

■ **Please list** any hospital, surgical or medical insurance you or your dependents now carry or have an application pending for. Also indicate if you intend to terminate this coverage if your application for coverage under this plan is approved.

Company	Type of Plan	Coverage to be Terminated?
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="checkbox"/> Yes <input type="checkbox"/> No

**IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS
(i.e. lawful spouse and unmarried, dependent children under age 25):**

Spouse's full name (last, first, middle initial):	Date of Birth (mm/dd/yy)	Place of Birth	Height (Ft., In.)	Weight (lbs.)	<input type="checkbox"/> Male <input type="checkbox"/> Female
Child (full name):					<input type="checkbox"/> Male <input type="checkbox"/> Female
Child (full name):					<input type="checkbox"/> Male <input type="checkbox"/> Female
Child (full name):					<input type="checkbox"/> Male <input type="checkbox"/> Female

**COMPLETE HEALTH QUESTIONS BELOW: ANSWER THE FOLLOWING
QUESTIONS AS THEY APPLY TO YOU AND ALL DEPENDENTS TO BE INSURED**

- | | YES | NO | | | YES | NO |
|---|--------------------------|--------------------------|--|--|-----|----|
| 1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 20 or more hours per week at your usual place of business? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 2. 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? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 3. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 4. During the past 5 years, has any person to be insured consulted any physician or other practitioner, been hospitalized or had an operation or had any illness, disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 5. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 6. Is any person to be insured now pregnant? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 7. During the past 10 years, has any person to be insured ever had: | | | | | | |
| a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| b. Arthritis, back trouble, bone or joint disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| c. Fainting spells, convulsions, or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| d. Sugar, blood, albumin or pus in urine? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| e. Diabetes, kidney trouble, ulcers or digestive disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| f. Disorder of breast or reproductive organs or functions? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| g. Nervous or mental disorder, emotional condition or psychiatric care? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| h. Cancer, tumor or cyst? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| i. Varicose veins, hemorrhoids or hernia? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| j. Disorder of eyes, ears, nose or sinuses? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| k. Thyroid, liver or respiratory disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| l. Alcoholism or drug habit? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| m. Disorder of the blood? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| n. Other health or physical impairment including: | | | | | | |
| (i) Testing positive for exposure to HIV infection, or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC) caused by the HIV infection, or other sickness or condition derived from such infection? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| (ii) Any other disorder of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| (iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, or undiagnosed symptoms, in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| (iv) Any other impairment? | <input type="checkbox"/> | <input type="checkbox"/> | | | | |
| 8. If you have answered Question 1 "No," or any other Questions "Yes," give complete details below. (Attach a separate sheet if necessary, sign and date.) | | | | | | |

Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Practitioners and Hospitals where confined or treated:

I request the group insurance shown on the reverse side. 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 has the right to require additional information and, if necessary, an examination by a physician, and that such insurance may be subject to any impairment restriction(s) established by New York Life. 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 and that any misstatements or failure to report information material to the 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 first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I am actively performing any and all duties of my occupation and any approved dependents are actively performing the normal activities of a person in good health of like age on the date of approval; (b) any person who is not performing such duties/activities as required will not become insured until the day he/she is performing such duties/activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the Group Policyholder. I also understand that benefits may not be payable for up to two years after the effective date of coverage for losses due to a disease or condition which I or any person to be covered, now have/has or have had in the past, and which is not disclosed on this form.

AUTHORIZATION: I authorize disclosure of the types of information detailed in this AUTHORIZATION, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, 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 the 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 to New York Life, its subsidiaries or the plan administrator with nonmedical 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 otherwise use or disclose information about me without my further written authorization as described in the HIPAA NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION. New York Life may release information covered by this AUTHORIZATION 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 New York Life or any other person already has disclosed or collected information or taken other

DETACH AND RETAIN FOR YOUR RECORDS

**IMPORTANT NOTICE: How New York Life Underwrites
Your Request For Coverage**

Information regarding insurability will be treated as confidential. In considering whether the persons in your request for Insurance quality for coverage, we will rely on the medical information you provide, and on the information you authorize us to obtain from your doctor, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (Medical Information Bureau). New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. New York Life may use or disclose information as described in the HIPAA Notice of Privacy Practices for Protected Health Information. We may make a brief report to MIB; however, we will not disclose our underwriting decision. 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.

MIB is a nonprofit organization of life insurance companies which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or non medical information may be given to the Bureau, which may then be furnished to member companies.
(continue on reverse)

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 this AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agency. In this case, the information may no longer be protected by the rules governing this AUTHORIZATION. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent will receive a copy of this signed AUTHORIZATION.

Member's Signature x _____
(PLEASE SIGN IN INK)

DATE

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

Spouse's Signature x _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

DATE

Form GPA-AC-1
G-29074-0

5/04ed

COMPLETE THIS FORM AND RETURN TO:
CBCA ADMINISTRATORS, INC.
P. O. Box 996
Fort Worth, TX 76101-0996

**DO NOT SEND YOUR CHECK WITH THIS APPLICATION FORM.
YOU WILL BE BILLED FOR THE APPROPRIATE AMOUNT.**

Page 4

DETACH AND RETAIN FOR YOUR RECORDS

IMPORTANT NOTICE (continued)

Upon written request to New York Life or MIB, you will be provided with nonmedical information; generally medical information, will be given directly to the proposed insured or to a medical professional designated by the proposed insured. If you question the accuracy of the information provided by MIB, you may contact the MIB and seek a correction.

If we cannot provide the coverage you request 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. For U. S. residents, your request is handled in accordance with the Fair Credit Reporting Act procedures. MIB's information office is at P. O. Box 105 Essex Station, Boston, MA 02112, telephone 617.426.3660. For Canadian residents, the address is 330 University Avenue, Suite 403, Toronto, Ontario, Canada M5G 1R7, telephone, 416.587.0590.

If we can provide the coverage you requested, we will inform you as to when such coverage will be effective. Under no circumstances will coverage be effective prior to this date. Payment of a premium contribution with your application does not mean that there is any insurance in force before the effective date as determined by New York Life.

NEW YORK LIFE INSURANCE COMPANY

5/04ed