07/07/08 09:42:56

Member Enrollment Form

REQUEST FOR GROUP INSURANCE
AARP LEVEL BENEFIT TERM LIFE

AARP | Financial
Life Insurance Program from NEW YORK LIFE
5505 West Cypress • Tampa, FL 33607-1707

Please Respond by: July 15, 2008

Please complete in ink.

Current rates for
Edward Hinerman
Age 55

$10,000 plan.....$18.12/month

$20,000 plan.....$32.23/month

$30,000 plan.....$46.35/month

$40,000 plan.....$60.47/month

$50,000 plan.....$74.58/month

(Please refer to the rate chart for complete details.)

0046542582

Edward Hinerman
[redacted]
Salida CO 81201

Social Security No. [redacted] (Must be provided)

Phone Number (719) [redacted] - 4688

Date of Birth 03/14/1953 ☐ Male ☐ Female

AARP Membership No. 3068904477

A. Coverage Amount Requested (Check Only One Coverage)

☐ $10,000 ☐ $20,000 ☐ $30,000 ☐ $40,000 ☒ $50,000 ☐ Other $_____

B. Payment Options (Choose Option 1 or 2)

1. ☐ BILL ME LATER
   I wish to pay (check one): ☐ Monthly ☐ Quarterly ☐ Semi-annually ☒ Annually
2. ☐ CHECK ENCLOSED – START COVERAGE AT THE EARLIEST POSSIBLE DATE
   A check for my first payment of $_____ is enclosed. For future payments, please bill me (check one):
   ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually
   Make check payable to AARP Life Insurance Program. Be sure payment reflects billing frequency selected.

Would you like to take advantage of our convenient automatic premium payment? ☐ YES ☒ NO
If yes, premiums will be deducted automatically from your checking account each month.
Please enclose a voided check for the checking account from which you wish payments to be made.

C. Beneficiary Designation

(If More Than One Beneficiary Is Designated, Proceeds Will Be Divided Equally Unless You Indicate A Share)

Beneficiary Name (Please Print)	Relationship To You	Share
Pamela A Hinerman	Wife	100%

D. Statement of Health (Please Check YES or NO For All 3 Questions)

1. In the past 2 years, have you consulted a doctor or had treatment for heart trouble, stroke, cancer, lung disease or disorder, diabetes, liver or kidney disease, AIDS, AIDS Related Complex, or immune deficiency? ☒ YES ☐ NO
2. In the past 2 years, for any condition, have you been admitted to or confined in a hospital, sanitarium, nursing home, extended care or special treatment facility? ☒ YES ☐ NO
3. In the past 3 months, have you consulted a doctor or had treatment or diagnostic tests of any type? (Note: You are not required to report negative AIDS or HIV tests.) ☒ YES ☐ NO

For any "Yes" answer, circle each condition or event above. List date(s) of onset below, along with types of treatment, medicine and dosage. (Please print. Attach a separate sheet if needed.)

1. 1991
2. Surgery for broken leg
3. Treatment & testing for diabetes

E. Read and Sign

Is the insurance applied for intended to replace, discontinue or change any existing insurance or annuity? ☐ YES ☐ NO

I understand that insurance will be effective on the date of the certificate, provided my premium is received within 31 days of such Insurance Date. I understand that premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life, and that benefits may be denied during the first two years if material facts have been misstated here. I represent that I am an AARP member, and that, to the best of my knowledge and belief, the information on this request is true and complete. **Note:** 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 is a crime and subjects such person to criminal and civil penalties. Penalties may include imprisonment, fines or a denial of insurance benefits if a person provides false information. **For 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.

X [signature] 7/1/08

Edward Hinerman Must Sign. (Please Do Not Print.) Month / Day / Year

Code: PAAWEBE12 M 55

SPOUSE ENROLLMENT FORM ON REVERSE SIDE

Form GPA AA

753-03-NATL

Apply Today!

1. Choose the coverage amount you need.

2. Complete all sections, including the 3 health questions, and sign the form.

3. Mail in the postage-paid envelope provided.

If you want coverage to take effect at the earliest date possible, include a check, payable to AARP Life Insurance Program, for your first premium. Otherwise, send no money now.