN ACADEMY OF OPHTHALMOLOGY

AMERICAN ACADEMY™ OF OPHTHALMOLOGY
Protecting Sight. Empowering Lives.

To Apply: Complete This Form and Return To:
ADMINISTRATOR
AAO GROUP INSURANCE PROGRAM
PO BOX 10374 • Des Moines, IA 50306-8812

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

QUESTIONS? Call: 1-888-424-2308
customerservice.service@mercer.com

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

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Member Information:

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Please check one: ❑ Home address ❑ Business address

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

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address: _____
Mercer Consumer will not share your email information.

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

Height: _____ft _____in. Weight _____lbs.

❑ Civil Union* ❑ Domestic Partner* (Submit a completed Declaration of Domestic Partnership form—not applicable in OR.)
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

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

2. Membership Affiliation – Occupational Status:

A. Are you now a Member of the American Academy of Ophthalmology? ❑ Yes ❑ No Membership # _____

B. What is your occupation? _____

Main Duties: _____

C. "FULL-TIME WORK" means the active performance of the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours per week at the place such duties are normally performed. Are you at "FULL-TIME WORK"? ❑ Yes ❑ No

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

Bonus $ _____ Commissions $_____

Total $ _____

E. YOUR ANNUAL NET EARNED INCOME $_____
Is your ANNUAL NET EARNED INCOME more than 25% above or below your previous year? ❑ Yes ❑ No
If YES, what was your ANNUAL NET EARNED INCOME last year? $ _____
If YES, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? $ _____

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

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

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

I request the following coverage: ❑ new ❑ additional
If you are increasing or altering your present amount of coverage, indicate the new TOTAL AMOUNT in item A. below.

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

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

A. **Monthly Benefit Option:** $_____

B. **Benefit Period:** ❑ Career Plan ❑ Two Year Plan

C. COLA Benefit (Career Plan Only) ❑ Yes ❑ No

D. **Waiting Period:** ❑ 90-day ❑ 180-day (Career Plan Only)

E. Payment Option Selected:

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

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

❑ **Option 2:** Periodic Billing: ❑ Quarterly ❑ Annual ❑ Semiannual

F. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability?
❑ Yes ❑ No IF YES, PLEASE LIST

Company	Plan	Monthly Benefit	Benefit Period

G. Do you intend to discontinue any of the disability insurance listed in "f," above, if the coverage applied for is approved? ❑ Yes ❑ No
(If "YES," please indicate which coverage and the date it will be terminated.) _____

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

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

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

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

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

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

8. During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... YES ❑ NO ❑

9. Tobacco/Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?..... YES ❑ NO ❑
If "Yes," please state when you last used tobacco or nicotine products and specify the product used:

_____ Mo/Yr _____ Product

10. Except for the residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?..... YES ❑ NO ❑

For residents of Minnesota and Connecticut, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?..... YES ❑ NO ❑

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

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

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

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, 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, representative or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

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

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

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

8/14 ed.

Fraud Notices

FRAUD NOTICE – *For residents of all states <u>except</u> 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. **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 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 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 DC, 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 is 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 any insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.

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

Residents of NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Residents of NY: Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Residents of OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.

Residents of PR: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for 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 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.

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IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income Insurance Plan

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, 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 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, Inc. 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901.

Information for consumers about MIB may be obtained on its Web site at www.mib.com.

For NM Residents: PROTECTED PERSONS[1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION[2]*** *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1]PROTECTED PERSON *means a victim of domestic abuse; who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured or prospective insured person.*

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

New York Life Insurance Company **7/15 ed.**

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Group Disability Income Insurance Plan

For Members of the American Academy of Ophthalmology
Underwritten by New York Life Insurance Company

INSURE YOUR INCOME—ONE OF YOUR MOST VALUABLE ASSETS

One of your most valuable assets is your ability to earn income. A sudden accident or illness could jeopardize the career and the lifestyle you have worked so hard to build. This Plan can help replace the sizable amount of lost income you would suffer if you were Totally Disabled — income you'll need to help meet personal expenses: food, clothing, loans, mortgages, cars, tuitions, medical expenses, bills, credit cards, phone and other utilities, and more. That's something medical insurance can't do for you.

Even if you have some disability insurance, it may not be enough coverage, or it may only protect against short-term disabilities. The Academy is pleased to make available to you affordable long-term disability coverage that can be used to supplement benefits you already have, or serve as primary protection.

WHO IS ELIGIBLE?

Members of the Academy who are under age 64 and at FULL-TIME WORK can request coverage, provided they reside in the United States (except TN, VT, WA and territories) and Puerto Rico and have an ANNUAL NET EARNED INCOME of at least $20,000. However, members on active duty in the armed forces and full-time students are not eligible.

"FULL-TIME WORK" means the active performance of the regular duties of your normal occupation on the basis of at least 20 hours per week at the place where such duties are normally performed.

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

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

HOW THE PLAN WORKS

This coverage helps protect the investment you've made in your education and career as an ophthalmologist. Both of the following Plans pay monthly benefits when you are Totally Disabled. "Totally Disabled" is defined in the group policy as being prevented by illness or injury from performing the material and substantial duties of your regular occupation as a specialist in ophthalmology, provided: (a) that was your primary occupation at the time of disability; and (b) you are not otherwise working for pay or profit.

Choice of Plans

You can choose either the Career Plan or the Two-Year Plan.

BENEFITS ARE PAYABLE: (MAXIMUM BENEFIT PERIOD)*

If Total Disability Begins	Career Plan	Two-Year Plan
Before age 64	To age 65	Two Years
At ages 64 through 69	One Year	One Year

*See Exclusions and Limitations for certain inner limits.

Choice of Monthly Benefit Options

You have a choice of Monthly Benefit Options from $500 to $10,000, in $100 units. The amount issued, together with any other amount of disability coverage you may have or for which you are applying, cannot exceed 60% of your AVERAGE MONTHLY INCOME. Depending on your state of residence, you may be eligible to receive disability benefits under a state plan. You should check to see if your state offers this type of benefit.

Note: Under the Two-Year Plan, Monthly Benefit Options are available up to $4,000. Upon specific request, and with underwriting approval, of course, higher options may be available.

AVERAGE MONTHLY INCOME means, as of any date, the greater of:

(a) your ANNUAL NET EARNED INCOME for the preceding 12-month period, divided by 12; or (b) your ANNUAL NET EARNED INCOME for the preceding 24-month period, divided by 24.

Choice of Waiting Periods

A waiting period is the number of consecutive days you must be Totally Disabled before benefits can begin. You have a choice of waiting periods: 90 days or 180 days. (Note: the 180-day waiting period is available under the Career Plan only).

PLAN FEATURES

Cost of Living Adjustment (COLA)

If requesting coverage under the Career Plan, you can, **for an additional premium,** request the Cost of Living Adjustment (COLA) benefit. This benefit allows you to keep pace with the rate of inflation. If you become Totally Disabled before age 64, monthly benefits will be adjusted annually, beginning in the second year of disability. (Years are measured from the start of the Waiting Period.) The adjustment is based on a formula reflecting changes in the Consumer Price Index for Urban Consumers (CPI-U) up to a maximum of 5%. Once you are no longer disabled and benefit payments stop, the Monthly benefit returns to its original amount.

Waiver of Premium Payments
After six months of covered Total Disability, premium contributions due thereafter will be waived for as long as disability benefits are paid, provided the disability began before age 60.

Benefits for Recurring Disability
Successive periods of disability due to the same or related causes will be considered a single period of disability unless separated by return to FULL-TIME WORK for at least 180 days as will unrelated disabilities that are not separated by return to FULL-TIME WORK.

Rehabilitation Benefits
This benefit is designed to help certain disabled persons return to the workforce. A professional staff will review cases of disabled members and identify those who appear to be prospects for rehabilitation. Individuals selected by New York Life Insurance Company will be offered the option to participate in a rehabilitation program at no cost to them. Participation is optional and Monthly Benefits will not be reduced due to participation in a program.

Residual Benefits
If you return to work after a Total Disability which began before age 64, and which lasted at least 30 consecutive days, you may be eligible for a Residual Benefit, provided your current average earnings do not exceed 75% of your AVERAGE MONTHLY INCOME. The benefit payable is a percentage of your Monthly Benefit Option equal to the percentage reduction in your monthly earnings. (See the Certificate of Insurance for conditions and limitations.)

ADDITIONAL INFORMATION

Effective Date
You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you are at FULL-TIME WORK on that date. If you are not at FULL-TIME WORK as required, coverage will not become effective until the day you are at FULL-TIME WORK, provided such date is within three months of the date insurance would have become effective and you are still eligible for insurance.

Payment of a premium contribution for insurance does not mean that there is any coverage in force before the effective date as specified by New York Life Insurance Company.

There are instances where insurance may be provided, at the same rates, by eliminating coverage for a specific condition or impairment.

When Coverage Ends
Your insurance can remain in force until you reach age 70. Coverage will end earlier if: you cease to be a member of the Academy; you fail to make premium payments when due; you begin full-time active duty in the armed forces; you cease FULL-TIME WORK (other than for disability); or the group policy is terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong.

Exclusions And Limitations
The Plan does not provide benefits for any disability that is due or related to: intentionally self-inflicted injury while sane or insane *[**Missouri Residents:** This exclusion is not applicable to injury caused by an intentionally self-inflicted injury while insane];* declared or undeclared war or act thereof; PRE-EXISTING LIMITATION (see below); military service; pregnancy or childbirth (except complications thereof); or any impairment or disease specifically excluded from the insured's coverage.

This Plan limits benefits for disability due to Mental Illness and Chemical Dependency to a maximum of 24 monthly benefit payments.

No more than six monthly benefits will be paid if you are outside the U.S. or the Virgin Islands when these benefits are payable.

No benefits will be paid unless the disability occurs while you are insured under the Plan and you are under the care of a licensed physician other than yourself (or immediate family/household member) during the period of disability.

Pre-Existing Condition Limitation
PRE-EXISTING CONDITION is an injury or sickness for which you consulted a doctor, received any medical services or supplies, or took any medication during the 12 months immediately before becoming insured under this Plan.

Benefits are not payable for a disability which is classified as a PRE-EXISTING CONDITION until the end of: 12 consecutive months during which you have not consulted a doctor, received any medical services or supplies, or taken any medication for the condition; or 24 consecutive months during which you have been insured under the Plan.

HOW TO APPLY

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

If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form or go to www.aaoinsure.com to download the form.

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

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

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

If you have any questions about your eligibility or the features of this Plan, call a service representative toll-free at 1-888-424-2308, 7:30 a.m. to 4:00 p.m., CT, Monday through Friday.

ABOUT YOUR REQUEST FOR COVERAGE

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

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

30-DAY FREE LOOK

If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days. Your coverage will be invalidated and you will receive a full refund — no questions asked!

HOW TO FILE A CLAIM

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

This Group Disability Insurance Plan
Is Underwritten By:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-14308-0
on Policy Form GMR-FACE/G-14308-0

This Group Disability Insurance Plan
Is Administered By:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
ACADEMY Group Insurance Program
P.O. BOX 10374
Des Moines, IA 50306-8812

AR Insurance License #100102691
CA Insurance License #0G39709
In CA d/b/a Mercer Health & Benefits Insurance Services LLC

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are as set forth in the group policy issued by New York Life Insurance Company to the Trustees of the Ophthalmologists Insurance Trust.

The Academy incurs costs in connection with this sponsored program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The Academy also receives a fee for the license of its name and logo for use in connection with this Plan.

7/13 ed.

YOUR COST

Cost is based on the Waiting Period, Plan and Monthly Benefit Option selected, and on your age when coverage becomes effective. The cost increases on the premium contribution due date on or immediately after you reach a higher age bracket. Premium contributions will vary depending upon the options and amount chosen.

Career Plan – Current 2018 Quarterly Premium Contributions

Member Age	Smoker $1,000 Monthly Benefit Option Waiting Period 90 days	180 days	Non-Smoker $1,000 Monthly Benefit Option Waiting Period 90 days	180 days
Under 35	$40.70	$35.70	$34.40	$30.00
35–39	50.00	45.00	42.50	38.20
40–44	68.80	62.50	58.80	53.20
45–49	90.70	81.30	76.90	69.40
50–54	123.80	108.80	105.00	92.30
55–69†*	157.50	141.80	133.90	120.80

Member Age	Smoker $2,500 Monthly Benefit Option Waiting Period 90 days	180 days	Non-Smoker $2,500 Monthly Benefit Option Waiting Period 90 days	180 days
Under 35	$101.75	$89.25	$86.00	$75.00
35–39	125.00	112.50	106.25	95.50
40–44	172.00	156.25	147.00	133.00
45–49	226.75	203.25	192.25	173.50
50–54	309.50	272.00	262.50	230.75
55–69†*	393.75	354.50	334.75	302.00

Member Age	Smoker $5,000 Monthly Benefit Option Waiting Period 90 days	180 days	Non-Smoker $5,000 Monthly Benefit Option Waiting Period 90 days	180 days
Under 35	$203.50	$178.50	$172.00	$150.00
35–39	250.00	225.00	212.50	191.00
40–44	344.00	312.50	294.00	266.00
45–49	453.50	406.50	384.50	347.00
50–54	619.00	544.00	525.00	461.50
55–69†*	787.50	709.00	669.50	604.00

Member Age	Smoker $7,500 Monthly Benefit Option Waiting Period 90 days	180 days	Non-Smoker $7,500 Monthly Benefit Option Waiting Period 90 days	180 days
Under 35	$305.25	$267.75	$258.00	$225.00
35–39	375.00	337.50	318.75	286.50
40–44	516.00	468.75	441.00	399.00
45–49	680.25	609.75	576.75	520.50
50–54	928.50	816.00	787.50	692.25
55–69†*	1,181.25	1,063.50	1,004.25	906.00

Member Age	Smoker $10,000 Monthly Benefit Option Waiting Period 90 days	180 days	Non-Smoker $10,000 Monthly Benefit Option Waiting Period 90 days	180 days
Under 35	$407.00	$357.00	$344.00	$300.00
35–39	500.00	450.00	425.00	382.00
40–44	688.00	625.00	588.00	532.00
45–49	907.00	813.00	769.00	694.00
50–54	1,238.00	1,088.00	1,050.00	923.00
55–69†*	1,575.00	1,418.00	1,339.00	1,208.00

†Benefits are payable to age 65 for covered disabilities commencing before age 64, and benefits are payable up to one year for covered disabilities commencing at age 64 but before age 70.

*Renewal only for ages 65–69. Coverage terminates at age 70.

The premium contributions shown reflect the current rate and benefit structure. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life and the Trustees of the Ophthalmologists Insurance Trust.

Premium contributions may be changed by New York Life Insurance Company on any premium due date and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insureds. For example, a class of insureds is a group of people with the same issue age.

Two-Year Benefit Plan – Current 2018 Quarterly Premium Contributions

Member Age	Smoker $500 Monthly Benefit Option Waiting Period 90 days	Non-Smoker $500 Monthly Benefit Option Waiting Period 90 days
Under 35	$6.35	$5.35
35–39	7.25	6.20
40–44	8.95	7.65
45–49	11.85	10.00
50–54	21.70	18.40
55–61	45.70	38.85
62	60.65	51.50
63–69†*	78.75	66.95

Member Age	Smoker $1,000 Monthly Benefit Option Waiting Period 90 days	Non-Smoker $1,000 Monthly Benefit Option Waiting Period 90 days
Under 35	$12.70	$10.70
35–39	14.50	12.40
40–44	17.90	15.30
45–49	23.70	20.00
50–54	43.40	36.80
55–61	91.40	77.70
62	121.30	103.00
63–69†*	157.50	133.90

Member Age	Smoker $2,000 Monthly Benefit Option Waiting Period 90 days	Non-Smoker $2,000 Monthly Benefit Option Waiting Period 90 days
Under 35	$25.40	$21.40
35–39	29.00	24.80
40–44	35.80	30.60
45–49	47.40	40.00
50–54	86.80	73.60
55–61	182.80	155.40
62	242.60	206.00
63–69†*	315.00	267.80

Member Age	Smoker $3,000 Monthly Benefit Option Waiting Period 90 days	Non-Smoker $3,000 Monthly Benefit Option Waiting Period 90 days
Under 35	$38.10	$32.10
35–39	43.50	37.20
40–44	53.70	45.90
45–49	71.10	60.00
50–54	130.20	110.40
55–61	274.20	233.10
62	363.90	309.00
63–69†*	472.50	401.70

Member Age	Smoker $4,000 Monthly Benefit Option Waiting Period 90 days	Non-Smoker $4,000 Monthly Benefit Option Waiting Period 90 days
Under 35	$50.80	$42.80
35–39	58.00	49.60
40–44	71.60	61.20
45–49	94.80	80.00
50–54	173.60	147.20
55–61	365.60	310.80
62	485.20	412.00
63–69†*	630.00	535.60

†Benefits are payable up to one year for covered disabilities commencing at age 64 but before age 70.
*Renewal only for ages 65–69. Coverage terminates at age 70.
The premium contributions shown reflect the current rate and benefit structure. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life and the Trustees of the Ophthalmologists Insurance Trust. Premium contributions may be changed by New York Life Insurance Company on any premium due date and any date on which benefits are changed. However, your rates may change only if they are changed for all others in the same class of insureds. For example, a class of insureds is a group of people with the same issue age.
Please Note: This rate chart is based on quarterly rates. However, you may also select a semi-annual or annual premium payment schedule. Simply multiply the quarterly amount by 2 or 4, respectively.

Rates continued on next page ➡

Additional Quarterly Premium for COLA per $100 Monthly Benefit Option (Career Plan Only)	
Member Age	
Under 35	$1.88
35–39	2.50
40–44	3.83
45–49	5.10
50–54	4.55
55–59	4.23
60–64	1.88

How To Determine Your Cost For Other Options

If you wish to request a Monthly Benefit Option (in $100 units) other than those shown above, please contact the Administrator for assistance. The minimum monthly benefit is $500.

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