GROUP LEVEL TERM LIFE INSURANCE TO AGE 65 APPLICATION

FOR MEMBERS OF THE IEEE

IEEE

NEW YORK LIFE

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

To Apply: Complete This Form And Return To:
ADMINISTRATOR
IEEE GROUP INSURANCE PROGRAM
P.O. Box 10374 • Des Moines, IA 50306-8812

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

QUESTIONS? Call: 1-800-493-IEEE(4333)
ieee.service@mercer.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:

(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*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any IEEE Group Life Insurance Plans? ❑ Yes ❑ No
If "yes," indicate which Plan(s) and provide details (person insured and amount of insurance): ❑ Term Life
❑ Level Term Life to Age 65 ❑ Universal Life ❑ Permanent Whole Life ❑ 10-Year Level Term Life ❑ 20-Year Level Term Life
Details:_____

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

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

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

		DATE OF BIRTH: MO. DAY YR.	**HEIGHT:**	**WEIGHT:**	**SEX:**
Member:	_____	____/____/____	____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 of the The Institute of Electrical and Electronics Engineers, Incorporated? ❑ Yes ❑ No
Membership # _____ Exp. Date _____
(Membership in IEEE is required for participation in this plan. Affiliate members are not eligible.)

3. Payment Option:

(Choose only one)

Total Semiannual Premium Contribution Enclosed: $_____

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the IEEE 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/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

❑ **OPTION 2: PERIODIC BILLING:** Semiannual (March 1 and September 1)

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

Total* Member Insurance Amount Requested: $ _____ Total* Spouse Insurance Amount** Requested: $ _____

Total Child Insurance Amount Requested: ❑ $10,000 each eligible child ❑ None

Note: Member coverage must be in force to request dependent coverage.

*Increased coverage requested in this application, if approved, will be issued in a separate, new Certificate of Insurance.

**Spouse coverage cannot exceed 100% of member's coverage.

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

Member: $ _____ Spouse: $_____

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

Member: $_____Company _____ Spouse: $_____ Company _____

b. 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)?

Member: ❑ 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)

c. INSURANCE REPLACEMENT:

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

Residents of New York: I have read the Important Replacement Information above.

Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

Residents of All Other States:

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

Member: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

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

I make the following beneficiary designation with respect to only the insurance requested in this application for Group Level Term Life Insurance to Age 65. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, or change the beneficiary for insurance under any other IEEE Group Level Term Life Insurance to Age 65 Certificate, 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 Member: _____

Beneficiary Social Security #:_____

Beneficiary Date of Birth: _____

Street Address: _____

City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____

Beneficiary Name:_____ (Last First MI)

Beneficiary's Relationship to Member: _____

Beneficiary Social Security #:_____

Beneficiary Date of Birth: _____

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.

AUTHORIZATION: (continued)

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.

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

Spouse's Signature X _____ **Date** _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Owner's Signature X _____ **Date** _____
(NECESSARY ONLY IF OTHER THAN MEMBER)

For purposes of the Insurance Companies Act (Canada), this document was issued in the course of New York Life Insurance Company's insurance business in Canada.

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.

4/14 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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group 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.

For Canadian residents the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590.

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 Level Term Life Insurance to Age 65 Plan

Underwritten by New York Life Insurance Company

For IEEE Members and Their Families

INSURANCE PROTECTION WITH A LEVEL PREMIUM

You can help protect your family from the financial hardships associated with your premature death with term life insurance that guarantees the same annual premium up to age 65. Once you are accepted into the IEEE Group Level Term Life Insurance to Age 65 Plan, you can relax knowing you'll pay the same attractive premium contribution year after year until age 65 when coverage terminates – regardless of age, health or even inflation. Your benefit and premium will remain the same.

WHO IS ELIGIBLE?

IEEE members ages 50–59 are eligible to apply for coverage for themselves, their lawful spouses age 50–59, and their unmarried dependent children ages 14 days through 22 years (24 if a full-time student). In order to become insured, individuals must provide satisfactory evidence of insurability and the required premium contribution must be paid.

A dependent who is a member is eligible for either member or dependent coverage, but not both. If both the member and spouse are covered as members, neither may insure the other as spouse and only one may insure any eligible children.

Non-Dependent Family Members: Any eligible "non-dependent" family members may also apply for coverage as long as they join IEEE as an Associate Member. For membership information, please call IEEE directly at 1-800-678-IEEE.

This coverage is available only for residents of the United States (except territories), Puerto Rico and Canada (excluding Quebec).

WHAT YOU CAN CHOOSE

MEMBER OPTIONS – $10,000 to $1,000,000 in multiples of $10,000.

SPOUSE OPTIONS – $10,000 to $1,000,000 in multiples of $10,000 (may not exceed 100% of member coverage).

EACH ELIGIBLE DEPENDENT CHILD — $10,000.

The total amount of coverage an individual may have under all group life insurance plans underwritten by New York Life Insurance Company may not exceed $2,000,000.

In addition, the total amount of coverage for an individual insured under all group life insurance plans issued by New York Life Insurance Company to the Trustee of the IEEE Life Insurance Plan may not exceed the maximum benefit option for any insured person.

PLAN FEATURES

Nonsmoker Discount Helps Reduce Costs

If you qualify, you can take advantage of the program's nonsmoking rates.

Volume Discounts for Member and Spouse

If you or your spouse becomes insured for options of $160,000 through $490,000, you'll receive a discount based on volume; and for options of $500,000 through $1,000,000 of coverage, you'll receive another volume discount.

Keep Your Cost Even More Manageable

You have the option to pay your premium contributions on a monthly basis via the Electronic Funds Transfer (EFT) Option (your monthly cost would be approximately one-sixth of the amount you calculate from the rate chart).

Valuable Living Benefit Provision "Accelerated Death Benefit"

The "Accelerated Death Benefit" option is available to help terminally ill insureds during a difficult and often financially challenging time. Under this provision, you may request one advance payment equal to 50% of a qualified terminally ill person's in force life insurance to be paid while that person is still alive. The request must be made at least 12 months prior to the insured person's scheduled coverage termination age, and the amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs…medical bills…outstanding debts…to help pay for experimental treatments…the cost of modifications to your home…or for a family vacation — the choice is yours.

To qualify, a terminally ill insured must provide New York Life Insurance Company with proof of terminal illness and anticipated life expectancy (12 months or less), as well as any other necessary medical information requested. For additional details and limitations, please see the Certificate of Insurance.

Please note that 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 with the appropriate social services agency and seek the advice of a qualified tax advisor.

Current 2021 Semiannual Premium Contributions

The cost of this coverage is based upon the member's and spouse's amount of insurance requested, usage of tobacco/nicotine products and attained age on the date coverage is issued. Premium contributions will vary depending upon the options chosen. **Manitoba and Ontario, Canada Residents:** Please see tax notice under HOW TO APPLY section.

Rates for Each $10,000 Option of Coverage

	Options less than $160,000		Options $160,000 but less than $500,000		Options $500,000 or higher	
Issue Age	Non-Smoker	Smoker	Non-Smoker	Smoker	Non-Smoker	Smoker
50	$11.46	$20.82	$9.72	$17.76	$9.36	$17.22
51	11.52	21.36	9.78	18.24	9.42	17.70
52	11.58	21.96	9.84	18.66	9.48	18.18
53	11.88	22.74	10.08	19.32	9.78	18.78
54	12.72	24.48	10.80	20.40	10.50	20.22
55	13.98	26.88	11.88	22.86	11.52	22.14
56	15.60	30.36	13.32	25.86	12.84	25.08
57	17.76	34.50	15.12	29.34	14.70	28.50
58	20.40	39.54	17.34	33.60	16.86	32.64
59	22.98	44.46	19.50	37.80	18.90	36.66

The current semiannual premium contribution for children is $3.00 for $10,000 of coverage for each child.

The premium contributions shown reflect the current rate and benefit structure.

How to Calculate Your Semiannual Cost*

To calculate your semiannual premium contribution, please follow the instructions below.

1. Decide on the amount of insurance you wish to request.
2. Determine the total amount of $10,000 member options and $10,000 spouse options you are requesting.
3. Multiply the cost per option (depending on whether non-smoker or smoker rates apply and whether your coverage option qualifies for a volume discount) by the number of options desired for member and/or spouse coverage.
4. If you wish to request child coverage, add $3.00 to cover all eligible children for $10,000.

For example, a member, age 55, requests $200,000 in coverage for him/herself and for his/her spouse, age 52, and both are qualified non-smokers. To calculate the cost of member coverage, multiply $11.88 by 20 = $237.60. To calculate the cost of spouse coverage, multiply $9.84 by 20 = $196.80. Add the cost for member coverage and the cost for spouse coverage to find your total semiannual cost ($237.50 + $196.80 = $434.40).

*If you select the convenient monthly Electronic Funds Transfer (EFT) Option, your cost will be approximately one-sixth of the semiannual cost shown. (Note: the amount billed may differ slightly due to rounding.)

ADDITIONAL PLAN PROVISIONS

No Exclusions

Benefits are paid for death from any cause, at any time, anywhere in the world. The validity of any amount of your life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and nonpayment of premium contributions.

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.

Group Conversion Privilege

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

Effective Date

You and your dependents will become insured on the date specified by New York Life Insurance Company provided the first premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you and your dependents are alive on that date. Coverage for any dependent who is confined at home, in a hospital or other medical institution or incapacitated so as to be unable to perform his or her normal activities on the date coverage would otherwise become effective will not become effective until the date he or she is no longer so confined or incapacitated, provided you are insured on that day and the dependent 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 Insurance Company.

When Coverage Ends

Your member coverage will terminate at the earliest of the date: (a) you reach age 65; (b) the premium contributions are not paid when due; (c) you cease IEEE membership; (d) the group plan is terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong; or (e) you request to terminate the coverage. Your dependent coverage will terminate when your member coverage terminates or if earlier, on the date: (a) your spouse reaches age 65; (b) your child reaches age 23 (25 if a full-time student); (c) your spouse ceases to be your lawful spouse; or (d) your child ceases to be your unmarried dependent child. Upon your death, coverage for insured dependents may continue as described in the Certificate of Insurance.

Certificate of Insurance

This information is only 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 Institute of Electrical and Electronics Engineers, Inc. Life Insurance Plan.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the Plan.

30-DAY FREE LOOK

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

Renewal Payments and Claims

Once you are accepted into the Plan, you will have a 31-day grace period for your payment of renewal premium contributions. When you want to submit a claim, call or write the Administrator for claim forms.

HOW TO APPLY

Consider Your Eligibility

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

Get Quicker, Easier Service When You Apply

The information provided 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.

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

The Group Level Term Life Insurance to Age 65 Plan is medically underwritten based on the information provided by you on the Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company approval and more medical information may be requested. A physical exam, EKG, blood test or other information may be required. If so, 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 Plan.

Apply in Three Easy Steps

Just follow these three easy steps to apply:

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 amount due, payable to: Administrator, IEEE Group Insurance Program.

   If you choose the convenient Electronic Funds Transfer (EFT) Option, be sure to include a voided check in addition to the check for the first monthly 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.ieeeinsurance.com to download the form.

IMPORTANT NOTICE TO RESIDENTS OF MANITOBA AND ONTARIO, CANADA: Manitoba and Ontario, Canada have enacted laws requiring taxation (Manitoba 7% and Ontario 8%) of all group insurance purchased by individuals. This tax will be added to the amount of any premium contributions due (in U.S. dollars), which is then reported and remitted to the province.

3. Mail the completed application with your check to:

   Administrator
   IEEE Group Insurance Program
   P.O. Box 10374
   Des Moines, IA 50306-8812

Residents Of Puerto Rico:

Please send your completed application and check for the initial premium contribution 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 Service Representative toll-free at 1-800-493-IEEE(4333).

This Group Level Term Life Insurance to Age 65 Plan Is Administered By:

Mercer

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

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

This coverage is available to residents of Canada (except Quebec). Mercer (Canada) Limited, represented by its employees Pauline Tremblay and Nicole Swift, acts as broker with respect to residents of Canada.

Any questions? Please call us toll-free at 1-800-493-IEEE(4333), between the hours of 7:30 am and 7:00 pm CT, Monday through Friday. You can also e-mail us at ieee.service@mercer.com, or visit our web site at www.ieeeinsurance.com.

This Group Level Term Life Insurance to Age 65 Plan Is Underwritten By:

NEW YORK LIFE

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-8100-1
on Policy Form GMR-FACE/G-8100-1

IEEE is compensated in connection with this sponsored group plan to provide and maintain this valuable membership benefit.

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