FOR RESIDENTS OF CALIFORNIA ONLY. (RESIDENTS OF OTHER STATES: CONTACT THE ADMINISTRATOR FOR THE PROPER FORM.)

06897 074030010101

To Apply:
Complete This Form And Return To:
ADMINISTRATOR
AMBA Administrators, Inc.
Sponsored by The State Bar of California
P.O. BOX 14536 • Des Moines, IA 50306
QUESTIONS?
Call: 1-800-343-0132
customerservice.service@getamba.com

Request for Group Insurance From:
New York Life Insurance Company
51 Madison Ave. • New York, NY 10010

GROUP TERM LIFE INSURANCE APPLICATION

FOR MEMBERS OF THE STATE BAR OF CALIFORNIA

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:

(Please make any necessary corrections to your full name and street address if shown below.)

Name:_____
Last First MI

Add 1: _____

Add 2: _____

City, St., Zip: _____

Member's Social Security #:
☐☐☐ – ☐☐ – ☐☐☐☐

Spouse's Social Security (if applying) #:
☐☐☐ – ☐☐ – ☐☐☐☐

Home Phone: (____)_____

Work Phone: (____)_____

Fax: (____)_____

Email Address: _____
AMBA will not share your email information

Marital Status: ❑ Married ❑ Divorced ❑ Single ❑ Widow(ed)
❑ Civil Union* ❑ Domestic Partner*
*Eligibility of Domestic Partner/Civil Union partners is determined by State law.

Are you presently insured under any CA BAR Group Life Insurance Plans? ❑ Yes ❑ No
If "yes," indicate which Plan(s) and provide details: ❑ Term Life ❑ 10-Year Level Term Life ❑ 20-Year Level Term Life

Details:_____
(Person insured and amount of insurance)

Do you or your spouse (if proposed for insurance) intend to reside outside the U.S. within the next 12 months?
Member: ❑ Yes, Country_____ For how long? _____ ❑ No
Spouse: ❑ Yes, Country_____ For how long? _____ ❑ No

		DATE OF BIRTH: MO. DAY YR.	HEIGHT:	WEIGHT:	SEX:
Member:	_____	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Spouse*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____	____ft. ____in.	_____lbs.	❑ M ❑ F
Child(ren)*:	_____ Name (if proposed for insurance) First/MI/Last	____/____/____			
	_____ Name (if proposed for insurance) First/MI/Last	____/____/____			

* See Plan Information/Plan Details 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.

2. Licensing Information Affiliation:

Are you now licensed attorney with The State Bar of California? ❑ Yes ❑ No

License # _____ Exp. Date _____

3. Payment Option: (Choose only one)

❑ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** I request and authorize the Association Member Benefits & Insurance Agency to make monthly withdrawals against the account specified on the attached voided check and such bank to process these Withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Term Life Insurance Plan. (Enclose a VOIDED check.)

X_____

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT DATE

❑ **OPTION 2: PERIODIC BILLING:** ❑ Quarterly ❑ Semiannual ❑ Annual

G-30921-0

BE SURE TO COMPLETE ALL PAGES AND SIGN ➡

4. Insurance Requested: (Refer to the Plan Information/Plan Details for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES:

a.Initial Member Insurance Amount: $ _____ **Initial Spouse Insurance Amount: $** _____(use $25,000 increments)

Initial Child Insurance Amount: $5,000 each eligible child ($1,000 for ages under 6 months): ❑
Note: Member coverage must be in force to request Child Coverage.

b.Increase Member Insurance Amount from $_____ **to $**_____
Increase Spouse Insurance Amount from $_____ **to $**_____
*Spouse coverage cannot exceed 100% of Member's coverage.

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

Do you have other insurance applications pending? If "Yes," indicate amount and company:
Member: $_____ Company _____ Spouse: $_____ Company _____

d. TOBACCO/NICOTINE USE: Have you and/or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum, and electronic cigarettes)?

Member: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT) Spouse: ❑ Yes ❑ No If "Yes," _____ (TYPE OF PRODUCT)

When did you last use tobacco or nicotine product? _____/_____ (MONTH/YEAR) When did you last use tobacco or nicotine products? _____/_____ (MONTH/YEAR)

e. Is the insurance applied for intended to replace, discontinue or change an existing policy?
Member: ❑ Yes ❑ No Spouse: ❑ Yes ❑ No

5. Member's Beneficiary Designation: (Insert name, relationship and address)

I make the following beneficiary designation with respect to all 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 designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

❑ Primary ❑ Secondary %: _____
Licensed Attorney (Applicant)
Beneficiary Name:_____ (Last First MI)
Beneficiary's Relationship to Member: _____
Beneficiary Social Security #:_____
Beneficiary Date of Birth: _____
Street Address: _____
City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____
Spouse Applicant
Beneficiary Name:_____ (Last First MI)
Beneficiary's Relationship to Member: _____
Beneficiary Social Security #:_____
Beneficiary Date of Birth: _____
Street Address: _____
City _____ State _____ Zip Code _____

Spouse's Beneficiary Designation: (Insert name, relationship and address)

I make the following beneficiary designation with respect to all 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 designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the Administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust. (Attach a separate sheet if necessary, then sign and date it.)

❑ Primary ❑ Secondary %: _____
Beneficiary Name:_____ (Last First MI)
Beneficiary's Relationship to Member: _____
Beneficiary Social Security #:_____
Beneficiary Date of Birth: _____
Street Address: _____
City _____ State _____ Zip Code _____

❑ Primary ❑ Secondary %: _____
Beneficiary Name:_____ (Last First MI)
Beneficiary's Relationship to Member: _____
Beneficiary Social Security #:_____
Beneficiary Date of Birth: _____
Street Address: _____
City _____ State _____ Zip Code _____

6. Statement of Health: (Please initial and date any changes you make on this form.)

To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured:

	YES	NO
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?	❑	❑
b. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❑	❑
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?	❑	❑
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?	❑	❑
e. Is any person to be insured now pregnant?	❑	❑

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:

	YES	NO
1. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	❑	❑
2. Arthritis, back trouble, bone or joint disorder?	❑	❑
3. Fainting spells, convulsions, or epilepsy?	❑	❑
4. Sugar, blood, albumin or pus in urine?	❑	❑
5. Diabetes, kidney trouble, ulcers or digestive disorder?	❑	❑
6. Disorder of breasts or reproductive organs or functions?	❑	❑
7. Nervous or mental disorder, emotional condition or psychiatric care?	❑	❑
8. Cancer, tumor or cyst?	❑	❑
9. Varicose veins, hemorrhoids or hernia?	❑	❑
10. Disorder of eyes, ears, nose or sinuses?	❑	❑
11. Thyroid, liver or respiratory disorder?	❑	❑
12. Alcoholism or drug habit?	❑	❑
13. Disorder of the blood?	❑	❑
14. 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, or chronic fatigue, in the past five years?	❑	❑
(iii). Any other impairment?	❑	❑

g. Have you or your spouse (if proposed for insurance) 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: This question is not applicable to MD residents.]	❑	❑
h. Within the past two years have you or your spouse (if proposed for insurance) participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as 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?	❑	❑

i. Driver's License No.: Member _____ Spouse _____

State in which issued: Member _____ Spouse _____

Have you or your spouse (if proposed for insurance) had a driver's license suspended or revoked, or had any moving violations, within the last five years?	❑	❑
j. In the last seven years, have you or your spouse (if proposed for insurance) been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	❑	❑

IF YOU HAVE ANSWERED ANY QUESTIONS "YES" GIVE COMPLETE DETAILS BELOW.

(If you need more space, use a signed and dated separate sheet.
Please avoid the use of such terms as "etc.", "various" or "miscellaneous".)

Question Letter/No.	Name 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:

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 plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** to authorize the disclosure of information to and from the providers noted above and in the IMPORTANT NOTICE, including making a brief report of our protected health information to MIB, LLC; and **attest** to having read the IMPORTANT NOTICE enclosed and Fraud Notice indicated below, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

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.

Member's Signature X _____ **Date** _____

(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X _____ **Date** _____

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

Owner Information is required if owner is other than Applicant
(If Owner is a Trust, please submit a copy of the document with this application.)

Full Name: Last	First	Middle Initial	Relationship to Proposed Insured	Daytime Phone

Mailing Address Street	City	State	Zip Code

Tax ID#	Date of Birth	Social Security Number
	/ /	☐☐☐ – ☐☐ – ☐☐☐☐

Owner's SignatureX _____ **Date** _____

(NECESSARY ONLY IF OTHER THAN MEMBER)

10/18 ed.

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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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request For The Group Term Life Insurance Plan

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.**

Group Term Life Insurance

For Members of The State Bar of California and Their Families

Underwritten by New York Life Insurance Company

PROTECTION is what life insurance is all about.

Life insurance is a real answer to help safeguard financial security. What if your family loses you tomorrow or next month—or even two years from now? Some day your family's future may depend on the benefits your life insurance provides. Will there be enough?

Estimate how much money you spend each month. Be sure to include your rent or mortgage payments, car loan, medical expenses, utility bills, charge accounts and grocery bills. Add in the amount you save each month for future plans such as vacations and a good education for your children. Now, divide the amount of your present life insurance by your monthly expenditures.

How many months would your family survive at a reasonable standard of living on your current life insurance?

As you become more established, you improve your standard of living. Do you have efficient life insurance that keeps up with the constant changes and growing needs of your family?

Life insurance helps your family in many ways. It's a good solution to help safeguard your financial security.

Right now, you and/or your spouse or domestic partner has the opportunity to purchase up to $3,000,000 of Group Term Life Insurance. And with specially negotiated premium rates, this coverage is too important to pass up!

Who Is Eligible?

California State Bar members and/or their spouses or domestic partners under age 70 are eligible to apply for up to $3,000,000 of Term Life Insurance coverage with an Accelerated Death Benefit. Your children ages 6 months to 26 years are each eligible for $5,000 of life insurance. Children under age 6 months may be insured for $1,000 each. Just $7.00 per year for 5,000 benefit amount covers all children no matter how many.

This coverage is available only for residents of the United States.

COVERAGE AMOUNTS

Choose the amount of Group Term Life Insurance you need to help protect you and your family.

Member–$50,000 to $3,000,000 in $25,000 multiples.
Spouse–$50,000 to $3,000,000 in $25,000 multiples.

The total amount of coverage for an individual insured under this policy issued by New York Life Insurance Company to the State Bar may not exceed $3,000,000. The total amount of coverage for an individual may have under all group life insurance policies underwritten by New York Life Insurance Company may not exceed $3,000,000.

FEATURES

VALUABLE ACCELERATED DEATH BENEFIT.....

for the same premium

The Living Benefit or "accelerated death benefit" is designed to provide members with the option to have a portion of a terminally ill insured's life insurance benefit paid while he/she is still alive.

The money received under this feature can be used however you see fit. For example, it can help pay medical bills and other outstanding debts and financial obligations…it can help you keep your savings and assets intact…it can help you maintain your quality of living.

To qualify for this benefit, a person must be insured under this policy and diagnosed as having a life expectancy of 12 months or less. Proof of terminal illness will consist of a statement from a doctor and any other medical information New York Life Insurance Company believes necessary to confirm the person's status.

You can request payment equal to 60% (not to exceed $250,000) of a qualified terminally ill person's in force coverage. The amount payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

Please note that the receipt of this benefit may affect your eligibility for public assistance programs and may be taxable. You may wish to consult the appropriate social services agency and a qualified tax advisor about how this may affect your personal situation.

Exclusions and Limitations

Your Group Term Life Insurance provides benefits for death from any cause, except suicide during the first two years your coverage is in force … at any time … in any place throughout the world. If a person commits suicide within 2 years from the date his insurance takes effect, the benefit will be limited to the premiums paid. The validity of any amount of life insurance which has been in force for two years during an insured's lifetime will not be contested except for insurance eligibility provisions and nonpayment of premium contributions.

Your Choice of Beneficiary

You may select any person, persons, trust or other legal entity as your beneficiary. If, at the time of your death, there are no surviving beneficiaries, benefits will be paid to the executor or administrator of your estate, or at the option of New York Life Insurance Company, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

Premiums Are Waived If You're Totally Disabled

If you become totally disabled before age 60, your insurance will be continued as long as you remain totally disabled without additional premium contributions until you reach age 70. You may be asked to provide evidence of your continued total disability from time to time.

When Will My Insurance End?

Your insurance will continue until you or your spouse reach age 80 (age 26 for children) as long as you pay your premium when due, maintain your membership, all insureds remain eligible, and the group policy remains in force.

Group Conversion Privilege

The Policy provides a conversion privilege under certain circumstances of involuntary termination as described in the Certificate of Insurance.

EFFECTIVE DATE

You and your dependents will become insured on the first of the month after your application is approved by New York Life Insurance Company provided the initial premium contribution has been paid, satisfactory evidence of insurability has been submitted, and you and your dependents are actively performing the normal activities of a person in good health of like age on the date NC RESIDENTS (a person like age) of approval. Any person who is not performing his/her normal daily activities as required will not become insured until the day he/she is performing such activities.

CERTIFICATE OF INSURANCE

This brochure contains only a brief description of some of the principal provisions and features. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to The State Bar of California.

When you become insured, you will be sent a Certificate of Insurance summarizing your benefits under the policy.

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 be sent a full refund, no questions asked!

RENEWAL PAYMENTS AND CLAIMS

Once you are accepted into the policy, you will have a 31-day grace period for your payment of renewal premium contribution. When you want to submit a claim, call or write the Administrator for claim forms.

HOW TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing with the State Bar. Please wait until your application for membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact the State Bar directly.

Get Quicker, Easier Service When You Apply

The information provided when you fill out your Application can make the medical underwriting process quicker and easier. By providing complete and accurate information, you avoid delays that may occur while we wait for missing information to be received and shorten the time needed for underwriting decisions and approvals. We also request that you provide the following information for everyone you are requesting coverage on as well as on any named beneficiary: full name, address, date of birth, Social Security number, and telephone number.

New York Life Insurance Company relies on your answers and statements. Misstatements or failures to report information on your application may be used as the basis for invalidating your insurance.

The Group Term Life Insurance is medically underwritten based on the information provided by you on your Application. It is important that you complete the form truthfully and completely. Your Application is subject to New York Life Insurance Company's approval and more medical information may be requested. A physical exam, EKG, blood test or other medical information may be required. If so we will arrange for an independent professional paramedic to contact you and arrange to perform these simple tests at your convenience. The exam and the blood test will be paid for by the policy.

Apply in Three Easy Steps

1. Refer to the policy description for benefits and premium costs as you fill out the application. Be sure to indicate whether you are requesting coverage for your spouse and children.
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.
3. Mail the completed application to the Administrator in the postage-paid envelope provided.

If you have questions about your eligibility or the features of this Policy, call a Customer Service Representative toll-free at 1-800-343-0132.

This Group Term Life Insurance is Administered by:

Association Member Benefits & Insurance Agency

CA BAR Group Insurance Program
P.O. BOX 14536
Des Moines, IA 50306

Any questions?
1-800-343-0132
www.mybarbenefits.com

CA Insurance License #0I96562

This Group Term Life Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-30921-0
on Policy Form GMR-FACE/G-30921-0

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company, registered in the United States and other countries. Other trademarks used herein are the property of their respective owners.

The State Bar receives sponsorship fees from insurance programs to offset the cost of program oversight, support member benefits and subsidize approved programs.

YOUR COST

Current 2026-2027 Annual Premiums per $1,000

The initial cost of this life insurance is based upon the member and spouse's gender, amount of insurance requested, usage of tobacco/ nicotine products, health status, and attained age on the date coverage is issued. The cost increases as the insured person enters the higher age brackets.

Band 1 - $50K-$99K

Attained Age	Female Standard	Female Tobacco/ Nicotine User	Male Standard	Male Tobacco/ Nicotine User
20-29	$0.90	$1.29	$1.37	$2.18
30-34	1.19	1.78	1.53	2.46
35-39	1.55	2.44	1.69	2.86
40-44	1.88	3.11	2.42	4.31
45-49	2.73	4.44	3.36	5.23
50-54	4.02	6.03	4.59	7.03
55-59	6.28	9.03	6.92	10.38
60-64	8.51	11.70	11.15	16.45
65-69	13.25	17.39	17.85	25.66
70-74	18.80	24.68	27.58	38.62
75-79	27.88	36.60	44.53	60.74

Band 2 - $100K-$249K

Attained Age	Female Preferred	Female Standard	Female Tobacco/ Nicotine User	Male Preferred	Male Standard	Male Tobacco/ Nicotine User
20-24	$0.16	$0.29	$0.69	$0.47	$0.86	$1.68
25-29	0.17	0.33	0.76	0.40	0.72	1.45
30-34	0.26	0.49	1.15	0.46	0.86	1.70
35-39	0.40	0.75	1.77	0.66	1.26	2.46
40-44	0.66	1.23	2.91	0.96	1.73	3.58
45-49	0.99	1.80	4.20	1.52	2.73	5.56
50-54	1.35	2.48	5.73	2.07	3.83	7.66
55-59	2.05	3.68	7.67	3.59	6.61	11.62
60-64	3.22	5.91	11.14	4.86	9.01	15.04
65-69	4.81	8.82	16.09	8.10	15.02	23.30
70-74	7.46	13.69	24.09	12.89	23.91	33.74
75-79	12.09	22.21	37.69	21.44	39.77	51.06

The premium contributions shown reflect the current rate and benefit structure. Premium contributions may be changed by New York Life Insurance Company on any premium due date and 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 insurance under this group policy. For example, a class of insureds is a group of people all with the same issue age. Benefit amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and The State Bar of California.

YOUR COST

Current 2026-2027 Annual Premiums per $1,000

The initial cost of this life insurance is based upon the member and spouse's gender, amount of insurance requested, usage of tobacco/ nicotine products, health status, and attained age on the date coverage is issued. The cost increases as the insured person enters the higher age brackets.

Band 3 - $250K-$499K						
Attained Age	Female Preferred	Female Standard	Female Tobacco/ Nicotine User	Male Preferred	Male Standard	Male Tobacco/ Nicotine User
20-24	$0.15	$0.26	$0.62	$0.43	$0.78	$1.52
25-29	0.15	0.29	0.69	0.36	0.65	1.30
30-34	0.24	0.45	1.03	0.41	0.78	1.53
35-39	0.36	0.67	1.60	0.59	1.14	2.21
40-44	0.60	1.11	2.62	0.86	1.56	3.22
45-49	0.89	1.62	3.78	1.37	2.46	5.01
50-54	1.21	2.23	5.16	1.87	3.45	6.90
55-59	1.85	3.31	6.91	3.23	5.94	10.46
60-64	2.90	5.31	10.03	4.38	8.11	13.54
65-69	4.33	7.94	14.48	7.29	13.51	20.97
70-74	6.72	12.32	21.68	11.60	21.51	30.37
75-79	10.90	19.98	33.92	19.29	35.79	45.96

Band 4 - $500K-$3,000K						
Attained Age	Female Preferred	Female Standard	Female Tobacco/ Nicotine User	Male Preferred	Male Standard	Male Tobacco/ Nicotine User
20-24	$0.14	$0.25	$0.59	$0.40	$0.74	$1.43
25-29	0.15	0.28	0.65	0.34	0.61	1.23
30-34	0.23	0.42	0.97	0.39	0.74	1.45
35-39	0.34	0.64	1.51	0.56	1.07	2.09
40-44	0.56	1.05	2.48	0.81	1.47	3.04
45-49	0.85	1.53	3.57	1.29	2.32	4.72
50-54	1.15	2.10	4.88	1.77	3.26	6.52
55-59	1.74	3.12	6.52	3.05	5.61	9.87
60-64	2.74	5.02	9.46	4.13	7.66	12.79
65-69	4.10	7.50	13.68	6.89	12.77	19.80
70-74	6.34	11.63	20.48	10.96	20.32	28.68
75-79	10.24	18.85	32.04	18.22	33.79	43.41

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