Group Long Term Disability Income Insurance

Underwritten by New York Life Insurance Company

Benefits Guide for California County Medical Association & Society Members

County Medical Associations & Societies

Questions?

800.842.3761

E-mail:

CMACounty.Insurance@marsh.com

MARSH

"Stand alone" OR "Supplement"

This group coverage can be your sole, "stand-alone" disability insurance coverage. If you have some type of disability coverage through an employer, this plan can be an excellent supplement to it. That's an approach some of our members take because these benefits are NOT taxable, unlike most employer plans—and the coverage is 100% portable, provided you pay the premiums.

Eligibility

As a member, you are eligible to request coverage under this group plan if you are:

- Under age 60
- At FULL-TIME work*
- A resident of the U.S.;** except territories

Diagnostics: 3 Key Reasons Physicians May Need Disability Coverage

1 Your income is substantial and your lifestyle is based on the assumption of that income stream

2 Your expenses are significant, including:

- mortgage(s)
- children's college education savings to fully fund
- retirement savings to fully fund
- monthly living expenses
- healthcare costs, insurance
- student loan debt
- office rent/maintenance

3 Your livelihood demands full use of your mind and body

Common Accidents & Medical Conditions Can Result in "Disability"

- Motor Vehicle Accident
- Sports Injury
- Fall (ex: from ladder doing work around the home)
- Arthritis
- Neuropathic Damage
- Degenerative Disc Disease
- Post-Traumatic Stress Disorder+
- Depression, Anxiety Disorder
- Visual or Auditory Impairment
- Stroke, Heart Attack, Aneurysm
- Multiple Sclerosis, Parkinson's Disease, ALS
- Cancer

* 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 30 hours per week at the place such duties are performed.

** Not available in all states at this time. Contact the Administrator for current information

+ The policy limits benefits for Mental/Nervous disorders and Chemical Dependency.

Advantages—How This Plan Works

★ **Your benefit payments are TAX-FREE— you could collect 40% more each month**
Under current tax laws, if you pay your own disability premiums, your benefits are tax-free. This means you'll generally collect 40% higher benefit checks through this plan than you'd receive from a comparable program offered through an employer. Or, you may be able to claim part of your plan premiums as a tax deduction if you own your own practice. Consult with your tax advisor for more details.

Example: $10,000 monthly benefit taxed vs. tax-free:
(40% paid to state and federal income taxes)

Taxable Plan	vs.	Tax-Free CMA/County Plan
$6,000.00		$10,000.00 (you net 40% more)

TAX-FREE benefit payments assume you don't choose to take your insurance premiums as a tax deduction. Of course, always consult with your tax advisor for the best advice for your individual situation.

★ **You can collect if you cannot work as a physician within YOUR specialty**
As a physician, your occupation is highly specialized. And if you can't perform the duties of your occupation due to a covered Total Disability, the plan will pay your monthly income benefits for up to 10 years after your disability begins.

★ **Your coverage is portable—you can take this plan with you anywhere you go***
Unlike hospital, healthcare systems, or other employer-paid or sponsored plans, you own your group coverage. It can go wherever you go, as long as you remain a CMA/County member. You don't have to worry about losing your disability insurance because you change employers or if you strike out on your own as part of a practice or as a sole practitioner.

★ **You pay group rates—typically a savings over individual coverage**
This plan is only available to members. Rates have been specifically negotiated on your behalf. The plan pays monthly benefits if you are Totally Disabled.

Totally Disabled means an incapacity from an injury or sickness that completely and continuously prevents you from doing the material and substantial acts of your optometric specialty, during the waiting period and the first 10 years thereafter. After this period, you will be considered Totally Disabled if you are unable to perform any occupation in which you can reasonably be expected to perform satisfactorily in light of age, education, training, experience, station in life and physical and mental capabilities.

★ **For Disabilities beginning: Maximum Benefit period:**

Before age 60	To his or her normal retirement age (NRA)+
At age 60 but before age 63	Five years
At age 63 but before age 65	Two years
At age 65 but before age 70	One year

Benefits for disabilities due to mental disorders and chemical dependency/alcoholism are limited to 24 months.

* Subject to policy terms and U.S. government regulations on restricted countries.

+ The Normal Retirement Age (NRA) will gradually increase to age 67 from age 65, depending on year of birth. For example, members born in 1938 have an NRA of 65 years 2 months. Members born in 1960 or later have an NRA of 67 years.

Advantages—How This Plan Works

You collect benefits regardless of any other coverage

This plan will pay you in addition to whatever you may collect from any other disability coverage (private, group, employer, any type) OR from any Social Security or other government benefit. Your benefit payments under this plan are never reduced because of other insurance/disability funds you may be entitled to collect. However, please note that your coverage amount, together with any other disability coverage you may have, may not exceed 66⅔% of your AVERAGE MONTHLY INCOME.

AVERAGE MONTHLY INCOME means, as of any date, your average monthly 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 expenses that are deductible for income tax purposes—for the immediately preceding 12-month period. It does not include income from interest, dividend, rent royalties, annuities, other insurance or other unearned income.

You have a broad choice of monthly benefit options to fit your needs/budget—from $500 to $10,000

If you are under age 50, you may apply for up to $10,000 in Monthly Benefits (in $500 units). If you are between the ages of 50 and 59, you may apply for up to $6,000 in Monthly Benefits. However, the option you choose, together with any other disability income insurance you may have, cannot exceed 66⅔% of your AVERAGE MONTHLY INCOME.

Starting at age 65, your Monthly Benefit amount is reduced 5% each year through age 69. Benefits will not be reduced while you are on a claim.

You have 100% freedom and control of your benefit payments—NO restrictions on how you use the money

All benefit payments are sent to you directly, by check. The benefit is never paid to any medical provider, mortgage company, or other person unless you specifically direct it. Use the money however you choose with no limitations or requirements.

Your premiums are waived during disability—you owe $0 premiums if you become Totally Disabled

The last thing you should worry about during a disability is paying for your coverage. So, we made sure you wouldn't owe any premiums if you become Totally Disabled. After you have been Totally Disabled for at least six months, all future premium contributions will be waived for that disability. Please see your certificate for more detailed information.

You can collect "Residual Disability" benefits—helps you supplement lost income while recovering from a Total Disability

If, while recovering from a Total Disability, you are able to resume some but not all of said duties prior to age 65, you may be eligible for a Residual Disability Benefit. This benefit is based on a percentage of your pre-disability earnings. To qualify for the Residual Disability Benefit, you may not be earning more than 80% of your pre-disability AVERAGE MONTHLY INCOME and you must not have reached the Maximum Benefit Period. Refer to your Certificate of Insurance for more information on this benefit. This benefit will end if you return to work in an occupation other than your own medical specialty.

You have a choice of 3 waiting periods

Create custom coverage that suits your income needs and gives you the right benefit/price combination. Help replace your lost income so you can continue to pay your monthly expenses. You may also select waiting periods of 90, 120 or 180 days. Coverage with a longer waiting period will be less expensive.

Optional Benefits

For an extra premium cost, you can add one or more of the following benefits:
Cost-of-Living | **Catastrophic Benefit** | **Recovery Benefit** | **Automatic Increase Benefit**

You can choose a "Cost-of-Living" Benefit—helps your benefit amount keep pace with inflation
This optional benefit offers disability coverage that, once benefits begin, can help keep pace with the rate of inflation. Monthly benefits will be adjusted annually from the date the waiting period begins if you are Totally Disabled prior to age 65. Adjustments may be made to the monthly benefit paid in the second and each succeeding year. The adjustment amount will be based on the consumer price index for urban consumers (CPI-U) up to a maximum six percent increase per year and an overall maximum increase of one times the original benefit. Once you are no longer disabled and benefit payments stop, the monthly benefit returns to the original option amount.

Catastrophic Benefit Option
This option is designed to provide an additional layer of protection for severe disabilities. This benefit provides an additional $1,000, $2,500 or $5,000 monthly benefit while on disability if your Total Disability causes: a loss of the ability to perform, for at least 30 consecutive days, two or more ACTIVITIES OF DAILY LIVING; COGNITIVE IMPAIRMENT; or have a life expectancy of less than 12 months as described in the Certificate of Insurance. The benefit will be paid for a maximum of 24 months.

ACTIVITIES OF DAILY LIVING are: bathing, dressing, toileting, transferring, continence and eating.

COGNITIVE IMPAIRMENT means deterioration or irreversible loss of intellectual capacity, a deficiency in short or long term memory, orientation as to people, place or time, deductive or abstract reasoning, and judgment as it relates to safety awareness. Cognitive Impairment will be measured according to generally accepted medical standards.

Recovery Benefit
You can receive a lump sum recovery benefit upon your return to FULL-TIME WORK following a Covered Total Disability for which you received a Total Monthly Benefit. The benefit payable will be ¼ of the Total Monthly Benefit amount received for each full month of Total Disability to a maximum of three times the last Total Monthly Benefit. For more information, please refer to your Certificate of Insurance.

Automatic Increase Benefit
If you are under age 50 and not receiving Covered Disability Benefits, you may apply for this benefit, which would allow you to increase your Monthly Benefit amount without having to provide evidence of good health. You can increase your Monthly Benefit by 10% of the initial Basic Monthly Benefit, up to a maximum of 40% of the initial Basic Monthly Benefit, but not to exceed the maximum Basic Monthly Benefit available. For more information, please refer to your Certificate of Insurance.

You have a voluntary rehabilitation benefit—designed to help you return to the work force
This plan offers a Rehabilitation Benefit that is designed to help certain disabled individuals return to the work force. Under this benefit, 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.

You can never be singled out for a rate increase
This is a group plan exclusively for CMA/County members, which means you can never be singled out for a premium increase, even if there is a change in your health or where you reside.

Current 2010/2011 Group Rates for Members

Quarterly Premium–per $1,000 of Monthly Benefit

Example: For a $9,000 monthly benefit, multiply the rate for your age by 9.

Supplemental Plan

Quarterly Individual Premiums (without COLA)—per $1,000 of monthly benefit amount 10 yr medical Specialty

Age	90-Day	120-Day	180-Day
Under AGE 30	$40.23	$35.18	$31.99
AGE 30 but before AGE 35	$44.19	$39.85	$36.22
AGE 35 but before AGE 40	$44.60	$41.18	$37.44
AGE 40 but before AGE 45	$55.82	$52.53	$47.75
AGE 45 but before AGE 50	$69.47	$65.21	$59.29
AGE 50 but before AGE 55	$90.28	$83.90	$76.27
AGE 55 but before AGE 60	$138.75	$127.66	$116.05
AGE 60 but before AGE 65*	$127.44	$118.76	$95.01
AGE 65 but before AGE 69	$127.44	$118.76	$95.01

ACT NOW to request protection before an accident, injury or illness makes it harder—or impossible to get!

Supplemental Plan

Quarterly Individual Premiums (with COLA)—per $1,000 of monthly benefit amount 10 yr medical Specialty

Age	90-Day	120-Day	180-Day
Under AGE 30	$46.27	$40.46	$36.79
AGE 30 but before AGE 35	$50.83	$45.81	$41.66
AGE 35 but before AGE 40	$51.29	$47.36	$43.05
AGE 40 but before AGE 45	$64.18	$60.41	$54.92
AGE 45 but before AGE 50	$79.89	$75.00	$68.18
AGE 50 but before AGE 55	$103.83	$96.49	$87.72
AGE 55 but before AGE 60	$159.57	$146.80	$133.45
AGE 60 but before AGE 65*	$146.57	$136.57	$109.26
AGE 65 but before AGE 69	$146.57	$136.57	$109.26

ACT NOW to request protection before an accident, injury or illness makes it harder—or impossible to get!

+ Renewal only. Coverage terminates at age 70.

* At age 65, benefits reduce 5% per year through age 69. The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any anniversary date and any date on which benefits are changed and on January 1 when you attain a new age. 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. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Association and Society Group Insurance Trust.

Current 2010/2011 Group Rates for Members

For the following options, add these additional premiums to the Supplemental quarterly rate chosen above.

Catastrophic Benefit Option

Insured Member's Age	$1,000 Monthly Benefit		$2,500 Monthly Benefit		$5,000 Monthly Benefit	
	90-Day	180-Day	90-Day	180-Day	90-Day	180-Day
Under AGE 30	$3.51	$3.19	$8.78	$7.97	$17.56	$15.94
AGE 30 but before AGE 35	$4.73	$4.30	$11.81	$10.75	$23.63	$21.50
AGE 35 but before AGE 40	$6.59	$5.95	$16.47	$14.88	$32.94	$29.75
AGE 40 but before AGE 45	$9.35	$8.43	$23.38	$21.06	$46.75	$42.13
AGE 45 but before AGE 50	$12.51	$11.26	$31.28	$28.16	$62.56	$56.31
AGE 50 but before AGE 55	$16.65	$14.96	$41.63	$37.41	$83.25	$74.81
AGE 55 but before AGE 60	$25.29	$22.70	$63.22	$56.75	$126.44	$113.50
AGE 60 but before AGE 65	$40.63	$36.30	$101.56	$90.75	$203.13	$181.50
AGE 65 but before AGE 69	$69.08	$59.91	$172.69	$142.28	$345.38	$284.56

Automatic Increase Benefit Option

Year 1	Quarterly Premium Rate
1st Increase	Quarterly Premium Rate x 1.18
2nd Increase	Quarterly Premium Rate x 1.35
3rd Increase	Quarterly Premium Rate x 1.53
4th Increase	Quarterly Premium Rate x 1.70

Recovery Benefit Option

Insured Member's Age	
Under AGE 30	$13.06
AGE 30 but before Age 35	$15.09
AGE 35 but before Age 40	$15.09
AGE 40 but before Age 45	$19.16
AGE 45 but before Age 50	$19.16
AGE 50 but before Age 55	$29.61
AGE 55 but before Age 60	$29.61
AGE 60 but before Age 65	$44.99
AGE 65 but before Age 69	$44.99

SEND NO MONEY NOW 30-Day Free Look

As a member in good standing, you are NOT required to send any premium payment with your application. All applications will be processed promptly and coverage issued for every eligible member whose evidence of insurability is found to be satisfactory.

We want you to be 100% satisfied with your coverage before you pay. As soon as your request for coverage is approved, you'll be sent a Certificate of Insurance with more information about your group coverage benefits. Review it for a full 30 days.

If you are not satisfied for any reason: Return your Certificate marked "Cancel" and your coverage will be invalidated, no questions asked, provided there have been no claims. You'll owe nothing.

When Coverage Starts (Effective Date)
You will become insured on the date specified by New York Life Insurance Company provided the first premium contribution is paid when due, satisfactory evidence of insurability has been submitted and you are at FULL-TIME WORK on that date.

If you are not at FULL-TIME WORK as required, coverage will not become effective until the day you are at FULL-TIME WORK provided such date is within three months of the date insurance would have been effective and you are still eligible for insurance.

Payment of a premium contribution for insurance does not mean there is any coverage in force before the effective date specified by New York Life Insurance Company.

When Coverage Ends
Once coverage is validly in force, it may be continued to the premium due date on or immediately after you reach age 70. Coverage will end earlier if: you cease FULL-TIME WORK other than for reasons of disability, cease to be a CMA/County member, fail to pay premium contributions when due, enter full-time active duty in the armed forces (coverage may be restored upon termination of active duty status, subject to policy guidelines), group policy is terminated or modified to exclude coverage for the group of individuals to which you belong or the association sponsors a similar plan of disability income insurance for members.

Exclusions & Limitations
The plan does not provide benefits for any disability that occurs during or is due or related to: intentionally self-inflicted injury while sane or insane, declared or undeclared war or any act thereof, or incarceration or participation in (except as a victim) an illegal occupation/activity or the commission of a crime, flying in any aircraft, except as a fare-paying passenger on a licensed commercial carrier: PREEXISTING CONDITION (except as noted below) or any impairment or disease specifically excluded from your coverage.

No benefits are payable for any disability for which you are not under the regular care of a licensed physician or surgeon other than yourself, your business associate, or member of your immediate family or household.

The plan limits benefits for disabilities due to mental disorders to 24 months. Benefits for disabilities due to chemical dependency are limited to 24 months.

A PREEXISTING 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 plan. Benefits are not payable for a disability due to a PREEXISTING CONDITION until the end of the earlier of: 12 consecutive months during which you have not consulted a physician, take medication, or received medical services or supplies; or 24 months.

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

Not all applicants will have to supply additional information. However, if required, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the plan.

Request for insurance will be processed promptly and coverage will be issued for members whose evidence of insurability has been found to be satisfactory.

Questions?

Call Toll-Free 1-800-842-3761 • 8:00 AM - 5:00 PM Monday-Friday

If you have any questions about your eligibility, what the plan covers, rates, or how to complete the application, please do not hesitate to call. A Client Service Representative will be able to immediately provide you with the information you need. Or you can e-mail us: CMACounty.Insurance@marsh.com.

This brochure contains a partial description of some of the principal provisions and definitions of the coverage. The complete terms are set forth in the policy issued by New York Life Insurance Company to the CMA/County Medical Associations & Societies.

Marsh is part of the family of MMC companies, including Guy Carpenter, Mercer and the Oliver Wyman Group (including Lippincott and NERA Economic Consulting).

About Our Role and Compensation
The California County Medical Associations and Societies/NORCAP have selected New York Life Insurance Company for this insurance program. Alternative insurance products may be available in the insurance marketplace. Marsh is providing this single insurer option on behalf of the California County Medical Associations and Societies/NORCAP. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability, or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E382518545880 or call us at 1-888-206-5088 for specific details.

CA Ins. Lic. #0633005 • AR Ins. Lic. #245544 • d/b/a in CA Seabury & Smith Insurance Program Management

800-842-3761 • CMACounty.Insurance@marsh.com • www.MarshAffinity.com

Endorsed by: **County Medical Associations & Societies**

Underwritten by: NEW YORK LIFE *The Company You Keep®*

New York Life Insurance Company
51 Madison Avenue / New York, NY 10010
Under Group Policy No. G-29322-0
on Policy Form GMR-FACE/G-29322-0

Administered by: MARSH

777 S. Figueroa Street
Los Angeles, CA 90017

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Important Notice:

How New York Life Obtains Information and Underwrites Your Request for Group Disability Income Insurance

Information regarding insurability will be treated as confidential. In considering your request 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. (formerly known as Medical Information Bureau). 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.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying the Administrator 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.

New York Life may release this information to the plan administrator, MIB, other insurance companies to whom you may apply for insurance, or to whom a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. 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 not-for-profit organization of 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.

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 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 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 or a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company **2.09ed.**

Underwritten by New York Life Insurance Company, 51 Madison Ave., New York NY 10010
Under Group Policy No. G-29322-0 • On Policy Form GMR-FACE/29322-0

County Medical Associations & Societies Group Disability Income Insurance Plan

NEW YORK LIFE The Company You Keep®

MARSH

FOR MEMBERS OF THE CALIFORNIA COUNTY MEDICAL ASSOCIATIONS & SOCIETIES 1-155

★ **REQUEST FOR GROUP INSURANCE FROM NEW YORK LIFE INSURANCE COMPANY, 51 MADISON AVENUE, NEW YORK, NEW YORK, 10010.**
PLEASE PRINT IN INK OR TYPE ALL ANSWERS. DO NOT USE FLUID OR GEL PENS. INITIAL ANY CHANGES YOU MAKE.

PART 1 Member Information

Name: _____

Address 1: _____ Address 2: _____

Please check one:

City: _____ State: ____ Zip: _____ ☐ Home Address ☐ Business Address

Home Phone #: (____) _____ Work Phone #: (____) _____ E-mail Address: _____

Member's Date of Birth _____ Sex: ☐ Male ☐ Female Height: _____ ft. _____ in. Weight: _____ lbs.

Do you intend to reside outside the U.S. or Canada in the next 12 months? ..... ☐ Yes ☐ No

If "Yes," countries _____ For how long? _____

PART 2 Membership Affiliation—Occupational Status

A. Are you a member of your County Medical Association/Society? ..... ☐ Yes ☐ No
County: _____ 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 30 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 ___ /___ /___

Bonus $ _____ Commissions $ _____ Total $ _____

PART 3 Insurance Requested: Refer to the Benefits Guide for details of eligibility, options, rates and coverage description.

I request the following coverage: ..... ☐ New ☐ Additional

I hereby apply for the coverage indicated below, based upon all my statements made in this application: ..... ☐ Long-Term Disability Income

Indicate Monthly Benefit Option Desired.
Choose amount of protection from $500 to $10,000 in increments of $500, ($6,000 if age 50 or over): $ _____

You may choose any Monthly Benefit Option provided it and other disability income you may have does not exceed 66⅔% of AVERAGE MONTHLY INCOME (as defined in the brochure).

OVER, PLEASE

G-29322-0

GPA-DI-FMU

PART 3 Insurance Requested: Refer to the Benefits Guide for details of eligibility, options, rates and coverage description.

A. Waiting Period: ☐ 90 days ☐ 120 days ☐ 180 days

B. Payment Option Selected:

Option 1: PERIODIC BILLING: ..... ☐ Semiannually ☐ Quarterly

Option 2: ELECTRONIC FUNDS TRANSFER (EFT): I request and authorize the Administrator, Marsh/Seabury & Smith Insurance Program Management, to make withdrawals against the account specified on the attached voided check or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions under this plan. (Enclose a VOIDED CHECK.)

X _____ Date _____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED AGAINST THIS ACCOUNT

C. Optional Benefits:

☐ Cost-of-Living Benefit ☐ Catastrophic Benefit: ☐ $1,000 ☐ $2,500 ☐ $5,000 / ☐ 90 days ☐ 180 days

☐ Automatic Increase Benefit ☐ Recovery Benefit

D. Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? ..... ☐ Yes ☐ No

IF "YES," PLEASE LIST

Company	Plan	Monthly Benefit	Benefit Period

E. Do you intend to discontinue any of the disability insurance listed above, if the coverage applied for is approved? _____

..... ☐ Yes ☐ No

If "Yes," please indicate which coverage and the date it will be terminated: _____

PART 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:
[For CA Residents: California law prohibits an HIV test from being required or used by health insurance companies as a condition for obtaining health insurance coverage.]

1. Are you now ill or taking prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ☐ Yes ☐ No
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? ..... ☐ Yes ☐ No

   b. Other health or physical impairment including:

   (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ..... ☐ Yes ☐ No

   (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? ..... ☐ Yes ☐ No

   (iii) Any other impairment? ..... ☐ Yes ☐ No

OVER, PLEASE

PART 4 Statement of Health: Please initial and date any changes you make on this form.

3. During the past five years, have you ever been counseled, treated or hospitalized for the use of alcohol or drugs? ..... ☐ Yes ☐ No

4. Are you now pregnant? ..... ☐ Yes ☐ No

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? ..... ☐ Yes ☐ No

6. During the past two years, have you participated in, or plan to participate in: aircraft flying other than as a 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? ..... ☐ Yes ☐ No

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? ..... ☐ Yes ☐ No

9. ***Except for Residents of CT and MN:*** Have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ..... ☐ Yes ☐ No

   Residents of CT and MN: 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? ..... ☐ Yes ☐ No

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

OVER, PLEASE

PART 5 Member Declarations:

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 AR/LA/MD/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 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 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 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.

AUTHORIZATION AND SIGNATURE

I understand that New York Life 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 authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc., 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 subsidiaries, or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings and treatment but excluding psychotherapy notes.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of the AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, I request the insurance indicated and consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE; and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated above, including how 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 **X** _____ Date **X** _____

PAYMENT OF A PREMIUM CONTRIBUTION FOR INSURANCE DOES NOT MEAN THERE IS ANY COVERAGE INFORCE BEFORE THE EFFECTIVE DATE AS SPECIFIED BY NEW YORK LIFE.

For more information, or answers to your questions, please call a Marsh Client Service Representative at 800-842-3761.
Or e-mail us at CMACounty.Insurance@marsh.com

Mail completed application to: Marsh, attn: Association Department, 777 S. Figueroa St., Los Angeles, CA 90017

About Our Role and Compensation

The California County Medical Associations and Societies/NORCAP have selected New York Life Insurance Company for this insurance program. Alternative insurance products may be available in the insurance marketplace. Marsh is providing this single insurer option on behalf of the California County Medical Associations and Societies/NORCAP. In accordance with industry custom, we are compensated through commissions that are calculated as a percentage of the insurance premiums charged by insurers. We may also receive additional monetary and nonmonetary compensation from insurers, or from other insurance intermediaries, which may be contingent upon volume, profitability, or other factors. This compensation may include payment from insurers for marketing related expenses or investments in technology. Our compensation may vary depending on the type of insurance purchased and the insurer selected. We will provide you additional information about our compensation and information about alternative quotes, upon your request. You may obtain this information by referring to https://www.personal-plans.com/disclosure and entering the security code E382518545880 or call us at 1-888-206-5088 for specific details.

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