To Apply: Complete This Form And Return To:
ADMINISTRATOR
PGA GROUP INSURANCE PROGRAM
P.O. 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: 1-800-459-2851
customerservice.service@mercer.com

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

GROUP TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE PROFESSIONAL GOLFERS' ASSOCIATION OF AMERICA

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

1. Applicant Information:

(Please make any necessary corrections to your full name and street address if shown below.)

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Social Security #: ☐☐☐ – ☐☐ – ☐☐☐☐

Home Phone: (____)_____

Work Phone: (____)_____

Fax: (____)_____

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

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

❑ 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.

Are you presently insured under any PGA Group 10-Year Level Term Life Insurance Plans? ❑ Yes ❑ No

If "yes," indicate which Plan(s) and provide details (person(s) insured and amount of insurance)

Details:_____
(Person insured and amount of insurance)

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?

Applicant: ❑ Yes, Country_____ For how long? _____ ❑ No

Spouse: ❑ Yes, Country_____ For how long? _____ ❑ No

		DATE OF BIRTH: MO. DAY YR.	**HEIGHT:**	**WEIGHT:**	**SEX:**
Applicant:	_____	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Spouse*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Child(ren)*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F

* See Plan Information/Plan Details for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

2. Membership Affiliation:

Are you now a member or apprentice of the PGA? ❑ Yes ❑ No Membership # _____ Exp. Date _____

Or are you employed by a PGA member* for at least 30 consecutive days and actively performing the regular duties of your occupation at least 30 hours per week, at the place such duties are normally performed or other location to which travel is required? ❑ Yes ❑ No

Employment Start Date: _____/_____/_____
MO DAY YR

(FOR EMPLOYEES ONLY, ENTER NAME AND ADDRESS OF PGA MEMBER)

(Name) (Street Address) (City) (State) (Zip Code)

3. Payment Option*: (Choose only one)

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

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

❑ **OPTION 2: PERIODIC BILLING:** ❑ monthly ($2.00 billing fee applies) ❑ semiannual ($2.00 billing fee applies) ❑ annual

*Select Annual Billing or EFT to avoid a $2.00 billing fee.

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES: ❑ **New** ❑ **Additional**

a. Initial Applicant Insurance Amount: $ _____ **Initial Spouse Insurance Amount: $** _____
Initial Child Insurance Amount: ❑ **$2,500** ❑ **$5,000** ❑ **$7,500** ❑ **$10,000**
Note: Member coverage must be in force to request dependent coverage.

b. Increase Applicant Insurance Amount from $_____ **to $**_____
Increase Spouse* Insurance Amount from $_____ **to $**_____

c. Total Child Insurance Amount Requested: ❑ $2,500 ❑ $5,000 ❑ $7,500 ❑ $10,000 ❑ None
*Dependent coverage cannot exceed 50% of Applicant's coverage.

d. Do you have other life insurance in force? If "Yes," total amount in all companies:
Applicant: $ _____ Spouse: $_____

Do you have other insurance applications pending? If "Yes," indicate amount and company:
Applicant: $_____ Company _____ Spouse: $_____ Company _____

e. TOBACCO/NICOTINE USE: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?
Applicant: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT) Spouse: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT)

When did you last use tobacco or nicotine products? _____/_____ (MONTH/YEAR) When did you last use tobacco or nicotine products? _____/_____ (MONTH/YEAR)

f. 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?
Applicant: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Residents of All Other States:
Is the insurance applied for intended to replace, discontinue or change an existing policy?
Applicant: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

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

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

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Applicant: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name: _____
Last First MI

Beneficiary's Relationship to Applicant: _____

Beneficiary Social Security #: _____

Street Address: _____

City _____ State _____ Zip Code _____

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

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	YES	NO
a. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	❑	❑
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❑	❑
c. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	❑	❑
d. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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

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

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

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

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

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

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company or MIB, 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 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 indicated below and Fraud Notices indicated below, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

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

Spouse's Signature X _____ **Date** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED; PLEASE SIGN AND DATE IN INK)

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

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

6/16 ed.

FRAUD NOTICE – For residents of all states except those listed below and NEW YORK: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which may be a crime and may subject such person to criminal and civil penalties.

RESIDENTS OF CO, the following also applies: Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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

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

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

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

RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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

RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

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IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Term Life 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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PGA Group Term Life Insurance Plan

For Professional Golfers' Association of America Members and Their Families

Underwritten by New York Life Insurance Company

A Plan Designed For Your Family's Needs

You have worked hard and planned for your future. By taking time to review your current financial situation, you will be taking an active role in helping to keep your family's financial security up to date.

The **PGA Group Term Life Insurance Plan** can also help you and your family to take that first step. No matter where you are in your career, no PGA member should be without the financial protection this Plan can offer.

The PGA Group Term Life Insurance Plan is designed to help meet your family's needs. Unlike employer-sponsored coverage, if you change jobs or retire, your PGA Group Term Life coverage does not automatically terminate. And, if you have employees, they may also be eligible for this Plan.

Primary Protection

Life insurance is one of the cornerstones of sound financial planning. It helps ensure that even if you die prematurely, your family would be able to meet current expenses–such as mortgage and car payments–as well as future expenses such as college tuition.

HOW THE PLAN WORKS

Who Is Eligible?

If you are a PGA member or apprentice under age 65 and a resident of the United States (excluding VT, WA, and territories) and Puerto Rico you are eligible to apply. You can request up to $250,000 for yourself, and up to $100,000 of coverage for your lawful spouse under age 65, not to exceed 50% of member coverage. Each unmarried, dependent child, ages 14 days through 18 years (through age 22 if a full-time student), may also be insured for up to $10,000.

A dependent who is also a member or apprentice is eligible for either member or dependent coverage, not both.

Employees Of PGA Members Are Eligible Too!

Your FULL-TIME employees who are under age 65 and have been employed for a minimum of 30 consecutive days may apply for coverage for themselves and their eligible dependents subject to the same conditions which apply for members and apprentices.

FULL-TIME means actively performing the regular duties of your normal occupation, at least 30 hours per week, at the place such duties are normally performed or other location to which travel is required.

Choose The Amount Of Insurance You Need

For Applicant

Options from $10,000 to $250,000
(in multiples of $10,000)

For Lawful Spouse

Options from $5,000 to $100,000
(in multiples of $5,000)

For Each Eligible Dependent Child

Options from $2,500 to $10,000
(in multiples of $2,500)
Child benefits at ages 14 days through 6 months are limited to $2,500 under all options.

Dependent coverage may not exceed 50% of member coverage.

The total amount of coverage an individual may have under all group life insurance plans underwritten by New York Life may not exceed $2,000,000. In addition, the total amount of coverage for a member or spouse insured by more than one group policy issued to the Trustee of the PGA Insurance Trust may not exceed the maximum benefit option for any insured person.

Volume Discounts and Discounted Rates for Qualified Non-Smokers

These two Plan features offer potential cost savings for you. If you or your spouse are qualified non-tobacco users, that person can take advantage of lower premium contributions. Additionally, premium contributions have been discounted for amounts of coverage of $100,000 or more.

PLAN FEATURES

Accelerated Death Benefit

The Accelerated Death Benefit is designed to help avoid financial suffering, should you or an insured family member become terminally ill. This benefit gives you the right to request part of the terminally ill person's life insurance benefits while he/she is still alive. The money is available to be used as desired to help pay for the high cost of medical and hospital care, or for personal expenses.

To qualify for the Accelerated Death Benefit, a person must be insured under the PGA Group Term Life Plan and diagnosed as having a life expectancy of 12 months or less. Proof of terminal illness will consist of a statement from a physician and any other medical information that New York Life believes is necessary to confirm that person's status.

Under this benefit, you can request payment equal to 50% of the terminally ill person's in force term life face amount. The benefit is payable only once during the insured person's lifetime, and payment will be made to you. Any amount of insurance payable after the insured's death will be reduced by this amount (Premium contributions will not be reduced.)

Receipt of this benefit may affect eligibility for public assistance programs and may be taxable. Therefore, prior to making a claim for this benefit, you should seek advice from your tax advisor for clarification of the current tax law, and how this benefit may affect your personal situation.

Note: *This benefit is not available to residents of Massachusetts.*

Premium Waived If You're Disabled

If you become totally disabled before age 60 and remain totally disabled for 180 days or more, your PGA Group Term Life Insurance will be continued for both you and your insured dependents without additional premium contributions, until coverage terminates when you reach age 75. The amount continued will be based on the options for which you and your dependents were insured at the time the disability began. From time to time, evidence of continued total disability may be required.

You Name Your Beneficiary

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

Incontestability

The validity of any amount of your insurance that has been in force for 2 years during your lifetime will not be contested except for insurance eligibility provisions or nonpayment of premium contributions.

Group Conversion Privilege

The Plan provides conversion privileges under certain circumstances of involuntary termination as described in the Certificate of Insurance.

Exclusions

Benefits for a covered person's death due to suicide, attempted suicide or intentionally self-inflicted injury during the first 24 months of coverage will be limited to the return of premium contributions, if New York Life can show that suicide was intended at the time of application.

When Insurance Ends

Many term life insurance programs have an automatic benefit reduction because of your age. Your coverage under the PGA Group Term Life Insurance Plan will not be reduced because of your age.

Insurance can continue until you reach age 75, provided: you continue to make premium contributions when due; and the Plan is not terminated or modified by the Policyholder or New York Life to end coverage for the group of insureds to which you belong. Dependent coverage ends when your coverage ends or, if earlier, when the dependent ceases to be a lawful spouse or eligible dependent child. Your spouse's coverage ends when he/she reaches age 75; your child(ren) coverage will end when he/she (they) reach(es) age 19, or 23 if a full time student. If an employee, your coverage will end when you are no longer working FULL TIME for a PGA member.

The coverage for your dependents can continue if you die as described in your Certificate of Insurance.

EFFECTIVE DATE

Note: *Residents of NC: Any references to "performing the normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured remain the same as stated in your application.*

You and your dependents will become insured on the date specified by New York Life provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you and your dependents are performing the normal activities of a person in good health of like age on that date. Coverage for any person who is not performing his or her normal activities as required will not become effective until the date he or she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance. (Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date as specified by New York Life.)

ESTIMATE YOUR FAMILY'S NEEDS

Just as important as having life insurance is having an amount of coverage that's adequate for your family's protection. If your family needed to rely on coverage you purchased 5 or 6 year ago, chances are that it would be insufficient for their needs today and in the future. Just as your life is constantly changing and growing, so are your financial responsibilities.

To help make sure you have adequate financial protection, it's important to periodically reassess your insurance needs. One way to do this, a simple guideline recommended by many financial planners, is to have from five to seven times your annual income in life insurance coverage, depending on your needs.

1. Determine Your Insurance Goal

Enter your total annual salary..... $_____

Enter any additional annual income..... $_____

Enter your total annual income..... $_____

Total annual income x 7..... $_____

Your life insurance goal..... $_____

2. Itemize Your Current Protection

Individual life insurance coverage ..... $_____

PGA Group Life Insurance Coverage ..... $_____

Pension plan death benefits ..... $_____

Other retirement benefits (IRA, annuities, etc.) available to your beneficiary upon your death ..... $_____

Total amount of your existing benefits ..... $_____

3. Determine the Amount of Additional Life Insurance You May Need

Your life insurance goal from Part #1..... $_____

Subtract your total existing protection from Part #2 ..... $_____

Total amount of additional life insurance ..... $_____*

*Please note that this is only a simple conservative estimate. You may have other expenses, liabilities or assets which are not included in this calculation. This formula should serve as one guide when making decisions concerning an adequate level of life insurance.

30-DAY FREE LOOK

Once you become insured, you will be sent a Certificate of Insurance summarizing your benefits under this plan. If you're not completely satisfied with the terms of your Certificate of Insurance, you may return it, without claim, within 30 days and your premium will be promptly refunded in full. Your coverage will then be invalidated.

HOW TO APPLY

Prompt, Easy Service When You Apply

The information you supply when you fill out your application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals.

Complete medical information should include the name of the physician(s) or hospital(s), street address (and suite or room number), city, state and zip code. Also, a brief description of the nature of illness or injury, symptoms, treatment and results.

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

NOTE: Under certain circumstances, and for higher amounts of coverage, the underwriter may request a physical exam, EKG, blood test or other medical information. (This may be necessary even when complete, accurate information was initially provided.) If required, an independent professional paramedic will contact you to arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the Plan.

Apply in Three Easy Steps

1. Refer to the Plan description for benefits and premium costs as you fill out the application. Be sure to indicate whether you are requesting coverage for your spouse and children.
2. Make out your check for the total premium contribution due, payable to: Administrator, **PGA** Group Insurance Program.

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.

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.pgainsurance.com to download the form.

3. Mail the completed application with your check to the Administrator in the postage-paid envelope provided.

Residents of Puerto Rico:

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

If you have questions about your eligibility or the features of this Plan, call a Customer Services Representative toll free at 1-800-459-2851.

HOW TO FILE A CLAIM

To file a claim or request the proper forms, please write or call the Administrator at the address listed below.

The PGA Group Term Life Plan Is Administered By:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
PO Box 10374
Des Moines, IA 50306-8812

1-800-459-2851
www.pgainsurance.com

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

The PGA Group Term Life Plan Is Underwritten By:

NEW YORK LIFE

51 Madison Avenue
New York, NY 10010
under Group Policy No. G-5379-0
on Policy Form GMR-FACE/G-5379-0

This brochure contains a brief description of the principal provisions and features of the Plan. The complete terms and conditions are set forth in the Group Policy issued by New York Life to the Trustee of the Professional Golfers' Association of America Insurance Trust.

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

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YOUR COST

The initial cost for insurance is based on your attained age (for your coverage) and your spouse's attained age (for spouse coverage) when insurance becomes effective. The cost increases as you and your spouse grow older.

CURRENT 2018 QUARTERLY PREMIUM CONTRIBUTIONS

	No Volume Discount for Amounts of Coverage Less Than $100,000		**Volume Discount for Amounts of Coverage $100,000 Through $250,000**				
Issue Age	**Applicant $10,000 Option**		**Applicant $10,000 Option**		**Spouse $5,000 Option**		**Child(ren) $2,500 Option***
	Non-Smoker	**Smoker**	**Non-Smoker**	**Smoker**	**Non-Smoker**	**Smoker**	
Under 35	$2.05	$2.50	$1.65	$2.10	$1.05	$1.25	$1.35
35–39	2.95	3.70	2.45	3.10	1.50	1.85	1.35
40–44	4.25	5.30	3.65	4.60	2.10	2.65	1.35
45–49	7.20	9.10	6.35	8.00	3.60	4.55	1.35
50–54	12.35	15.40	10.95	13.70	6.15	7.70	1.35
55–59	21.80	27.25	19.45	24.35	10.90	13.65	1.35
60–64†	32.05	40.05	28.60	35.85	16.00	20.05	1.35

*Premium contribution is the same for all eligible children, regardless of how many are covered.

†Contact the Administrator for renewal rates for ages 65–74. Coverage terminates at age 75. See Group Conversion Privilege.

Note: Select Annual Billing or Electronic Funds Transfer (EFT) to avoid a $2.00 billing fee.

The premium contributions shown reflect the current rates and benefit structure. Premium contributions may be changed by New York Life on any January 1st and on 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 under this group policy. For example, a class of insureds is a group of people all with the same issue age and tobacco/nicotine use. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life and the Trustee of the Professional Golfers' Association of American Insurance Trust.

How To Calculate Your Quarterly Cost

1. Decide on the amount of insurance you wish to request.
2. Determine the number of $10,000 applicant units and $5,000 spouse units in the total amount of coverage you are requesting.
3. Multiply the cost per unit by the number of units desired for the quarterly premium. Be sure to use the appropriate rate column.
   FOR EXAMPLE: if you are age 36, a qualified non-smoker, and choose $100,000 in term life coverage, multiply $2.45 X 10 = $24.50.
4. If you wish to request child coverage, multiply the cost per $2,500 unit by the number of units desired and add it to the cost of the applicant or applicant and spouse coverage.