GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF ORGANIZATIONS PARTICIPATING IN THE ENGINEERING AND SCIENTIFIC ASSOCIATIONS ACCIDENT AND HEALTH INSURANCE TRUST

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

TO APPLY:
Complete this form and return with your premium check to:
ADMINISTRATOR
ESAHT GROUP INSURANCE PROGRAM
P.O. BOX 14533 • Des Moines, IA 50306
For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023918 • San Juan, PR 00902-3918

QUESTIONS?
Call: 1-800-424-9883
customerservice.service@getamba.com

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: _____

Social Security #: _____

Home Phone (_____)_____

Work Phone (_____)_____

Email Address: _____
AMBA will not share your email information.

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

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. weight _____lbs.

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

❑ Civil Union* ❑ Domestic Partner*
*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 ESAHT Trust of which your association is a participant? ❑ Yes ❑ No

Association Name:_____ Membership # _____ Exp. Date _____

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 30 hours per week at the place such duties are usually 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 $ _____

3. Insurance Requested:

Refer to the Plan Information/Insurance Brochure for eligibility, options, and coverage description.

I hereby apply for the following coverage: ❑ New ❑ Additions
Note: If you are increasing or altering present coverage in any way, indicate in item a. below, the TOTAL AMOUNT of coverage you are requesting.
You may choose any Monthly Benefit Option provided it and other disability income coverage you may have does not exceed the applicable percent shown below of your AVERAGE MONTHLY INCOME (as defined in the Plan Information/Insurance Brochure). If you have been self-employed for less than one year, your monthly benefit is limited to $1,100, with a 90-day waiting period under the Five-Year Plan.
I hereby apply for the coverage indicated below, based upon all my statements made in this Application:
a. Principal Monthly Benefit Option: $_____ (not to exceed 60% of your AVERAGE MONTHLY INCOME)
b. Benefit period (choose one): ❑ Career Plan ❑ Five-Year Plan
c. Waiting period (choose one): ❑ 90-day ❑ 180-day ❑ 365-day

3. Insurance Requested: (*continued)*

d. Payment option selected*:

❑ Option 1**:** Electronic Funds Transfer (EFT): I request and authorize the ESAHT Group Insurance Program, Inc. to make ❑ quarterly ❑ semiannual ❑ annual 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 Disability Income Insurance. (Enclose a VOIDED check)

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

❑ Option 2: Periodic Billing: ❑ Annual (April 1) ❑ Semiannual (April 1 and October 1) ($2.00 billing fee applies)
❑ Quarterly (January 1, April 1, July 1 and October 1) ($2.00 billing fee applies)

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

e. Do you now have or are you now applying for any other insurance that provides benefits if you are unable to work because of disability?
❑ Yes (please list below) ❑ No

Proposed Insured Company	Plan	Monthly Benefit	Benefit Period

f. Do you intend to discontinue any of the disability insurance listed in "e," 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 any 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?..... ❑ ❑

6. During the past two years, have you participated in, or 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?..... ❑ ❑

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

During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... ❑ ❑

8. **Except for the residents of CT and MN,** have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?..... ❑ ❑

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

YES NO

For residents of CT and MN only, 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?..... ❑ ❑

9. If you have answered any of the above Questions 1-8 "YES," give complete details below. (if you need more space, use 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 and the Fraud Notices indicated on the attached, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature _____ **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.

6/21 ed.

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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 your protection California law requires the following to appear on this form.
Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

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

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, LLC ("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, LLC 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

FOR MEMBERS OF ORGANIZATIONS PARTICIPATING IN THE ENGINEERING AND SCIENTIFIC ASSOCIATIONS ACCIDENT AND HEALTH INSURANCE TRUST

Underwritten by New York Life Insurance Company

INSURE YOUR INCOME – YOUR MOST VALUABLE ASSET

Your most important asset is your ability to earn income. Even if you are young and healthy, a serious illness or injury could put you out of work for months or even years - thus jeopardizing your livelihood. A reliable source of disability income protection is this Group Disability Income Insurance for members of the participating association.

Even if you have some disability insurance through your employer, it may not be enough. Many employers provide only a short-term salary continuation policy or short-term disability income. This Policy can be used to supplement benefits provided by your employer policy or as primary protection.

This Policy is designed to provide you with a regular monthly income when you are Totally Disabled and unable to work as the result of injury or sickness.

WHO IS ELIGIBLE?

The members of the participating association under age 65 who are at FULL-TIME WORK are eligible to request coverage. (Student members are not eligible unless working full-time.)

"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 30 hours per week at the place such duties are usually performed or other location to which travel is required.

This coverage is available to residents of the United States (except LA, NH, OR, SD, VT, WA and territories) and Puerto Rico.

HOW IT WORKS

Both policies pay monthly benefits when you are Totally Disabled. "Totally Disabled" means you are prevented by injury or sickness from performing the material and substantial duties of your usual occupation, provided you are not otherwise working for pay or profit. Benefits begin at the end of the waiting period, provided you are Totally Disabled.

Choice of Coverage

Career Coverage: If you are Totally Disabled before age 63, benefits are payable up to age 65. There is a two year maximum benefit for Total Disabilities starting at ages 63 through 69.

Five-Year Coverage: Benefits are payable up to five years for Total Disabilities starting before age 60. For Total Disabilities starting at ages 60 through age 62, benefits may continue up to age 65. For Total Disabilities starting at ages 63 through 69, benefits may continue for up to two years.

Choice of Monthly Benefit

You have a wide choice of Monthly Benefit Options, from $110 to $7,700 (in $110 units). However, members age 60 through 64 may not request a Monthly Benefit Option in excess of $1,650. The Principal option you choose, together with any other disability income insurance you have or for which you are applying, cannot exceed 60% of your AVERAGE MONTHLY INCOME.

NOTE: On the premium due date on or immediately after reaching age 65, Principal coverage in excess of $2,200 reduces to $2,200.

AVERAGE MONTHLY INCOME means your average monthly wages, salaries, commissions, fees and other amounts received for personal services - before deduction of income or social insurance taxes and after deduction of the normal business expenses which are deductible for income tax purposes - for the immediately preceding tax year, 24-month period or the entire period, if less than 12 months, whichever produces the highest average. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

Choice of Waiting Period

You also have a choice of four waiting periods before benefit payments begin: 90, 180, or 365 days. A waiting period is the number of consecutive days that you must be Totally Disabled before benefits commence. You should choose one that will provide benefits when your employer-provided salary continuation coverage runs out. Coverage with a longer waiting period is less expensive.

FEATURES

Waiver of Premium

For disabilities beginning before age 60, after you have been Totally Disabled for six consecutive months and have begun to receive benefits for Total Disability, all future premium contributions under the Policy will be waived for as long as you receive benefits for that disability.

Benefits for Recurring Disability

Successive periods of disability which are due to the same or related causes will be considered a single period of disability unless separated by return to FULL-TIME WORK for three consecutive months or more. Disabilities due to different or unrelated causes which are not separated by return to Full-Time Work will also be considered a single period of disability.

Rehabilitation Benefit

This benefit is designed to help certain disabled individuals return to the work force. Under this provision, a professional rehabilitation staff reviews case histories and identifies those individuals who appear to have the greatest likelihood of rehabilitation. Individuals selected by New York Life Insurance Company will be offered the option of participating in a rehabilitation program at no cost to them. Participation is voluntary and benefits will not be reduced due to participation in the program.

Spouse/Eldercare Benefit

An additional benefit of up to $500 per month, for up to 12 months, may be payable to a member who is receiving benefits for disability, is participating in an approved rehabilitation program, and has an eligible, terminally ill or disabled spouse or other specified family member, as described in the Certificate of Insurance.

Residual Disability Benefit

While you are recovering from a disability, you may be eligible to receive a Residual Disability Benefit if you return to work but are earning less than before you were disabled.

You must become disabled prior to age 65, be performing at least one of the material and substantial duties of your occupation on a full- or part-time basis, experience a 20-80% loss of earnings due to your disability, and be under the regular care of a physician other than your self or immediate family/household member. (A loss of earnings of more than 80% will be considered under the provisions for Total Disability.)

Benefits will be calculated as a percentage of your Principal Monthly Benefit Option relative to your loss of earnings, as described in the Certificate of Insurance.

The waiting period for Residual Disability Benefits will be the same as for Total Disability, but Residual Disability Benefits are not payable while Total Disability Benefits are payable under the group policy. However, the Residual Disability waiting period may be met by continuous disability that qualifies as either Total or Residual Disability.

Organ Transplant Benefit

If your disability results from a surgical procedure to donate an organ for transplant, you will be considered Totally Disabled. No waiting period will apply, and benefits will be payable from the first day of Total Disability. However, this benefit is payable only once in your lifetime, and no more than 6 monthly payments may be made.

Survivor Benefit

If you die - from any cause -after receiving disability benefits for at least 12 consecutive months before your death, the Monthly Benefit Option in force on the date of your death will be payable for six months (or until the maximum benefit period is reached, if sooner) to your surviving relative(s) in the following order of survival: your lawful spouse; or your children, equally; or your brothers and sisters, equally; otherwise, if there is no surviving relative, to the executor or administrator of your estate.

ADDITIONAL INFORMATION

Effective Date

You will become insured on the first of the month on or after 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 been effective and you are still eligible for insurance.

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

Note: There are instances where New York Life Insurance Company may be able to offer insurance, at the same cost, by eliminating coverage for a specific impairment or disease.

When Coverage Ends

Once coverage is validly in force, it may be continued to the premium due date on or immediately after you reach age 70. Your coverage will end earlier if: the maximum benefit period has been reached, you cease FULL-TIME WORK other than for reasons of disability, you cease to be a member of the participating association, the association ceases to be a participating organization, you fail to pay premium contributions when due, you enter full-time active duty in the armed forces (coverage may be restored upon termination of active duty status, subject to policy guidelines) or the group policy is terminated or modified by the policyholder or New York Life Insurance Company to end insurance on the group of insureds to which you belong.

Exclusions And Limitations

This Coverage does not provide benefits for any disability that occurs during or is due or related to: intentionally self-inflicted injury while sane or insane*; a PRE-EXISTING CONDITION (see below); use of drugs/intoxicants/narcotics/barbiturates/hallucinogenic agents(unless as prescribed by a physician); declared or undeclared war or any act thereof; military service; operating or riding in or descending from any aircraft except when riding as a fare-paying passenger on a commercial, licensed, non-military aircraft; or your incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime. It also does not provide benefits for any disability that is due or related to: pregnancy or childbirth (except complications thereof); or any impairment or disease specifically excluded from your coverage.

This Coverage limits benefits for disabilities due to Mental Disorders and/or Chemical Dependency to a maximum of 24 monthly payments.

The Maximum Benefit Period for all Covered Disabilities due or related to Self-Reported Symptoms may not exceed the lesser of 24 month or the Maximum Benefit Period of a Covered Disability.

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

**Missouri residents: the exclusion for intentionally self-inflicted injury is not applicable to injury caused by an attempted suicide while insane.*

Preexisting Condition Limitation

PREEXISTING CONDITION is an injury or sickness for which you consulted a doctor, received any medical services or supplies, or took any medication during the six months immediately before becoming insured under this Policy; an injury or sickness which is specifically excluded from your coverage.

Benefits are not payable for a disability which is classified as a PREEXISTING CONDITION until the end of the earlier of six consecutive months during which you have not consulted a doctor, received any medical services or supplies, or taken any medication for the condition; 12 consecutive months during which you have been insured under this Policy.

YOUR COST

The insurance cost is based on your attained age when coverage becomes effective and increases on the premium due date on or immediately after the date you reach a higher age bracket. Premium contributions will vary depending upon the options and amounts chosen.

CURRENT 2024 SEMI-ANNUAL PREMIUM CONTRIBUTIONS PER $110 MONTHLY BENEFIT OPTION

Principal Career Coverage Cost

Age	90 Day Waiting Period	180 Day Waiting Period	365 Day Waiting Period
Under age 30	$5.00	$4.50	$4.00
30-34	7.00	6.50	5.50
35-39	7.00	6.50	5.50
40-44	12.50	11.00	10.00
45-49	12.50	11.00	10.00
50-54	20.50	18.50	16.50
55-59	20.50	18.50	16.50
60-64*	20.50	17.00	13.50
65-69*+	19.00	15.50	12.50

Principal Five -Year Coverage Cost

Age	90 Day Waiting Period	180 Day Waiting Period	365 Day Waiting Period
Under age 30	$3.50	$3.00	$2.50
30-34	4.50	4.00	3.00
35-39	4.50	4.00	3.00
40-44	8.00	7.00	5.50
45-49	8.00	7.00	5.50
50-54	15.00	12.50	10.00
55-59	15.00	12.50	10.00
60-64*	20.50	17.00	13.50
65-69*+	19.00	15.50	12.50

*For disabilities commencing on or after the premium due date on or immediately after reaching ages 60 and 63, the maximum benefit period is reduced as previously described.

+Renewal only. On the premium due date on or immediately after reaching age 65, coverage in excess of $2,200 will reduce to $2,200.

The premium contributions shown reflect the current rate and benefit structure. 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, waiting period and Coverage. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Engineering and Scientific Associations Accident and Health Insurance Trust.

How to Calculate the Semi-annual Cost

1. Decide on the Coverage (Career or Five-Year).
2. Select your waiting period (90, 180 or 365 days).
3. Choose your Monthly Benefit Option (from $110 to $7,700 per month).
4. Determine the number of $110 units, and multiply the cost per $110 unit by the semi-annual premium contribution per unit based on the Policy, waiting period and your age.

For example, the rate for a $1,100 Monthly Benefit Option with a 90-day waiting period under the Career Coverage for a member age 35 is 10 x $7.00 or $70.00 semiannually.

Note: If you wish to pay annually, the premium is two times the semiannual cost; if you prefer to pay quarterly, the premium is one-half the semiannual cost.

HOW TO APPLY

The Group Disability Income Insurance is medically underwritten based on the information provided by you on the application. It is important that you complete the form truthfully and completely; failure to supply accurate information may invalidate coverage. Your application is subject to New York Life Insurance Company's approval and more medical information may be requested.

The exam and blood test will be paid for by the Policy.

1. Refer to the Policy description for benefits and premium cost as you fill out the application. Remember, only members (as described under Who Is Eligible) may apply.
2. Make out your check for the total amount of premium due, payable to: Administrator, Group Insurance Program. (Also, be sure to include a voided check, if you select the Electronic Funds Transfer (EFT) Option.)

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.

3. Mail the completed application with your check to:

   Administrator
   Group Insurance Program
   PO BOX 14533
   Des Moines, IA 50306
   (Residents of Puerto Rico, please see instructions below.)

RESIDENTS OF PUERTO RICO:

Please send the application and premium contribution (with your check payable to "Administrator, Group Insurance Program") to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan, PR 00902-3918

Consider Your Eligibility

Before you request coverage, you must be a member in good standing of the participating association. Please wait until your application for membership is accepted before initiating your insurance requests. If you have any questions regarding membership, contact your association directly.

CERTIFICATE OF INSURANCE

When you become insured you will be sent a Certificate of Insurance summarizing your insurance coverage. This brochure contains a partial description of some of the principal provisions ands definitions of the coverage. The complete terms are set forth in the policy issued by New York Life Insurance Company to the Trustees of the Engineering and Scientific Associations Accident and Health Insurance Trust.

MEDICAL REQUIREMENTS

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

Not all applicants will have to supply additional information. However, if required, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the Policy.

Requests for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

HOW TO FILE A CLAIM

To file a claim, call or write the Administrator for the proper forms.

30-DAY FREE LOOK

When you become insured, you will be sent a Certificate of Insurance summarizing your coverage. If you're not completely satisfied with the terms you may return it, without claim, within 30 days and your premium will be promptly refunded. No questions asked! Your insurance will then be invalidated.

This Group Disability Income Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-29275-0
on Policy Form G-29275-0/GMR-FACE

This Group Disability Income Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)

Group Insurance Program
P.O. Box 14533
Des Moines, IA 50306

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member Benefits & Insurance Agency

Questions?
We're Only a Phone Call Away

If you have questions about your eligibility, what the Policy covers or how to complete the application, just give us a call toll-free at 1-800-424-9883 between 7:30 AM and 6:00 PM, Monday through Friday, CST, or you can email us at customerservice.service@getamba.com.
One of our service representatives will be able to immediately provide you with the information you need.

The Engineering and Scientific Associations Accident and Health Insurance Trust incurs costs in connection with this sponsored policy. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The participating association may also receive a fee for the license of its name and logo for use in connection with the Policy.