University of Illinois Alumni Association

GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

UNIVERSITY OF ILLINOIS ALUMNI ALLIANCE

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

To Apply:

Complete this form and return to:
ADMINISTRATOR
ALUMNI GROUP INSURANCE PROGRAM
P.O. BOX 10374
Des Moines, IA 50306-8812

QUESTIONS?
Call: 1-888-560-2586

Send No Money Now

NEW YORK LIFE

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

1. Alum Information:

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

Name: _____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Alum

Sex ❑ M ❑ F Height _____ft. _____in. Weight _____lbs.

Date of Birth_____
(MM/DD/YYYY)

Social Security Number_____

Daytime Phone Number_____

E-Mail Address_____
Mercer Consumer will not share your email information

Fax Number_____

Spouse (if applying)

Spouse Name_____
First M.I. Last

Sex ❑ M ❑ F Height _____ft. _____in. Weight _____lbs.

Date of Birth_____
(MM/DD/YYYY)

Social Security Number_____

Daytime Phone Number_____

E-Mail Address_____
Mercer Consumer will not share your email information

Fax Number_____

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

Alum: ❑ Yes, Country_____ ❑ No
If "Yes," for how long? _____

Spouse: ❑ Yes, Country_____ ❑ No
If "Yes," for how long? _____

2. Payment Option: (Choose only one)

❑ **OPTION 1: PERIODIC BILLING:** You will be billed semiannually.
NOTE: After the first billing, you can select the monthly Electronic Fund Transfer (EFT) if you wish.

❑ **OPTION 2: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the Mercer Health & Benefits Administration LLC to make monthly withdrawals against the account specified on the attached and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group 10-Year Level Term Life Insurance Plan. (Enclose a VOIDED check.)

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

3. Insurance Requested: Refer to the brochure for eligibility, options and coverage description.

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):

A. FOR ALUM/SPOUSE NOT CURRENTLY INSURED UNDER THIS ALUMNI GROUP 10-YEAR LEVEL TERM LIFE INSURANCE PLAN:

I request this Group Term Insurance in the initial amount of (check one).

Alum: ❑ $250,000 ❑ $500,000 ❑ $1,000,000 ❑ *Other_____
Spouse: ❑ $250,000 ❑ $500,000 ❑ $1,000,000 ❑ *Other_____

*Must be in $25,000 increments, minimum of $50,000, maximum of $1,000,000.

3. Insurance Requested: (continued)

B. FOR ALUM/SPOUSE CURRENTLY INSURED UNDER THIS ALUMNI GROUP 10-YEAR LEVEL TERM LIFE INSURANCE PLAN:

I wish to increase amounts of insurance as follows: Alum: from $_____to $_____

Spouse: from $_____to $_____

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

Alum: $ _____ Spouse: $_____

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

Alum: $_____ Company _____ Spouse: $_____ Company _____

C. PRESENT OCCUPATION AND DUTIES: Alum:_____ Spouse:_____

D. 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)?..... **Alum** ❑ Yes ❑ No **Spouse** ❑ Yes ❑ No

Alum: ❑ 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)

E. INSURANCE REPLACEMENT: **Alum** **Spouse**

Is the insurance applied for intended to replace, discontinue or change an existing policy?..... ❑ Yes ❑ No ❑ Yes ❑ No

4. Alum Beneficiary Designation: Insert name, relationship and address.

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. 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 Middle Initial Beneficiary's Relationship to Alum & Social Security No.

Street Address City State Zip Code

❑ Primary ❑ Secondary %:_____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security No.

Street Address City State Zip Code

5. Spouse Beneficiary Designation: Insert name, relationship and address.

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. 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 Middle Initial Beneficiary's Relationship to Alum & Social Security No.

Street Address City State Zip Code

❑ Primary ❑ Secondary %:_____

Beneficiary Name: Last First Middle Initial Beneficiary's Relationship to Alum & Social Security No.

Street Address City State Zip Code

6. Statement of Health: Please initial and date any changes you make

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse (if also applying for coverage).

	Alum		Spouse	
	Yes	**No**	**Yes**	**No**
a. Are you and/or your spouse (if applying) disabled or receiving any disability or workers' compensation benefits or on waiver of premium for life or health insurance?	❑	❑	❑	❑
b. Are you and/or your spouse (if applying) now ill or receiving medical attention or surgical treatment?	❑	❑	❑	❑
c. During the past five years, have you and/or your spouse (if applying) 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 and/or your spouse (if applying) taking any kind of medication or, so far as you know, in impaired physical or mental health?	❑	❑	❑	❑
e. Are you and/or your spouse (if applying) now pregnant?	❑	❑	❑	❑
f. During the past five years, have you and/or your spouse (if applying) ever been medically diagnosed by a physician as having or been treated for:				
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 breast or reproductive organs or functions?	❑	❑	❑	❑
7. Nervous or mental disorder, emotional conditions 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, chronic fatigue in the past five years?	❑	❑	❑	❑
(iii) Any other impairment?	❑	❑	❑	❑
g. Have you or your spouse (if also applying) had a parent, brother or sister who, prior to age 60, had been medically diagnosed by a physician as having, or been treated for: cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness? (Note: This question is not applicable to Maryland residents.)	❑	❑	❑	❑
h. Within the past two years, have you or your spouse (if also applying) participated in, or do either of you plan to participate in: aircraft flying other than as passenger; scuba diving; ultralight flying; ballooning; parachuting; mountaineering; rodeo riding; snowmobiling; hang gliding; parasailing; bungee jumping; organized motorcycle racing; or any type of organized motorized racing?	❑	❑	❑	❑
i. Driver's License No.: Alum _____ Spouse _____ State in which issued: Alum _____ Spouse _____ Have you or your spouse (if also applying) had a driver's license suspended or revoked or had any moving violations within the past five years?	❑	❑	❑	❑
j. In the last 7 years, have you and/or your spouse (if also applying) been convicted of a crime or served time in prison because of a conviction or have an arrest pending? *(Or been arrested or convicted for any reason? – For residents of Connecticut and Minnesota.)*	❑	❑	❑	❑

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-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

7. Declarations:

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, 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 and Fraud Notices enclosed, 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.

Alum's Signature _____ **Date** _____
Please sign and date in ink

Spouse's Signature _____ **Date** _____
Please sign and date in ink

OWNER INFORMATION, REQUIRED IF OWNER IS OTHER THAN ALUM/SPOUSE.
(IF OWNER IS A TRUST, PLEASE SUBMIT A COPY OF THE TRUST DOCUMENT WITH THIS APPLICATION.)

FULL NAME: LAST	FIRST	MIDDLE INITIAL	RELATIONSHIP TO PROPOSED INSURED	DAYTIME PHONE
MAILING ADDRESS: STREET		CITY	STATE	ZIP CODE
TAX ID#	DATE OF BIRTH (MO./DAY/YR.)		SOCIAL SECURITY NUMBER	

Owner's Signature _____ **Date**_____
(NECESSARY ONLY IF OTHER THAN ALUM) PLEASE SIGN AND DATE IN INK)

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 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 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 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 10-Year Level Term Life 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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UNIVERSITY OF ILLINOIS
ALUMNI ALLIANCE

University of Illinois Alumni Association Sponsored Life Insurance Program

Underwritten by New York Life Insurance Company

Attention University of Illinois Alumni Association

Help protect all that you've worked for

with

up to $1,000,000

in Group 10-Year Level Term Life Insurance

- **Rates Will Not Increase for 10 Years and Benefits Will Never Decrease**
- **Benefits Paid In Addition to Any Other Insurance**
- **Spouse Coverage Available**
- **30-Day Free Look**

See inside for details…

MERCER
MAKE TOMORROW, TODAY

Provide for your family when it counts the most with the Alumni-sponsored 10-Year Group Term Life Insurance Plan.

This plan can provide your family with up to **$1,000,000** in important insurance protection. That means bill-paying benefits will be there for your loved ones to use toward funeral expenses, medical bills, mortgage payments, college tuition or lost income, should you or your spouse no longer be there for them.

Give yourself and your family the peace of mind they deserve – at an affordable price. Apply for this valuable insurance today.

Rates Will Not Increase for 10 Years – Benefits Will Never Decrease

Your rate is based upon your age when you apply. Once approved, the rate you start with is "locked-in" for 10 years. Your premium rates are guaranteed to remain the same during the initial 10 years of coverage, meaning no premium increases. After the initial 10-year term, premium rates are subject to change. For further details please see "How to Renew This Coverage After Your First 10 Year Term" in the "Things You Need to Know About This Coverage" section of the brochure.

Benefits Paid In Addition to Any Other Insurance

Regardless of any other life insurance you may have with another company, benefits are paid directly to anyone you choose – your spouse, children, anyone.

Spouse Coverage Available

Your lawful spouse, under age 65, can also apply for this coverage. Just have your spouse complete and sign the enclosed Application, too.

Eligibility

Alumni and their spouses under age 65 are eligible to apply. This coverage is available only for residents of the United States (except territories) and Puerto Rico. Coverage may not be available in all states. Call Mercer Consumer at 1-888-560-2586 for details.

Accelerated Death Benefit

The Accelerated Death Benefit option is available to help a terminally ill insured during a difficult and often financially challenging time.

An insured can receive 50% of his or her benefit amount before death if the insured is diagnosed as terminally ill.

Please see the "Things You Need To Know About This Coverage" section for details about this optional benefit.

Choice of 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.

30-Day Free Look

You will have 30 days from the date of receipt to review the insurance Certificate. If you are not satisfied with the terms of the Certificate, simply return it to the Insurance Administrator, without claim, and any premiums paid will be fully refunded. Your coverage will be invalidated, and you will receive a full refund, no questions asked!

Choose Your Payment Option

With the **Electronic Fund Transfer (EFT)** option, you have your premiums automatically deducted from your checking account on a monthly basis. That means no more writing checks and tracking due dates. You save time – and postage fees!

With the **Semi-Annual Direct Bill** option, you have your premiums billed to you directly on a semi-annual basis.

Volume Discount Premium Rates Available

If you become insured for $250,000 or more in life insurance, you will receive the Volume Discounted Premium Rates.

Other Insurance Products to Meet Your Needs

Your Alumni Association also sponsors other products to fit your and your family's lifestyle needs, such as Disability and Short Term Medical Insurance.

Please call toll-free at 1-888-560-2586 for more information about these and other insurance products.

It's Easy to Apply!

1. Complete, sign and date the enclosed Application. If your spouse is also applying, please complete the form and sign where indicated.
2. Send no money now. You will be billed when your Certificate is issued.
3. Mail your completed Application in the enclosed return envelope, ***or, mail to***:

   Mercer Consumer/Alumni Services
   P.O. Box 10374
   Des Moines, IA 50306-8812

Administered by:

MERCER
MAKE TOMORROW, TODAY

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

Questions?

If you have any questions or need more information about the Alumni-sponsored 10-Year Group Term Life Insurance Plan, please call toll-free at 1-888-560-2586.

Underwritten by:

NEW YORK LIFE

New York Life Insurance Company
51 Madison Ave.
New York, NY 10010
under Group Policy G-29126-0
on Policy Form GMR-FACE/G-29126-0

Answers to Your Most Common Questions

1. What is 10-Year Group Term Life Insurance? How does it work?

Term Life coverage is the purest kind of life insurance, meaning there are no costly savings features. This 10-Year Group Term Life Insurance is life insurance coverage that can be purchased at a level rate for ten years. Your benefit level of up to $1,000,000 will never decrease – and your rate will not increase for the first 10 years.

2. What Happens at the End of the Initial 10-Year Period?

Premiums are guaranteed to remain level for the first 10 years of coverage. At the end of the 10-year period, you may reapply for 10-year level term rates then in effect for a subsequent 10-year period, provided the insured person is under age 65 and otherwise eligible. If your application for a subsequent 10-year term of guaranteed rates is approved, your premium contribution will be based on the insured person's age, health and tobacco/nicotine use at the time coverage becomes effective and will be guaranteed for a new 10-year term. If you and your spouse are not approved for a subsequent 10-year term of guaranteed rates, or you do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis, under which premium contributions increase as the insured ages.

3. I already have coverage through my employer. Why do I need additional coverage?

Some experts recommend you carry up to ten times your annual salary in life insurance benefits in order to adequately protect your family. If you are starting a family or business, or have a new home, chances are you need even more. Group Term Life Insurance is the smart and easy way to purchase as a stand-alone or supplement to any other life insurance plan you may already have – at a competitive rate.

4. When does coverage begin?

Note: Residents of NC: Any reference to "performing normal activities of a person in good health" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application. Insurance will take effect on the date your application is approved by New York Life Insurance Company, provided the initial contribution is paid within 31 days after the date you are billed (send no money now) and any person to be insured is performing the normal activities of a person in good health of like age on the date of approval.

Any person who is not performing his/her normal daily activities as required will not become insured until the day he/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.

5. When does coverage end?

Your coverage will end when you reach age 80. Coverage will end earlier if the Group Policy is terminated or modified by the Policyholder to end insurance for the group of insureds to which you belong, or if your premiums are not paid when due. At age 80, you may convert to an individual life policy without providing any medical evidence of insurability.

6. Can my lawful spouse apply?

Absolutely. Your spouse, under age 65, is eligible to apply for this coverage. After that term, your spouse may also renew his/her coverage, subject to the same termination provisions noted above.

7. Why is my Alumni Association sponsoring this insurance plan?

The 10-Year Group Term Life Insurance Plan is sponsored by UIAA Alumni as an Alumni service to you. It allows you and your spouse to supplement your current insurance plan at an affordable rate. UIAA Alumni incur no expense through the sponsorship of these programs.

Administered by:

MERCER
MAKE TOMORROW, TODAY

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
Mercer Consumer/Alumni Services
P.O. Box 10374
Des Moines, IA 50306-8812

Questions?

If you have any questions or need more information about the UIAA Alumni-sponsored 10-Year Group Term Life Insurance Plan, please call toll-free at 1-888-560-2586.

Underwritten by:
New York Life Insurance Company
51 Madison Ave.
New York, NY 10010

NEW YORK LIFE

UIAA incurs costs in providing oversight of this program and also incurs administrative costs in connection with its sponsorship. To provide and maintain this valuable membership benefit, UIAA may be reimbursed for these costs.

Current 2019 "Preferred" and "Select" Monthly† Premium Contributions Per $25,000 Benefit Amount

Member/ Spouse Issue Age	$100,000 Coverage Amounts		Coverage Amounts of $125,000 - $225,000				Coverage Amount of $250,000 - $1,000,000			
	Male Select	Female* Select	Male Preferred Select		Female* Preferred Select		Male Preferred Select		Female* Preferred Select	
20-35	$2.71	$2.50	$1.69	$1.94	$1.50	$1.75	$1.15	$1.40	$0.98	$1.18
36	2.77	2.54	1.71	2.00	1.54	1.79	1.17	1.46	1.02	1.25
37	2.85	2.65	1.77	2.08	1.63	1.90	1.21	1.52	1.08	1.31
38	2.94	2.73	1.90	2.19	1.71	1.98	1.27	1.62	1.17	1.40
39	3.10	2.88	1.98	2.33	1.79	2.13	1.33	1.75	1.27	1.52
40	3.21	3.00	2.08	2.44	1.92	2.23	1.44	1.90	1.37	1.65
41	3.40	3.19	2.21	2.63	2.04	2.42	1.56	2.04	1.50	1.81
42	3.60	3.38	2.35	2.81	2.19	2.58	1.75	2.25	1.63	1.96
43	3.81	3.58	2.52	3.02	2.35	2.79	1.96	2.44	1.79	2.15
44	4.08	3.79	2.71	3.29	2.52	3.00	2.15	2.69	1.96	2.33
45	4.35	4.00	2.96	3.54	2.67	3.21	2.38	2.96	2.10	2.52
46	4.69	4.19	3.23	3.88	2.85	3.38	2.60	3.25	2.27	2.71
47	5.06	4.40	3.52	4.23	3.00	3.58	2.81	3.60	2.40	2.90
48	5.46	4.65	3.81	4.60	3.15	3.81	3.04	3.96	2.56	3.12
49	5.88	4.85	4.19	5.00	3.35	4.02	3.33	4.33	2.73	3.31
50	6.35	5.15	4.56	5.48	3.54	4.31	3.67	4.79	2.92	3.56
51	6.88	5.42	4.98	5.98	3.81	4.56	4.04	5.27	3.15	3.81
52	7.41	5.73	5.35	6.50	4.10	4.85	4.50	5.79	3.44	4.08
53	8.02	6.02	5.79	7.08	4.40	5.15	4.98	6.33	3.74	4.38
54	8.69	6.40	6.31	7.73	4.71	5.50	5.54	6.96	4.04	4.71
55	9.42	6.81	6.85	8.42	5.06	5.92	6.13	7.63	4.38	5.06
56	10.17	7.23	7.46	9.15	5.35	6.31	6.69	8.35	4.67	5.44
57	10.98	7.67	8.06	9.94	5.69	6.73	7.31	9.02	4.96	5.83
58	11.90	8.21	8.83	10.81	5.98	7.25	8.02	9.90	5.27	6.31
59	12.92	8.75	9.67	11.81	6.38	7.77	8.83	10.85	5.67	6.81
60	14.19	9.44	10.65	13.02	6.88	8.46	9.77	12.02	6.15	6.81
61	15.60	10.25	11.75	14.40	7.52	9.23	10.85	13.38	6.79	8.15
62	17.23	11.13	12.94	15.98	8.26	10.08	12.13	14.96	7.54	8.96
63	19.10	12.19	14.38	17.79	9.13	11.10	13.52	16.71	8.42	9.90
64	21.23	13.31	16.00	19.83	10.08	12.19	15.08	18.71	9.31	10.89

***Male rates apply to all coverage issued to Montana residents, regardless of sex.**

NOTE: Premiums are guaranteed to remain level for the first 10 years of coverage. Then, if still eligible, you may reapply for the 10-year level rates then in effect for a subsequent 10-year term. Rates for the subsequent term would be determined based on the insured person's then current age, health and tobacco/nicotine use and would be guaranteed for 10 years. If you or your spouse are not approved for a subsequent 10-year term of guaranteed rates, or do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis with increasing premiums as the insured ages.

Send no money now. You will be billed upon approval of your Application.

Payment Options

1. **Electronic Fund Transfer (EFT):** Have your premiums automatically deducted from your checking account on a monthly basis. No more writing checks and tracking due dates. You'll receive more information on this convenient payment option once your Application is processed.
2. **Semi-Annual Direct Bill:** Have your premiums billed to you directly on a semi-annual basis.

Current 2019 "Preferred" and "Select" Monthly† Premium Contributions Per $25,000 Benefit Amount

Member/ Spouse Issue Age	$100,000 Coverage Amounts		Coverage Amounts of $125,000 - $225,000		Coverage Amount of $250,000 - $1,000,000	
	Male Standard	Female* Standard	Male Standard	Female* Standard	Male Standard	Female* Standard
20-23	$5.85	$5.06	$4.98	$4.23	$4.33	$3.63
24	5.88	5.06	5.00	4.23	4.38	3.63
25	5.88	5.06	5.00	4.23	4.38	3.63
26	5.90	5.06	5.04	4.23	4.40	3.63
27	5.90	5.06	5.04	4.23	4.40	3.63
28	5.94	5.08	5.06	4.25	4.44	3.67
29	5.96	5.08	5.10	4.25	4.48	3.67
30	6.00	5.15	5.13	4.31	4.50	3.69
31	6.00	5.15	5.13	4.31	4.50	3.69
32	6.00	5.15	5.13	4.31	4.50	3.69
33	6.00	5.15	5.13	4.31	4.50	3.69
34	6.00	5.15	5.13	4.31	4.50	3.69
35	6.17	5.25	5.29	4.40	4.67	3.79
36	6.42	5.48	5.54	4.63	4.90	4.02
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51	21.25	14.94	19.85	13.75	18.69	12.79
52	22.65	15.83	21.19	14.63	19.98	13.65
53	24.08	16.77	22.60	15.54	21.33	14.52
54	25.73	17.71	24.17	16.44	22.85	15.38
55	27.63	18.71	26.00	17.40	24.58	16.31
56	29.71	19.58	28.02	18.25	26.52	17.13
57	31.94	20.44	30.19	19.06	28.63	17.90
58	34.48	21.31	32.63	19.92	30.98	18.75
59	37.44	22.46	35.48	21.02	33.73	19.81
60	40.92	24.00	38.83	22.50	36.96	21.23
61	44.69	25.94	42.48	24.38	40.48	23.04
62	48.79	28.25	46.46	26.63	44.29	25.21
63	53.63	30.92	51.13	29.19	48.77	27.65
64	59.52	33.92	56.81	32.08	54.35	30.44

***Male rates apply to all coverage issued to Montana residents, regardless of sex.**

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2. **Semi-Annual Direct Bill:** Have your premiums billed to you directly on a semi-annual basis.

Apply for up to $1,000,000 in Group Term Life Insurance today!

10-Year Group Term Life Insurance Plan

Things You Need To Know About This Coverage

Accelerated Death Benefit

The "Accelerated Death Benefit" option is available to help terminally ill insureds during a difficult and often financially challenging time.

This money can be used to help cover high prescription drug costs, medical bills, experimental treatments, or for a mortgage and daily household expenses - the choice is yours.

You can receive 50% of your (or your insured spouse's) benefit amount before death if you (or your insured spouse) are diagnosed as terminally ill. A terminal illness is a medical condition where the patient has a life expectancy of 12 months or less.

To qualify, a terminally ill insured must provide the insurance company with proof of terminal illness and anticipated life expectancy (12 months or less), as well as any other necessary medical information requested. The request must be made at least 12 months prior to the insured person's scheduled coverage termination age. (Your premiums will continue to be payable in full and the amount of insurance payable after the insured's death will be reduced by any payment made under this benefit.) For additional details and limitations, please see the Certificate of Insurance.

Please note that the receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult the appropriate social services agency and seek the advice of tax counsel.

Only One Exclusion

Coverage is provided for death from any cause, except death from suicide for the first two years coverage is in effect, whether sane or insane. The only benefit payable is the return of applicable premiums.

Note: Incontestability - Once your coverage has been in force for 2 years after your effective date your coverage is incontestable except for non-payment of premium.

Residents of Puerto Rico:
Please send the completed application to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, Puerto Rico 00902-3918

The 10-Year Level Term Life Plan is underwritten by:

New York Life Insurance Company
51 Madison Ave.
New York, NY 10010
under Group Policy G-29126-0
on Policy Form GMR-FACE/G-29126-0

The 10-Year Level Term Life Plan is administered by:

Mercer Consumer, a service of Mercer Health & Benefits Administration LLC
Mercer Consumer/Alumni Services
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

Questions?
If you have any questions or need more information about the 10-Year Group Term Life Insurance Plan or other insurance products, please call toll-free at 1-888-560-2586.

This brochure provides a general description of the insurance plan offered and is not a contract. Complete terms are detailed in Group Policy No. G-29126-0 (Policy Form GMR) issued to the Group Policyholder, the University of Illinois Alumni Association. Each insured individual will be provided with a Certificate of Insurance that summarizes the policy provisions affecting his/her coverage.

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