For Residents of Pennsylvania Only

Disability Income Insurance Application for Members of the Pennsylvania Bar Association

Your Other Partner

Request for Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

TO APPLY: Complete this form and return it to USI AFFINITY, 14 Cliffwood Avenue, Suite 310, Matawan, NJ 07747
Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes.

1. MEMBER INFORMATION:

Last Name _____ First Name _____ M.I. _____

Street Address _____ City _____ State _____ Zip Code _____

( ) _____ ( ) _____ ( ) _____

Home Phone Number Office Phone Number Mobile Phone Number

Home E-mail Address _____ Office E-mail Address _____

Social Security #: ____ - ____ - _____ Date of Birth: ____ /____ / ____ Height: ____ ft. ____ in. Weight: _____ lbs. ☐ Male ☐ Female

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed ☐ Civil Union* ☐ Domestic Partner*

*Eligibility of Domestic Partner/Civil Union is determined by state law. (Call administrator for Declaration of Domestic Partnership form to complete and return with application. Not applicable in OR.)

Are you now a member of the Pennsylvania Bar Association? ☐ Yes ☐ No If yes, Member ID#: _____

Are you presently insured by any other PBA-sponsored plan? ☐ Yes ☐ No

If yes, provide details: _____

Do you plan to reside outside the U.S. or Canada within the next 12 months?

Member: ☐ Yes, Country(ies) _____ For how long? _____ ☐ No

2. OCCUPATIONAL STATUS:

a) Occupation: _____ Main Duties: _____

b) "FULL TIME WORK" means actively performing the regular duties of your normal occupation for on the basis of at least 30 hours per week. Are you at FULL TIME WORK? ☐ Yes ☐ No

c) Gross Annual Income from: Salary: $_____ Self-Employment: $_____

Bonus: $_____ Commissions: $_____ **Total: $**_____

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

Is ANNUAL NET EARNED INCOME more than 25% above or below your previous year? $_____

If yes, what was your ANNUAL NET EARNED INCOME last year? $_____

If yes, what do you anticipate your ANNUAL NET EARNED INCOME will be for next year? $_____

3. PAYMENT OPTION (Choose only one):

☐ Bill Me Annually ☐ Bill Me Semi-Annually ☐ Charge My Credit Card (see below):

I request and authorize PBA Insurance Program, administered by USI Affinity, to make ☐ annual ☐ semi-annual charges against the credit card subsequently named by me, for the purpose of collecting premium contributions due under this plan. Please note, the charge will be listed as "USI Insurance Services" on your statement.

☐ Visa ☐ MasterCard Account #: _____ Exp. Date _____ 3-Digit Code:_____

Cardholder's Name: _____ Signature: _____

4. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to any benefits payable following the covered loss of my life under the AD&D portion of this coverage.

Beneficiary Name (First, MI, Last)	Beneficiary Address (Street, City, State, Zip)	Relationship	Social Security #

5. INSURANCE REQUESTED: (Refer to brochure for eligibility, options and coverage descriptions.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE, based upon all my statements made in this Request Form:

a) **Monthly Benefit Amount* Desired for Member Coverage:** $_____
*NOTE: If you are increasing or altering present coverage in any way, do NOT indicate just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting. Choose an amount within the ranges indicated below (in $100 increments):

Under Age 50: Up to $10,000/mo Age 50 - 54: Up to $6,000/mo Age 55 - 59: Up to $3,000/mo

b) **Waiting Period:** ☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days

c) **Optional Benefit Riders:** (select all those you desire)

☐ Automatic Benefit Increase (ABI) Option ☐ Future Purchase Option ☐ Recovery Option

d) Do you now have or are you applying for other insurance that provides benefits if you are unable to work because of a disability? ☐ Yes ☐ No If yes, provide details (insurance company, plan, monthly benefit, benefit period):

_____

e) Do you intend to discontinue any of the disability insurance listed in d) above, if the coverage applied for is approved? ☐ Yes ☐ No If yes, indicate which coverage and the date of termination:

_____

6. CONTACT INFORMATION: (Please initial any changes you make on this form.)

You will be contacted by a service provider on behalf of New York Life Insurance Company to ask about your medical history. What is the best time to contact you?

	Day of the Week	Time of Day	Preferred Telephone	Preferred E-mail Address
Member:	☐ Weekday ☐ Weekend	AM PM	( )	

Medical Requirements: Some, not all, members may need a physical exam, blood test, or EKG, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly—at your convenience and without any cost to you—through our professional paramedic service. A paramedic will contact you to make an appointment.

7. AUTHORIZATIONS AND SIGNATURES:

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, 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 representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked. 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 consents to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; and **attests** to having read the IMPORTANT NOTICE enclosed and Fraud Notices indicated below 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 Signature: _____ Date _____

(PLEASE SIGN AND DATE IN INK.)

FRAUD NOTICES

FRAUD NOTICE – 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.