# GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE ILLINOIS STATE BAR ASSOCIATION

ILLINOIS STATE BAR ASSOCIATION®

**TO APPLY:**
Send no money now.
Complete this form and return to:
**ADMINISTRATOR**
ISBA **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:** 1-800-503-9230
customerservice.service@getamba.com

NEW YORK LIFE

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

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: _____

Please check one: ❑ Home address ❑ Business address

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.

Height: _____ft _____in. Weight _____lbs.

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 the Illinois State Bar Association or a lawful spouse of such member ? ❑ Yes ❑ No
Membership # _____

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 25 hours per week at the place such duties are normally 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 $ _____

"ANNUAL NET EARNED INCOME" means your wages, salaries, commissions, fees and other amounts received for personal service—before deduction of income or social insurance taxes and after deduction of normal business expenses which are deductible for income tax purposes—for any twelve-month period. It does not include income from interest, dividends, rent, royalties, annuities, other insurance or other unearned income.

## 3. Insurance Requested: Refer to the Plan Information/Plan Details for eligibility, options, and coverage description.

I request the following coverage: ❑ new ❑ additional
If you are increasing or altering your present amount of coverage, indicate the new TOTAL AMOUNT in item A. below.

**You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you have** or for which you are applying **does not exceed 70% of your AVERAGE MONTHLY INCOME, as defined in the brochure.**

**I hereby apply for the coverage indicated below, based upon all my statements made in this application:**
A. **Monthly Benefit Option ($500 through $7,500 in $100 multiples) :** $_____

B. **Waiting Period:** ❑ 30-day ❑ 60-day ❑ 90-day ❑ 180-day ❑ 360-day

C. Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the ISBA Group Insurance Program, Inc. to make monthly withdrawals against the account specified on the attached voided check, and such bank to process the withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Insurance Plan. (Enclose a voided check.)

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

❑ **Option 2:** Periodic Billing: ❑ Quarterly ❑ Semiannual ❑ Annual A $2.00 billing fee will be included for modes other than Annual and EFT.

E. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability?
❑ Yes ❑ No IF YES, PLEASE LIST

| 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 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?..... | ❑ | ❑ |

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

| | | YES | NO |
|---|---|---|---|
| **6.** | During the past two years, have you participated in, or does any person 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: _____ | | |
| **8.** | During the past five years, have you had your driver's license suspended, revoked, or had any moving violations?..... | ❑ | ❑ |
| **9.** | **Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?..... | ❑ | ❑ |
| | **For residents of Minnesota and Connecticut,** 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?..... | ❑ | ❑ |

**10.** If you have answered any of the above Questions 1-9 "YES," give complete details below. (If you need more space, used 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: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |

**FRAUD NOTICE –** ***For residents of all states except 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. **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.

**FOR RESIDENTS OF CA:** 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 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 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 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.

**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, LLC ("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.

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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, LLC; and **attest** to having read the IMPORTANT NOTICE attached and the Fraud Notices indicated above, including how our 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.**

8/22 ed.

**IMPORTANT NOTICE:**

**How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income Insurance 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, 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** **8/12 ed.**

# Group Disability Income Insurance

**For Members of the** Illinois State Bar Association
**Underwritten by New York Life Insurance Company**

ILLINOIS STATE BAR ASSOCIATION®

## THIS INSURANCE CAN REPLACE A PORTION OF YOUR INCOME WHEN YOU CAN'T WORK

If a covered disabling accident or illness suddenly took away your ability to work and as a result also took away your ability to earn a paycheck how would you continue to afford the living expenses you must now pay? With the Group Disability Income Insurance sponsored by your association, your income would continue in the form of a monthly benefit that you select. You can select short-term or long-term insurance protection. Don't let a disability rob you of your income, Group Disability Income Insurance can help to protect you when you can't work due to a covered accident or illness.

## WHO IS ELIGIBLE?

ISBA Members who are under age 60 and at FULL-TIME WORK can request coverage, provided they reside in the state of Illinois. However, members on active duty in the armed forces and full-time students are not eligible.

"FULL-TIME WORK" means the active performance for pay or profit of the regular duties of your normal occupation on the basis of at least 25 hours per week.

## HOW THE COVERAGE WORKS

You can request a monthly benefit amount from $500 to $7,500, in $100 units. However, the monthly benefit which you are requesting, combined with any other disability coverage you have or for which you are applying, cannot exceed of 70% of your AVERAGE MONTHLY INCOME.

Monthly benefits will be paid up to the maximum benefit period: to age 65 for disabilities beginning before age 65, and; 2 years for disabilities beginning on or after age 65. For disabilities due to mental disorders or chemical dependency, the benefit period will not exceed two years, all ages.

### YOU CAN SELECT YOUR MONTHLY BENEFITS

AVERAGE MONTHLY INCOME means, as of any date:

1. If you're self-employed: your average monthly wages, salaries, commissions, fees and any other amounts received by such person for personal services. If your business is incorporated, it also includes the cost of fringe benefits and share of monthly net profit, whether received or not.
2. If you're not self-employed: the basic monthly rate of compensation from your employer, including commissions.

AVERAGE MONTHLY INCOME does not include income from bonus, overtime pay or other extra compensation. It is computed before deduction of any income taxes or social insurance taxes and after deduction of normal and usual business expenses that are deductible for income tax purposes. AVERAGE MONTHLY INCOME is the average for the immediate preceding tax year or two tax years, whichever produces the higher figure (or entire period, if less than 12 months).

### Waiting Period

A waiting period is the number of consecutive days that you must be disabled before benefits commence. Coverage with a longer waiting period is less expensive. Under this coverage, you can select from four waiting periods: 60, 90, 180 of 360 days.

## IMPORTANT FEATURES

### Waiver of Premium Benefit

After a covered total disability for which you have received benefits for six consecutive months, premiums will be waived for as long as you are continuously disabled and receiving benefits. When you stop receiving monthly benefits, premiums must again be paid when due.

### Related Disability Benefits

Successive periods of disability due to the same or related cause, when separated by a return to FULL-TIME WORK for less than 6 continuous months, shall be considered one period of total disability as will unrelated disabilities that are not separated by a return to FULL-TIME WORK of at least one day.

**Vocational Rehabilitation**

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.

## HOW IT WORKS

**Helps Protect You as a Trial Lawyer**

This coverage pays benefits if you are totally disabled. You will be considered totally disabled, during the waiting period and next 24 months, if due to covered Injury or Sickness, you are completely and continuously unable to perform the material duties of your regular occupation.

After the initial 24 month period, TOTAL DISABILITY is defined as the complete inability to perform the material duties of any occupation for which you may qualify based on your education, training or experience.

**Survivor Benefits**

If you die after receiving the monthly benefit for six consecutive months, an eligible survivor will receive a one-time benefit payment equal to three times the last net monthly benefit paid to you. Eligible survivors include your spouse or, if spouse is deceased, your surviving children under age 23. Only one such benefit is payable.

**CURRENT 2025 MONTHLY PREMIUMS**
**PER $100 OF BENEFIT**

| Insured Member's Age | 60 Day Waiting Period | 90 Day Waiting Period | 180 Day Waiting Period | 360 Day Waiting Period |
|---|---|---|---|---|
| Under Age 25 | $0.87 | $0.72 | $0.46 | $0.43 |
| 25 – 29 | 0.87 | 0.72 | 0.51 | 0.47 |
| 30 – 34 | 1.37 | 1.14 | 0.74 | 0.69 |
| 35 – 39 | 1.88 | 1.56 | 1.05 | 0.98 |
| 40 – 44 | 2.39 | 1.98 | 1.37 | 1.28 |
| 45 – 49 | 3.52 | 2.92 | 2.11 | 1.97 |
| 50 – 54 | 4.94 | 4.10 | 2.92 | 2.73 |
| 55 – 59 | 5.45 | 4.52 | 3.18 | 2.98 |
| 60 – 64* | 5.95 | 4.94 | 3.44 | 3.22 |
| 65 - 69* | 5.95 | 4.94 | 3.44 | 3.22 |

Your initial premium and all renewal premiums are based on your age and age at each renewal. All changes in premium and coverage will be calculated as of the next premium due date following attainment of age. 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. Benefits option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and Illinois State Bar Association.

Rates in this brochure will not be changed unless they are changed for all insureds in your classification, or when you reach the next age category.

*For renewal purposes only – only those under age 60 may apply. Insurance terminates at age 70.

If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To avoid the fee, select Electronic Funds Transfer (EFT) or Annual as a safe and secure payment option.

**TO COMPUTE YOUR PREMIUM**: Select Short-Term or Long-Term coverage. Multiply the premium listed for your age group by the number of $100 units of monthly coverage you select. The monthly benefit amount you select may not exceed 70% of your basic monthly pay, exclusive of bonuses, dividends and overtime pay.

# TERMS OF COVERAGE

## YOUR EFFECTIVE DATE

Insurance for this Disability Insurance becomes effective on the first of the month after the date the application is approved by the New York Life Insurance Company, provided the first premium is paid when due. You must be FULL-TIME WORK on the date insurance is to take effect. If not, insurance will take effect on the day you resume such FULL-TIME WORK.

## WHEN COVERAGE ENDS

Your insurance will end at the earliest of the following: the date group policy ends or is amended to end insurance for your class; the end of the period for which the last premium has been paid; the date you cease FULL-TIME WORK for reasons other than TOTAL DISABILITY; the date you receive covered total disability benefits for the Maximum Benefit Period, you begin full-time active military duty; or the premium due date coinciding with or next following the date you attain age 70.

## EXCLUSIONS AND LIMITATIONS

No benefits are payable for any period of disability during which the insured person is not under the direct care and treatment of a licensed physician. Moreover, no benefits are payable for any disability that is due or related to: intentionally self-inflicted injury whether sane or insane; war or act of war disability that is due or related to a condition which has an impairment restriction; normal pregnancy or childbirth or voluntary abortion (complications of pregnancy are covered); incarceration for or participation in (except as a victim) an illegal occupation/activity or the commission of a crime; PRE -EXISTING YOUR CONDITION as defined below; or; active military service. For disabilities due to mental disorders or chemical dependency, the benefit period is limited as previously noted.

A PRE -EXISTING CONDITION is an injury or illness for which you consulted a physician, took medication, or received medical services or supplies during the immediate 12 -month period prior to becoming insured under this policy. Benefits are not payable for a disability due to a PRE -EXISTING CONDITION until the end of: the earlier of 12 consecutive months during which you have not consulted a physician, took medication, or received medical services or supplies, or; 24 months.

**TAKE THIS TIME NOW TO COMPLETE THE APPLICATION THAT HAS BEEN ENCLOSED FOR YOUR USE.**

**SEND NO MONEY NOW! YOU WILL BE BILLED WHEN YOUR APPLICATION IS APPROVED.**

# HOW TO APPLY

**1.** Complete the enclosed Application Form. It is extremely important that you answer fully the questions about medical history on this form. New York Life Insurance Company will rely upon your answers, and failure to provide complete and truthful information may invalidate coverage. Please note that New York Life retains the right to request additional medical information and may contact you directly.

If you choose the Electronic Funds Transfer (EFT) Option, be sure to include a voided check.

2**.** Mail the Application Form to this address:

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

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

# ABOUT YOUR REQUEST FOR COVERAGE

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

Not all applicants will have to supply additional information. However, if it is required, we will arrange for a professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test are free of charge.

## 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 receive a full refund — no questions asked!

## HOW TO FILE A CLAIM

To file a claim, write the Administrator for claim forms.

**This Group** Disability **Insurance is Underwritten by:**

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. 30857-0
on Policy Form GMR-FACE/G-30857-0



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**This Group** Disability **Insurance is Administered by:**

Association Member Benefits Advisors, LLC (AMBA)

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

Any questions?
1-800-503-9230
www.isbainsuranceplans.com

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

This brochure contains only a partial description of some of the principal provisions and definitions of the coverage. The complete terms and conditions are as set forth in the group policy issued by New York Life Insurance Company to the Illinois State Bar Association.





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10/24 ed.