



Please complete this form and return to:
Pearl Insurance, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348
Questions: Please call 1-800-438-2366

A Preferred Group Trust Participating Organization
GROUP 10-YEAR LEVEL TERM LIFE INSURANCE APPLICATION

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

PART I Personal Info

1. Member Information:

Full Name <name> S.S.#: --

Last First Middle Initial

Street Address <address>

City <city> State (or Province) <state> Zip Code <zipcode>

Phone Numbers:

Home () Work ()

Fax () E-mail _____

For internal use only. E-mail address will never be sold or shared.

Member: _____ Date of Birth: MO./ DAY / YR. _____ ft. _____ in. _____ lbs. Sex: M F

Spouse*: _____ Date of Birth: MO./ DAY / YR. _____ ft. _____ in. _____ lbs. Sex: M F
Name if proposed for insurance

Child*: _____ Date of Birth: MO./ DAY / YR. _____ ft. _____ in. _____ lbs. Sex: M F
Name if proposed for insurance

Child*: _____ Date of Birth: MO./ DAY / YR. _____ ft. _____ in. _____ lbs. Sex: M F
Name if proposed for insurance

*See Plan information 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.

In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member: Yes No Country(ies) _____

Spouse: Yes No Country(ies) _____

2. Membership Affiliation:

Association Membership is required for participation in this plan. Membership # _____

3. Insurance Requested: Refer to plan information for eligibility, options and coverage description

I HEREBY APPLY FOR THE FOLLOWING GROUP 10-YEAR LEVEL TERM LIFE INSURANCE COVERAGE:

A. MEMBER OPTION: Insurance requested: \$ _____

SPOUSE OPTION*: Insurance requested: \$ _____ CHILD OPTION**: \$2,500 \$5,000 \$7,500 \$10,000

*Spouse coverage cannot exceed 100% of member's coverage. **Member coverage must be in force to request child coverage.

B. TOBACCO/NICOTINE USE: Have you or your spouse (if applying for insurance) used tobacco or nicotine in any form, including nicotine patches or nicotine chewing gum, within the last 24 months?

Member: Yes No Spouse: Yes No
If yes, when were tobacco or nicotine products last used? Member: _____ / _____ Spouse: _____ / _____
MONTH/YEAR MONTH/YEAR

C. INSURANCE REPLACEMENT:

RESIDENTS OF NEW YORK: I have read the Important Replacement Information enclosed in my package. 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 OTHER STATES: Is the Insurance applied for intended to replace, discontinue or change an existing policy?

Member: Yes No Spouse: Yes No

ALL RESIDENTS: IF ANY OF THE ABOVE ARE ANSWERED YES, PLEASE COMPLETE BELOW.

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 _____

4. 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 and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Administrator).

Beneficiary Name: _____
Last First Middle Initial

Beneficiary's relationship to Member, and Social Security #: _____

Street Address _____ City _____ State _____ Zip Code _____

PART II Your Coverage

5. Member Statement of Health: Please read, sign, and date.

Please answer the following questions as they apply to you and all dependents to be insured. YES NO

- a. Are you taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?
b. During the past five years have you ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?
c. During the past five years have you been counseled, treated, or hospitalized for the use of alcohol or drugs?

Details: (please fill out if answered "YES" to a, b, or c)

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.

What time and telephone number would be best to contact you?

6. Declaration:

I request the group insurance shown above. To the best of my knowledge and belief: (a) I am eligible for such insurance, and (b) the statements I have made are true and complete. 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 Insurance Company 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 and that any material misstatements or failures to report information material to risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) insurance will become effective on the date approved by New York Life Insurance Company if I and any approved dependents are performing the normal activities of a person in good health of like age (or with respect to North Carolina residents, performing the normal activities of a person of like age) on that date and the initial contribution is paid within 31 days after the date I am billed; and (b) any dividend apportioned to the group policy will be paid to the Trustee of the Preferred Group Trust.

Fraud Warning Statements

Any person who knowingly and with intent to defraud any insurance company or other person who 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 CO residents, 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 DC residents, the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant. For FL residents: 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. For LA residents: 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 PR residents: 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. For VA residents: 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.

AUTHORIZATION: I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering my request for insurance. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for insurance, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. 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, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). New York Life may release information covered by this AUTHORIZATION to the Plan Administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. 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. A photocopy of this request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

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

To the best of my knowledge and belief, the statements made regarding my health and tobacco/nicotine use are true and complete.

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

Owner Information, required if owner is other than the member (If Owner is a Trust, please submit a copy of the document with this application).

Full Name: LAST FIRST MIDDLE INITIAL Relationship to proposed insured:

Mailing Address: STREET CITY STATE ZIP CODE

Tax ID#: Date of Birth: / / Social Security #: - -

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

Be Sure To Complete All Pages and Sign Last Page

Do Not Send Payment: Upon approval, you will be notified of the premium due.