Trust for Insuring Educators

Member Insurance Program

Administered by Forrest T. Jones & Company®

Group Term Life Insurance Spouse & Dependents Coverage

INSTRUCTIONS

How do I apply?

1. **Complete the application online.** *(If you prefer to complete the application by hand, please type or print all answers in ink.)*

2. **Print the completed application — sign** *(We suggest you keep one copy of the signed application with your important papers)* and **mail** it to:

Forrest T. Jones & Company, Inc.
P.O. Box 418131
Kansas City, MO 64141-8131

We will contact you within seven business days to let you know if your request for coverage has been approved or if additional information is required.

30-Day Free Look

When you receive your certificate of insurance, review it carefully. If you are not completely satisfied with the terms of your coverage, simply return your certificate without claim within 30 days. Your insurance will be invalidated and your premium refunded promptly.

What if I have questions?

Contact us by e-mail, postal mail or telephone and our customer service representative will be happy to answer your questions.

info@ftj.com

Forrest T. Jones & Company, Inc.
P.O. Box 418131
Kansas City, MO 64141-8131

800.821.7303

Thank you for your interest in this valuable coverage.

Not available in all states.

Application begins on page 4 ▶

TIE Group Term Life Insurance

Explanation of Features & Benefits

Eligibility: Members of TIE-affiliated associations under the age of 55 are eligible for this EZ-Acceptance insurance offer.

No Medical Exam: No medical exam is required. Acceptance for this coverage is based on your answers to three health questions.

No Waiting Period: Full benefits are payable from the day your coverage begins. Coverage becomes effective the first day of the month following approval of your application providing your premiums are paid promptly and you are performing your normal daily activities and not confined to a hospital or other medical institution.

30-Day Satisfaction Guarantee: If for any reason you change your mind about this insurance, simply return your insurance certificate within 30 days without claim. Your paid premiums will be refunded in full, no questions asked.

Security & Dependability: TIE Group Term Life Insurance is underwritten by New York Life Insurance Company, one of the country's oldest and most stable life insurance companies in business since 1845. Forrest T. Jones & Company, the plan administrator, has served the needs of America's educators since 1953 and has been the TIE insurance administrator for over 50 years. Both are trusted names in the life insurance industry.

Accelerated Death Benefit: You are entitled to access 50% your benefit amount if you're diagnosed with a terminal illness and given a life expectancy of 12 months or less (Illinois 24 months).* Full premiums continue to be payable. Upon your death, the remaining benefit paid will be reduced by this amount.

Your coverage continues as long as you are disabled and is subject to decrease as shown under the rate table.

Disability Waiver of Premium: Your premiums are waived if you become totally disabled before age 60 and your disability lasts at least nine months.

Single Limitation: If death results from suicide in the first two years, benefits are limited to a refund of premiums paid. (Missouri residents: one year.)

Premium Payment: You have a choice of paying your premiums quarterly, semi- annually or annually. Premiums may be paid by check, credit card or electronic funds transfer (EFT).

Current Quarterly Rates: Premium rates increase each time you enter a new 5-year age band. **

When Coverage Becomes Effective: Coverage becomes effective on the first of the month following approval of your application by New York Life Insurance Company, provided your first premium payment is paid within 30 days and are not confined to a hospital or other medical institution and are performing normal daily activities that day

Your coverage continues as long as you remain a member of your association, premiums are paid when due, and the group policy is not terminated by New York Life Insurance Company or the Trust for Insuring Educators.

* *Accelerated death benefits are not available in Massachusetts. Receipt of accelerated death benefits may affect eligibility for Public Assistance Programs. Prior to applying for accelerated death benefits you should consult with the appropriate Social Service agency and/or financial advisor or attorney.*

** *You cannot be singled out for a rate increase. Rates shown are current and can be changed on any premium due date and on any date when benefits are changed. Benefit changes are by agreement between New York Life and the Trustee of the Trust for Insuring Educators. Automatic coverage reduction begins at age 60 to $13,350; at age 65 to $7,600 and age 70 to $600. Premiums do not reduce. Visit www.ftj.com for more details or contact the Plan Administrator.*

Current Quarterly Rates as of 2023

For $60,000 of Coverage

Member's Age	Non-Smoker	Smoker
Under 25	$5.40	$6.75
25-29	$5.58	$6.99
20-24	$8.55	$10.68
35-39	$12.60	$15.75
40-44	$17.55	$21.93
45-49	$24.75	$30.93
50-54	$42.75	$53.43

For $100,000 of Coverage

Member's Age	Non-Smoker	Smoker
Under 25	$9.00	$11.25
25-29	$9.30	$11.65
20-24	$14.25	$17.80
35-39	$21.00	$26.25
40-44	$29.25	$36.55
45-49	$41.25	$51.55
50-54	$71.25	$89.05

For $140,000 of Coverage

Member's Age	Non-Smoker	Smoker
Under 25	$12.60	$15.75
25-29	$13.02	$16.31
20-24	$19.95	$24.92
35-39	$29.40	$36.75
40-44	$40.95	$51.17
45-49	$57.75	$72.17
50-54	$99.75	$124.67

For $180,000 of Coverage

Member's Age	Non-Smoker	Smoker
Under 25	$16.20	$20.25
25-29	$16.74	$20.97
20-24	$25.65	$32.04
35-39	$37.80	$47.25
40-44	$52.65	$65.79
45-49	$74.25	$92.79
50-54	$128.25	$160.29

This is a brief description of the important features of this plan. It is not a contract. The complete terms and conditions are set forth in the group policy issued by New York Life to the Trustee for the Trust for Insuring Educators on Policy Form GMR-FACE-G6300.

Important Notice

How New York Life Obtains Information and Underwrites Your Request For Life Insurance

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.

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 applications 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 (TTY 866 346-3642). 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 website at www.mib.com.

For NM Residents: Protected Persons[1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION2 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 person 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 as family member, employer or associate of a victim of domestic abuse or a person withwhom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company 8.12 ed

Trust for Insuring Educators
Established 1973
Serving more than 60 associations representing more than 1.5 million members

Underwritten by:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

Administered by:
Forrest T. Jones & Company®
3130 Broadway / Box 418131
Kansas City, MO 64141-8131
(800) 821-7303 / www.ftj.com

Arkansas license #100107380. California license #0592939

#8948 0223

Trust for Insuring Educators

Group Term Life Insurance
Spouse & Dependent Application

S1
TIE-045-030
TIE-045-031

Request for Group Insurance from:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Complete this Form and Return to:

*Forrest T. Jones & Company® **
Group Insurance Administrator
P.O. Box 418131, Kansas City, MO 64141-8131
** Forrest T. Jones Consulting Company in Arizona*

Please print in ink or type; initial and date any changes.

1 Member Information:

Name: _____ Date of Birth: ____/____/_____
First Name Middle Initial Last Name

Address: _____
Street Apt./Room # City State ZIP

Association: _____ Are you a current member of your association? ❑ Yes ❑ No

Spouse Information:

Some states define eligibility to include domestic partner – Contact the Group Insurance Administrator for declaration of domestic partnership.

Name: _____ Date of Birth: ____/____/_____
First Name Middle Initial Last Name

Address: _____
Street Apt./Room # City State ZIP

Gender: ❑ Male ❑ Female Height *(ft. in.)*_____ Weight: *(lbs.)*_____ Social Security Number: _____

E-mail Address: _____ Daytime Phone: (_____) _____

Do you intend to reside outside the U.S. or Canada in the next 12 months?

❑ Yes ❑ No If yes, how long? _____ Country _____

Have you used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)?

❑ Yes ❑ No If "yes," please state when you last used tobacco or nicotine products and specify the product used.

(Mo/Yr) ____/_____ Product _____

2 Insurance Requested: (Refer to fact sheet for rates, eligibility, options and coverage description.)

I hereby apply for the following spouse coverage:

❑ $60,000 ❑ $100,000 ❑ $140,000 ❑ $180,000

Spouse coverage cannot exceed amount of member's coverage.

Current rates are shown in the attached Explanation of Features & Benefits; rates increase each time you enter a new 5-year age band. Current rates may be changed by New York Life on any premium due date and on 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 under this policy. For example, a class of insureds is a group of people with the same issue age and gender. Offer is limited to members and spouses under age 60. Rates increase as you enter a new age bracket. Automatic coverage reduction begins at age 65; see certificate for details.

Complete all pages; sign and date.

3 Dependent Coverage:

All eligible children can be covered for $3 per quarter per unit of coverage. One premium covers all children. Unit values are $600 each for children ages 14 days to six months, and $3,000 each for children ages 6 months to 21 years (23 years if a full-time student):

I request the following dependent coverage: ❑ 1 unit ($600 / $3,000) ❑ 2 units ($1,200 / $6,000) ❑ 3 units ($1,800 / $9,000) ❑ 4 units ($2,400 / $12,000)

If dependent coverage is requested, list eligible dependents, i.e. unmarried, dependent children between 14 days and 21 years (23 years if a full-time student. Attach a separate sheet if necessary, then sign and date it.

	Name of Proposed Insured(s) (First, Middle Initial, Last)	Address (Street, City, State, Zip)	Social Security Number	Telephone Number	Sex M/F	Date of Birth (mm/dd/yyyy)	Ht. (ft./in.)	Wt. (lbs.)
Child								
Child								
Child								
Child								

4 Other Insurance:

All residents: Do you have other life insurance in force? ❑ Yes ❑ No If "yes," total amount in all companies: $_____

Do you have other insurance applications pending? ❑ Yes ❑ No If "yes," total amount in all companies: $_____

Company: _____

5 Important Replacement Information:

Residents of NY: 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. Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? ❑ Yes ❑ No

Residents of other states: Is the Insurance applied for intended to replace, discontinue or change an existing policy? ❑ Yes ❑ No

6 Beneficiary Designation:

The beneficiary for spouse and dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the Group Insurance Administrator.)

7 Statement of Health:

To the best of your knowledge and belief, answer the following questions as they apply to you.

A. Are you now ill, receiving or considering medical attention or treatment, or considering surgery? . . . . . ■ Yes ■ No

B. Within the last five years, have you been counseled, hospitalized or treated for: (a) using alcohol or drugs; or (b) mental, emotional or nervous disorder? . . . . . ■ Yes ■ No

C. Within the last five years, have you been diagnosed by a physician as having, or been treated for: heart trouble, elevated blood pressure, cancer, diabetes, epilepsy, neurological or respiratory disorder, kidney or liver disorder, pancreas disorder, enlarged lymph nodes or tumors, disorder of the circulatory or digestive system, gynecological or genitourinary disorders, immunodeficiency or blood disorder, or unexplained weight loss? . . . ■ Yes ■ No

If you answered "Yes" to any question in Section 7, give complete details below. *Attach a separate sheet if necessary, then sign and date it.*

Question No.	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

8 Authorizations: (Please read, then sign and date)

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, 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.

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 and Fraud Notices on the following pages, 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)

9 Payment Options: (Select one of the following methods of payment)

B. ❑ **Monthly Electronic Funds Transfer (EFT):** ❑ Checking Account *(Enclose VOIDED check)*
❑ Savings Account *(Enclose Deposit slip)*

I authorize my bank to deduct my insurance premium from the financial account indicated above on a monthly basis. If I wish to discontinue this authorization, or my account number changes, I will notify the plan administrator in writing.

Signature: *(as it appears on account)* **X** _____

A. ❑ **Credit Card Billing:** ❑ Monthly ❑ Quarterly ❑ Semiannually ❑ Annually

❑ MasterCard ❑ VISA Card Number:_____ Expiration Date: ____/_____
MM YYYY

Name: *(as it appears on card)* _____ **Signature: X** _____

I authorize charges against this credit card for the purpose of collecting insurance premium payments due under this plan. If I wish to discontinue this authorization, or my credit card changes, I will notify the plan administrator in writing.

C. ❑ **Direct Bill:** ❑ Quarterly ❑ Semiannually ❑ Annually

Send no premium now. Return your application in the enclosed postage-paid envelope, or mail to: **Group Insurance Administrator,** P.O. Box 418131, Kansas City, MO 64141-8131.

Fraud Notices

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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: 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.

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.

New York Life Insurance Company 1/2023 ed.

The Master Policy is held by the Trust for Insuring Educators and administered by Forrest T. Jones & Company, Kansas City, MO.
In Arizona, the administrator is Forrest T. Jones Consulting Company.