ASCE | MEMBER ADVANTAGES
1200 E. Glen Ave., Peoria Heights, IL 61616

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Plan Administrator:
PEARL® INSURANCE
1200 E. Glen Ave., Peoria Heights, IL 61616
Questions: Please call 800.650.ASCE (2723)

Please complete the information below and return to: ASCE Plan Administrator, PO BOX 3930, Peoria, IL 61612-3930
Residents of Puerto Rico, please return application to: Global Insurance Agency, P.O. Box 9023918, San Juan, Puerto Rico 00902-3918

ASCE GROUP TERM LIFE INSURANCE APPLICATION (WITH CHRONIC ILLNESS RIDER)

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. MEMBER INFORMATION

Full Name		S.S.#
Street Address		
City	State (or Province)	Zip Code
Home Phone	Work Phone	Fax
Email		For internal use only. Email address will never be sold or shared.

Marital Status: ❍ Married ❍ Divorced ❍ Widowed ❍ Single ❍ Civil Union (Eligibility of Civil Union partners is determined by State Law) ❍ Domestic Partner

	Name	Date of Birth	Height	Weight	Sex
ASCE member		/ /	ft. in.	lbs.	❍ M ❍ F
Spouse*					
Child**					
Child**					

* Member date of birth must also be provided when requesting spouse coverage.
** See Plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada?

ASCE Member: ❍ Yes ❍ No	Country(ies)	How Long?
Spouse: ❍ Yes ❍ No	Country(ies)	How Long?

2. MEMBER AFFILIATION

To participate in this Plan you must be in good standing with the ASCE.	ASCE Member ID#

3. INSURANCE REQUESTED

I HEREBY APPLY FOR THE FOLLOWING GROUP TERM LIFE INSURANCE COVERAGE:

A. ASCE Member Option Insurance Requested

Total Member Amount Desired $ _____
(from $10,000 to $1,000,000 in units of $10,000)

Total Spouse Amount Desired $ _____
(from $5,000 to $1,000,000 in units of $5,000)

Child Option* ❍ $10,000 each eligible dependent
(14 days through 22 years; 24 for full-time student)

*ASCE member coverage must be in force to request child coverage.

B. Tobacco/Nicotine Use

Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? **ASCE Member:** ❍ Yes ❍ No **Spouse:** ❍ Yes ❍ No

If "Yes," please state **when** you last used tobacco or nicotine and specify the **product**.

ASCE Member: / / Nicotine Product Used: _____

Spouse: / / Nicotine Product Used: _____

C. Current Coverage

Do you have other life insurance in force? If "Yes," total amount in all companies: ASCE Member: $ _____ Spouse: $ _____

Do you have other insurance applications pending? If "Yes," indicate amount and company:

ASCE Member: $ _____ Company: _____ Spouse: $ _____ Company: _____

D. INSURANCE REPLACEMENT: IMPORTANT REPLACEMENT INFORMATION FOR RESIDENTS OF NEW YORK 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 above. Is the Life Insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **ASCE Member:** ❍ Yes ❍ No **Spouse:** ❍ Yes ❍ No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing policy?
ASCE Member: ❍ Yes ❍ No **Spouse:** ❍ Yes ❍ No

E. Chronic Illness Rider for Group Term Life Insurance (Indicate amount of life insurance that will be subject to this chronic illness rider. This chronic illness rider cannot be applied for without a request for term life insurance.)

a) Total Member Amount Desired (from $50,000 to $1,000,000 in units of $50,000): $ _____

b) Total Spouse Amount Desired (from $25,000 to $1,000,000 in units of $25,000): $ _____

NOTE: The amount selected cannot exceed your Group Term Life amount. The maximum amount payable for chronic illness is equal to 50% of the group term life insurance amount you indicate to accelerate above. For example, if you elect $400,000 for the rider, the maximum benefit amount payable after the 4th installment may not exceed $200,000. Please review the brochure/web site or contact the plan administrator for complete details.

Be sure to complete all pages and sign last page
DO NOT SEND PAYMENT: Upon approval, you will be notified of the premium due.

4. PAYMENT OPTION SELECTION (Do not send payment: Upon approval, you will be notified of the premium due.)

Following your initial billing, you will be billed twice a year on January 1 and July 1 or you can also access a secure website where you can register to have your premium withdrawn from your bank account or charged to your credit card. ❍ Direct Bill ❍ EFT ❍ Credit Card

5. BENEFICIARY DESIGNATION: Insert name, relationship, and SSN.

I make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you want to name a different beneficiary for spouse coverage, more than one beneficiary, or a trust, please contact the Plan Administrator.)

Beneficiary Name (Full Name)			Phone
Relationship to Applicant		Date of Birth	S.S.#
Street Address	City	State (or Province)	Zip Code

6. STATEMENT OF HEALTH: (PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM)		Member	Spouse
A.	Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	❍Y ❍N	❍Y ❍N
B.	Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❍Y ❍N	❍Y ❍N
C.	During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease, or injury?	❍Y ❍N	❍Y ❍N
D.	Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	❍Y ❍N	❍Y ❍N
E.	Is any person to be insured now pregnant?	❍Y ❍N	❍Y ❍N
F.	During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:		
	1. Heart or circulatory trouble, elevated blood pressure, pain, or pressure in chest?	❍Y ❍N	❍Y ❍N
	2. Arthritis, back trouble, bone or joint disorder?	❍Y ❍N	❍Y ❍N
	3. Fainting spells, convulsions, or epilepsy?	❍Y ❍N	❍Y ❍N
	4. Sugar, blood, albumin, or pus in urine?	❍Y ❍N	❍Y ❍N
	5. Diabetes, kidney trouble, ulcers, or digestive disorder?	❍Y ❍N	❍Y ❍N
	6. Disorder of breast or reproductive organs or functions?	❍Y ❍N	❍Y ❍N
	7. Nervous or mental disorder, emotional condition, or psychiatric care?	❍Y ❍N	❍Y ❍N
	8. Cancer, tumor, or cyst?	❍Y ❍N	❍Y ❍N
	9. Varicose veins, hemorrhoids, or hernia?	❍Y ❍N	❍Y ❍N
	10. Disorder of eyes, ears, nose, or sinuses?	❍Y ❍N	❍Y ❍N
	11. Thyroid, liver, or respiratory disorder?	❍Y ❍N	❍Y ❍N
	12. Alcoholism or drug habit?	❍Y ❍N	❍Y ❍N
	13. Disorder of the blood?	❍Y ❍N	❍Y ❍N
	14. Other health or physical impairment including:	❍Y ❍N	❍Y ❍N
	(i). Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related Conditions (ARC)?	❍Y ❍N	❍Y ❍N
	(ii). Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	❍Y ❍N	❍Y ❍N
	(iii). Any other impairment?	❍Y ❍N	❍Y ❍N
G.	Has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular, or mental illness? NOTE: Genetic Family History is not applicable to Maryland residents	❍Y ❍N	❍Y ❍N
H.	Within the past two years have you or your spouse participated in, or do either of you plan within the next two years to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, organized motorcycle racing, or any type of organized motorized racing?	❍Y ❍N	❍Y ❍N
I.	Has your or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years? Member Driver's License No. State/Province in which issued: Spouse Driver's License No. State/Province in which issued:	❍Y ❍N	❍Y ❍N
J.	**Except for residents of Minnesota and Connecticut,** in the last seven years, have you and/or your spouse 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,** in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	❍Y ❍N	❍Y ❍N

If you have answered **"Yes"** to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

Name(s) of Proposed Insured:	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated:

Depending on the amount of insurance you are requesting, you will be contacted by a service provider on behalf of New York Life Insurance Company to ask you about your medical history.

What time and telephone number would be best to contact you? _____

7. STATEMENT OF HEALTH FOR CHRONIC ILLNESS RIDER: (PLEASE INITIAL ANY CHANGES YOU MAKE ON THIS FORM)		Member	Spouse
Complete only if you selected the Chronic Illness Rider: To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:			
A.	Do you currently need or in the past five years have you needed human assistance or supervison to perform any of the following activities: bathing, dressing, eating, walking, moving in/out of a bed or chair or wheelchair, toileting, bowel or bladder control? (If "Yes," please circle all that apply.)	❍Y ❍N	❍Y ❍N
B.	Within the past five years, have you been bed-ridden at your home or any other private residence for two weeks or more?	❍Y ❍N	❍Y ❍N
C.	Within the past five years, have you had a fall or been diagnosed or treated by a member of the medical profession for a fracture, paralysis, numbness, balance problems or skin ulcers?	❍Y ❍N	❍Y ❍N
D.	Within the past five years, did you lose any part of your fingers, hands, feet or limbs due to amputation, accident, disease, or deformity; or been diagnosed or treated by a member of the medical profession for any conditions causing crippling or limited motion?	❍Y ❍N	❍Y ❍N
E.	Are you now, or have you been in the past five years, in a wheelchair or dependent on required supportive equipment such as braces, crutches, walker, cane, back support, or splint?	❍Y ❍N	❍Y ❍N
F.	Within the past six months, have you had or been recommended by a member of the medical profession to have physical therapy?	❍Y ❍N	❍Y ❍N
G.	Within the past five years, have you been evaluated, counseled, treated by a member of the medical profession or hospitalized for any problems with memory or ability to think or reason?	❍Y ❍N	❍Y ❍N
H.	Within the past five years, have you been confined or has confinement been recommended by a member of the medical profession, to a hospital, nursing home, rehabilitation facility or extended care facility?	❍Y ❍N	❍Y ❍N
I.	Have you received Medicaid benefits or any similar federal or state financial assistance within the past five years? NOTE: Medicaid is not the same as Medicare	❍Y ❍N	❍Y ❍N
J.	Have you received Medicare disability benefits within the past five years?	❍Y ❍N	❍Y ❍N
K.	In what type of dwelling do you reside? Private Home, Apartment, Retirement Home, Congregate Care Community, Nursing Care Facility, Mobile Home, Continuing Care/Care Community, Retirement Community, Assisted Living Unit, Personal Care Home or an Adult Care Home, Other (please specify) **Member:** **Spouse:**		
L.	Within the past five years, have you been declined for issue, reinstatement or renewal of any type of long-term care insurance?	❍Y ❍N	❍Y ❍N

If you have answered **"Yes"** to any of the above questions, give complete details below. (Attach a separate sheet if necessary, sign and date.)

Name(s) of Proposed Insured:	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and Address of Physicians or Other Medical Care Practitioners and Hospitals Where Confined or Treated:

DISCLOSURE: The Chronic Illness Rider is not intended to be federally tax-qualified long-term care insurance under Section 7702B of the Internal Revenue Code (IRC), as amended. Therefore, the premiums payable for the Chronic Illness Rider are not deductible from gross income for federal income tax purposes. The benefits provided by the Chronic Illness Rider are intended to be excludable from federal gross income under Section 101(g) of the IRC.

8. FRAUD NOTICE

For Residents of all states except 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. **FOR RESIDENTS OF CA:** 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. The falsity of any statement in the application for any policy shall not bear the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **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 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.

9. IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request for ASCE Group Term 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.

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 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. 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.

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

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 of 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.

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10. AUTHORIZATION AND SIGNATURE

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; any person proposed for insurance consents to authorize the disclosure of information to and from the providers noted in the attached IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc; and the member and any person proposed for insurance 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 their knowledge and belief, the answers provided to the questions are true and complete.

ASCE Member's Signature	Date
Spouse's Signature	Date

Necessary only if spouse coverage is requested.

ASCE | MEMBER ADVANTAGES

GROUP TERM LIFE INSURANCE

HOW TO CALCULATE YOUR MONTHLY COST

The initial cost of insurance for you and your lawful spouse is based on your age on the day your insurance becomes effective—the cost increases as you grow older. The chart below shows your monthly premium rate per $10,000 of coverage for members, and per $5,000 of coverage for spouses. You will be billed semiannually on March 1 and September 1. You can also make arrangements to pay your premium in increments other than semiannual.

The premium contributions shown below reflect the current rates and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date, but not more than once in any 12-month period, 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 group policy. For example, a class of insureds is a group of people with the same issue age and tobacco/nicotine usage. Premium contributions vary with the amount of benefit chosen. Benefit option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustee.

The annual rate is 12 times the monthly rate. Premiums increase on the premium due date coinciding with or next following the date that a member enters a new age bracket. All eligible children can be insured for a semiannual rate of $3.60 for $10,000 regardless of number or age.

CURRENT 2019 MONTHLY PREMIUM RATES

Member Age	Member Unit Amount $10,000		Spouse Unit Amount $5,000	
	NON SMOKER	SMOKER	NON SMOKER	SMOKER
< 30	$0.30	$0.35	$0.14	$0.16
30-34	$0.34	$0.40	$0.16	$0.18
35-39	$0.48	$0.56	$0.20	$0.23
40-44	$0.70	$0.83	$0.29	$0.34
45-49	$1.13	$1.34	$0.48	$0.56
50	$1.26	$1.49	$0.53	$0.62
51	$1.39	$1.63	$0.59	$0.69
52	$1.51	$1.78	$0.63	$0.75
53	$1.64	$1.93	$0.70	$0.81
54	$1.76	$2.07	$0.74	$0.87
55	$1.99	$2.34	$0.82	$0.97
56	$2.22	$2.61	$0.90	$1.06
57	$2.45	$2.88	$0.98	$1.16
58	$2.67	$3.14	$1.06	$1.25
59	$2.90	$3.41	$1.15	$1.34
60	$3.48	$4.10	$1.40	$1.64
61	$4.62	$5.44	$1.77	$2.07
62	$5.67	$6.68	$2.01	$2.37
63	$6.98	$8.22	$2.32	$2.72
64	$7.53	$8.87	$2.67	$3.13
65–68**	$9.95	$11.71	$3.54	$4.14
69–72**	$13.93	$16.40	$4.95	$5.80
73–76**	$19.90	$23.43	$7.07	$8.28
77-79**	$23.22	$27.33	$8.25	$9.66
80–99**	$36.83	$43.31	$13.07	$15.34

For more information about this coverage or any other plan available to you through your ASCE membership, contact us at **800.650.ASCE (2723)**. **You may also visit us online for additional information or to apply for coverage at ASCEinsurance.com.**

*To qualify as a non-smoker, the insured must not have used tobacco or nicotine in any form for the past 12 months.

**Amounts of insurance decrease with age; coverage terminates at member age 100. See Amounts of Insurance at Ages 65–99. Premiums do not reduce.