GROUP DISABILITY INCOME INSURANCE APPLICATION

FOR MEMBERS OF THE AMERICAN ASSOCIATION FOR JUSTICE

AMERICAN ASSOCIATION FOR JUSTICE
The Association for Trial Lawyers

AAJ EXTRAS
Products and Services that Enhance Your Practice

PREFERRED PROVIDER

TO APPLY:
Send no money now.
Complete this form and return to:
ADMINISTRATOR
AAJ GROUP INSURANCE PROGRAM
PO BOX 14533 • Des Moines, IA 50306

For residents of PR, the address is:
Global Insurance Agency, Inc.
P.O. Box 9023919 • San Juan, PR 00902-3919

QUESTIONS? Call: 1-800-482-2852
customerservice.service@getamba.com

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: _____

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.

Please check one: ❑ Home address ❑ Business address

Height: _____ft _____in. Weight _____lbs.

Marital Status: ❑Married ❑Divorced ❑Single ❑Widow(ed) ❑Civil Union* ❑Domestic Partner*

*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

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 American Association for Justice? ❑ 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 30 hours per week at the place such duties are normally performed. Are you now at "FULL-TIME WORK"? ❑ Yes ❑ No

D. Gross Annual Income from: Salary $_____ Self-Employment $_____ (Self-employment start date _____)
(Mo./Day/Yr.)

Bonus $ _____ Commissions $_____

Total $ _____

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 may have does not exceed 60% 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:** $_____

B. **Benefit Period:** ❑ Short-Term Plan ❑ Career Plan

C. **Waiting Period:** ❑ 30-day (Short-Term Plan Only) ❑ 90-day (Career Plan Only) ❑ 180-day (Career Plan Only)

D. Payment Option Selected:

❑ **Option 1:** Electronic Funds Transfer (EFT): I request and authorize the AAJ 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 ❑ Annual ❑ Semiannual 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 "Yes" to any of the above Questions 1-9 give complete details below. (If you need more space, use 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 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, 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.

8/18 ed.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Disability Income 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, 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.**

AMERICAN ASSOCIATION FOR JUSTICE
The Association for Trial Lawyers

AAJ EXTRAS
Products and Services that Enhance Your Practice

PREFERRED PROVIDER

Group Disability Income Insurance

For Members of the American Association for Justice
Underwritten by New York Life Insurance Company

INSURE YOUR INCOME—ONE OF YOUR MOST VALUABLE ASSETS

One of your most valuable assets is your ability to earn income. A sudden accident or illness could jeopardize the career and the lifestyle you have worked so hard to build. This Policy can help replace the sizable amount of lost income you would suffer if you were Totally Disabled — income you'll need to help meet personal expenses: food, clothing, loans, mortgages, cars, tuitions, medical expenses, bills, credit cards, phone and other utilities, and more. That's something medical insurance can't do for you.

Even if you have some disability insurance, it may not be enough coverage, or it may only protect against short-term disabilities. The AAJ is pleased to make available to you exclusively-priced long-term disability coverage that can be used to supplement benefits you already have, or serve as primary protection.

WHO IS ELIGIBLE?

AAJ Members who are under age 65 and at Full-Time Work can request coverage, provided they reside in the United States (except AK, DE, FL, LA, ME, MD, MO, MT, NH, NV, NC, OH, OR, SD, TX, UT, VT, WA, WY and territories) and Puerto Rico.
However, members on active duty in the armed forces and full-time students are not eligible.

HOW IT WORKS

This coverage helps protect the investment you've made in your education and career. Both of the following Plans pay monthly benefits when you are Totally Disabled.

Choice of Plans

You can choose either the Short Term Plan or the Career Plan. The maximum monthly coverage amounts for which members may apply, in $100 increments, according to age are:

	Career Plan	Short Term Plan
Before age 50	$10,000	$5,000
Ages 50-54	4,000	4,000
Ages 55-59	3,000	3,000
Ages 60-64	2,000	2,000

The Short Term Plan

Benefits are payable after the Waiting Period and continue for the next 12 months of your total disability. The Plan is designed to give maximum monthly benefits for the more frequent, shorter periods of disability.

The Career Plan

Benefits are payable after the Waiting Period, and may continue to age 65 if disability begins prior to age 64, or for two years, but not beyond age 70 if you are disabled on or after age 64. The Plan is designed to help protect you financially during prolonged disability.

The following chart shows the maximum duration of the benefit payment periods under the AAJ Career Plan.

If your disability begins...	**Monthly benefits continue...***
Prior to Age 64	Up to Age 65
On or After Age 64	Up to Two Years, but not beyond age 70

Monthly benefits will be paid up to the maximum benefit period selected. Monthly benefits under either plan will end on the date you fail to give required proof of continuing total disability, your total disability ends, the maximum benefit period ends or you die.

For disabilities due to mental disorder or chemical dependency, benefits are reduced as noted in LIMITATIONS AND EXCLUSIONS. The monthly benefit you apply for may not exceed 60% of your Average Monthly Income.

Reduction on Account of Other Income Benefits

The Monthly Benefit paid will be reduced to reflect any Other Income Benefits (as defined in your Certificate of Insurance) you are receiving. However, this reduction will not be made if your monthly benefit plus Other Income Benefits does not exceed the following percentage of your Average Monthly Income: 70% for Short Term Plan, 60% for the Career Plan.

Premiums Waived If You Are Totally Disabled

After six continuous months of covered total disability, premiums due thereafter will be waived during the remainder of the disability. When you stop receiving monthly benefits, premiums must again be paid when due.

IMPORTANT DEFINITIONS

Average Monthly Income means, as of any date:

- If you are self-employed, your wages, salaries, fees, commissions, and any other amounts received by such person for personal services
- If your business is incorporated, the cost of fringe benefits and your share of the monthly net profit of the corporation, whether received or not received; or
- If you are not self-employed, your basic rate of monthly compensation from your employer, including commissions.

Average Monthly Income does not include income from bonuses, overtime pay or extra compensation. It is deducted before income or social security tax and after deduction of normal and usual business expenses

Average Monthly Income is the average for the immediately preceding period that produces the highest figure:

- the immediately preceding tax year;
- the immediately preceding two tax years; or
- the entire period, if less than 12 months;

A **Total Disability** is a covered illness or injury that prevents you from performing the material and substantial duties of:

- *during the waiting period and the following five years*, your regular occupation;
- *thereafter*, any occupation for which you are or may become qualified by reason of education, training or experience.

"Regular Occupation" means the specialty in the practice of law which you were performing on the day before the disability began or the occupation being performed immediately prior to the disability.

Presumptive Disability: You will be considered Totally Disabled if a covered illness of injury results in the permanent and total loss of one of the following:

- Sight in both eyes
- Hearing in both ears
- Speech
- Controlled movement of two limbs. "Limb" is defined as a hand or foot.

Presumptive Disabilities are not subject to the Waiting Period. If you receive benefits for Presumptive Disability, you are not eligible for Residual Disability benefits.

The **Waiting Period** is the number of days you must be Totally Disabled before benefits can be paid. For the Short Term Plan, the Waiting Period is 30 days. For the Career Plan, you can choose a Waiting Period of either 90 or 180 days.

Full-Time Work means the active performance for pay or profit of the regular duties of one's normal occupation on a basis of at least 30 hours each week at a place where such duties are normally performed or other location to which travel is required

WHAT IT COSTS

Current 2026-2027 Semiannual Current Group Rates

The Short Term Plan

Available in $100 units from $500 to $5,000, depending on earnings and age. Benefits are payable from the 31st day of disability for up to a period of 12 months.

Short Term Plan Semiannual Premiums Per $100 Benefit Unit 30 Day Waiting Period

Under 30	$1.08
30-34	1.39
35–39	1.85
40–44	2.26
45–49	3.81
50–54	6.17
55–59	11.31
60–64	17.90
65–69*	21.34

The Career Plan

Available in $100 units from $500 up to $10,000, depending on earnings and age. Benefits are payable from either the 91st day or the 181st day of disability for either (1) to age 65, or (2) for two years, but not beyond age 70, depending on age when disability commences.

Career Plan Semiannual Premiums Per $100 Monthly Benefit Unit

Age	90-Day Waiting Period	180-Day Waiting Period
Under 30	$2.76	$2.38
30–34	4.37	3.45
35–39	5.97	4.89
40–44	7.58	6.38
45–49	11.18	9.83
50–54	15.70	13.61
55–59	17.31	14.82
60–69*	18.92	16.03

*Renewal rates only. Only those under age 65 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 save the fee, select the Annual payment mode or Electronic Funds Transfer (EFT) as a safe and secure payment option.

Premiums are based on the member's age on the effective date of insurance. Premiums increase on the policy anniversary date coinciding with or next following the member's reaching a new age bracket. The insurance company reserves the right to change premiums only on a class wide basis.

For disabilities commencing on or after your 65th birthday, the maximum monthly benefit is $500. Premium doesn't reduce for disabilities commencing on or after 65th birthday.

HOW TO CALCULATE YOUR COSTS

1.Choose the: ❑ Short Term Plan or the ❑Career Plan

2. If you choose the career Plan, choose the waiting period

Short Term Plan: 30-Day

Career Plan: ❑ 90-Day or ❑ 180-Day

3. Choose the monthly benefit you want in units of $100 (not to exceed 60% of your Average Monthly Income). The minimum monthly benefit is $500.

Monthly Benefit $_____

4. Find your age in the Age Column.

5.Multiply the cost shown by the number of $100 units desired.

For Example: If you are age 39 and choose the Career Plan with a 180-day waiting period and a $3,000 Monthly Benefit, you would multiply $4.89 x 30 = $146.70. This is your semiannual cost.

Cost for One Unit		Number of Units		Your Semiannual $100 Premium
$_____	x	_____	= $	_____

RESIDUAL DISABILTIY BENEFITS (Career Plan Only)

You may be eligible for Residual Disability Benefits if you return to work immediately following a period of total disability for which monthly benefits were payable, provided that your current average earnings do not exceed 80% of your pre-disability income Residual disability means you are engaged in a gainful occupation but are not able to perform, due to the same injury or sickness that caused total disability, one or more of the substantial and material duties of your occupation, or the substantial and material duties of your occupation for as much time as is normally required to perform them. You must be under the regular care of a Physician unless it is determined continued care is of no benefit.

The monthly residual disability benefit payable is determined each month by a formula based on loss of monthly income over prior basic monthly income times the monthly benefit that would be payable for a total disability.

WHEN INSURANCE ENDS

Your coverage can be automatically renewed until age 70, as long as the Group Policy remains in force, you pay your premium when due, you remain an AAJ member, insurance does not end for your class, you remain at Full-Time Work except for reasons of total disability and you remain a resident of the United States.

SURVIVOR INCOME BENEFIT (Career Plan Only)

If you should die while totally disabled after having received the Total Disability Benefit provided by the Group Policy for at least 12 continuous months and during a period for which benefits are payable, the Policy will pay your designated beneficiary, if living, a Survivor Benefit. This benefit is equal to the Monthly Benefit you were last entitled to receive for the month prior to your death.

The Survivor Income Benefit shall be payable on a monthly basis immediately after we receive written proof of your death. The benefit will end on the earliest to occur: 1) 3 monthly payments have been made to the beneficiary; 2) the end of the Maximum Period Payable; or 3) the death of the designated beneficiary.

G-30703-0

Successive Periods of Disability

Successive periods of disability due to the same or related cause, when separated by a return to active work of less than 6 continuous months (3 continuous months for the Career Plan), will be considered one period of total disability

EXCLUSIONS AND LIMITATIONS

Benefits are not payable for disabilities due or related to: war or an act of war; military service; intentionally self-inflicted injury, whether sane or insane; pregnancy or any termination of pregnancy (complications of pregnancy are covered); or any condition which is the subject of a waiver or impairment rider.

Benefits for mental, nervous, or emotional disorders, alcoholism and drug addiction are limited to a maximum of 24 monthly benefits (6 months for the Short Term Plan) that will be paid while such disability continues, unless hospital confined at the end of the 24-month period (6 months for the Short-Term Plan). For a disability that starts on or after the insured's 65th birthday, the maximum monthly benefit is $500.

Pre-Existing Conditions (Short Term Plan only)

No benefits will be paid for any disability which is a result of a pre-existing condition. A pre-existing condition is an injury or sickness for which a person incurred charges, received medical treatment, consulted a physician or took prescribed drugs during the 12 months immediately before the insured's Effective Date of Insurance. If disability is due to a pre-existing condition and it begins within 24 months of the insured's Effective Date of Insurance, no benefits will be paid unless the person has not incurred charges, received medical treatment, consulted a physician, or taken prescribed drugs for such condition, or any complication of it, for 12 continuous months, while insured.

EFFECTIVE DATE OF INSURANCE

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 actively at work on the date insurance is to take effect. If not, insurance will take effect on the day you resume such work.

RENEWAL PAYMENTS AND CLAIMS

Once you are approved, you will have a 31-day grace period for your payment of renewal premiums. When you want to submit claims, write to the Administrator for claim forms.

WHAT YOUR PARTICIPATION MEANS TO AAJ

By participating in the AAJ Group Insurance Program, you can help to support AAJ activities. When the AAJ Group Insurance Trust was established in 1975, its purpose was to provide insurance for our members and to create a source of funds to support the charitable, research, and educational activities that are so important to our profession. As a participating member, you have an annual option to request the return of your proportionate share of the group policy claims experience refund, if any, paid to the AAJ Group Insurance Trust. Your unclaimed share will remain with the Trust.

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 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.

2. Do not send any money until New York Life Insurance Company has approved your application and notifies you of the premium contribution due, based on the information you have provided.

If you choose the Electronic Funds Transfer (EFT) Option, be sure to include a voided check in addition to the check for the first payment due.

3. Mail the Application Form to the Administrator:

AAJ 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 9023919
San Juan, PR 00902-3919

ABOUT YOUR REQUEST FOR COVERAGE

New York Life 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 and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30703-0
on Policy Form GMR-FACE/G-30703-0

This Group Disability Insurance is Administered By:

Association Member Benefits Advisors, LLC (AMBA)

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

Any questions?
1-800-482-2852
www.personal.plans.com/aaj

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 American Association for Justice.

The AAJ Insurance Trust incurs costs in connection with this sponsored Program. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. The AAJ also receives a fee for the license of its name and logo for use in connection with this policy.

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