GROUP BENEFIT SOLUTIONS

Now is the Time…

…to convert your group accident insurance to an individual policy.

This document describes the Accidental Death and Dismemberment (AD&D) insurance coverage (including Family coverage) available to persons who are no longer eligible for insurance under a New York Life Group Benefit Solutions (NYL GBS) Accident Policy.

This is Accident insurance only. This is a supplement to health insurance and is NOT a substitute for major medical or other comprehensive health insurance coverage.

An issued policy only pays benefits related to a covered Accident.

IMPORTANT NOTICE -
AN ISSUED POLICY DOES NOT PROVIDE COVERAGE FOR SICKNESS

Take advantage of this opportunity NOW!

Standard (AD&D)
874445 Revised 12/2024

Now is the Time!

Because…

YOU UNDERSTAND the value of Accident Insurance. You've been enrolled in a Group Accident Insurance Policy (AD&D) with New York Life Group Benefit Solutions (NYL GBS), secure in the knowledge that your family will have the advantage of financial assistance in the event of a covered accident which results in death or dismemberment.

Because…

WE UNDERSTAND your interest in continuing your Accident Insurance protection without interruption. If you are under age 70, NYL GBS is providing this opportunity to convert all or part of your current AD&D coverage. You may convert your coverage when your group accident insurance coverage terminates because you have ceased to be eligible, or you have terminated employment with the policyholder. You may also convert if the group accident insurance policy has been terminated by your employer or amended to terminate insurance for your class and is available for all insureds who meet the requirements of the Policy. Please refer to your Certificate of Insurance for details.

Because…

IT'S EASY TO CONVERT TO INDIVIDUAL COVERAGE. You may enroll for this coverage without providing medical or other evidence of good health, by submitting a completed application along with your check or money order for the initial premium payment by the deadline stated in your certificate of insurance (which will not be less than 31 days from your last day worked).

Your Converted Policy…

will be effective on the day following the date coverage ended under your group insurance policy or the date application is made, if later. The insurance pays for loss caused by, and occurring within one year after, a covered accident:

Loss of

Life	Principal Sum
Two or more members*	Principal Sum
One Member	One-Half Principal Sum
Thumb and index finger of same hand	One-Quarter Principal Sum

*"Member" means hand, foot or eyesight.

Only one amount, the largest to which you are entitled, is payable for all losses resulting from one accident.

General Information

The policy is renewable with the Insurance Company consent until you reach age 70. The Insurance Company may change renewal premium rates only on a class basis, not an individual basis.

Any policy being issued to a NY resident will be underwritten by New York Life Group Insurance Company of NY (NYLGICNY), all other states will be underwritten by Life Insurance Company of North America (LINA).

You may cancel at any time after the policy's original term.

Note: This individual accident insurance is not available if the Insurance Company has already issued you an individual AD&D policy converted from the same employer's plan.

Family Plan

If you are an employee whose group AD&D coverage has terminated, you may elect Family Plan coverage, whether or not you insured dependents under the group policy. Family Plan coverage includes the following dependents:

1. You.
2. Your spouse, while he or she is under age 70.
3. Your dependent children.

If you had dependents insured under the group policy that are not eligible under the Family Plan coverage, each of those dependents may elect his or her own individual AD&D conversion policy. For example, a domestic partner who was insured under the group policy, or an insured child who doesn't meet the above definition, can apply for an individual AD&D conversion policy. In addition, if you do not elect Family Plan coverage, any dependent who was insured under the group policy and is age 18 or older, and who is no longer eligible (because of your termination of employment, divorce, child no longer eligible, etc.) can apply for an individual AD&D conversion policy.

Handicapped Dependents: Coverage may be kept in force, as a Dependent Child, after the eligibility age with proof of the child's incapacity and dependence.

If you insure your spouse and/or dependent child/ren under the Family Plan, the amount of insurance applicable to members of the family is based on the composition of the family at the time of loss, and is expressed as a percentage of your Principal Sum, as follows:

1) At the time of accident the family consists of You, Your Spouse and Dependent Children
   Insured 100%
   Spouse..... 40%
   Each Child 10%

2) At time of accident the family consists of You and Your Spouse but NO Dependent Children
   Insured 100%
   Spouse..... 50%

3) At time of accident the family consists of You and Your Dependent Child/ren but NO Spouse
   Insured 100%
   Each Child 15%

> ***Example:*** Under the Family Plan, your benefit is $100,000. The family consists of you, your spouse, and three children.
>
> Your Amount.....$100,000.00
> Your Spouse's Amount 40,000.00
> Each Child's Amount 10,000.00

Selection of your Principal Sum

The amount you may apply for is dependent upon the reasons the current NYL GBS insurance policy or any portion of it ended. Below is eligibility information on what you may apply for based on the reasons your NYL GBS accident plan is ending. Please refer to the eligibility rules that apply to you.

If your insurance or any portion of it ends for any of the following reasons:

a. employment termination or;
b. termination of membership in an eligible class.

You may apply for an amount of coverage that is:

a. in $1,000 increments;
b. not less than $25,000, regardless of the amount of insurance under the group accident policy; and
c. not more than the amount of insurance that is terminating under the group accident policy, except as provided above, up to a maximum amount of $250,000.

Beneficiary Information

a. ***Spouse's Beneficiary:*** Loss of life benefits will be paid to the owner. All other benefits will be paid to the spouse.
b. ***Child's Benefits:*** Loss of life and all other benefits will be paid to the owner.

Limitations and Exclusions

No benefits will be paid for loss resulting from:

1. Intentionally self-inflicted injuries or any attempt thereat, while sane or insane (in Missouri, while sane).
2. Declared or undeclared war or act of war.
3. Accident occurring while the Insured is serving on full-time active duty for more than 30 days in any Armed Forces. (Send us proof of service. We will refund any premiums paid for this time.) (Reserve or National Guard active duty for training is not excluded.)
4. Travel or flight (including getting in or out, on or off) in any aircraft or device which can fly above the earth's surface if:
   A. The aircraft or device is used:
      1) For test or experimental purposes; or
      2) By or for any military authority. (Aircraft flown by the U.S. Military Airlift Command (MAC) or similar service of another country are not excluded); or
      3) For travel, or is designed for travel, beyond the earth's atmosphere; or
   B. The Insured is:
      1) Serving as a pilot or crew member (or student taking a flying lesson) and is not riding as a passenger; or
      2) Hang-gliding; or
      3) Parachuting, except where the Insured has to make a parachute jump for self-preservation.
      4) Applicable to New York residents only; aviation, other than as a fare-paying passenger on a scheduled or charter flight operated by a scheduled airline.
5. Commission of a felony by the Insured.
6. Sickness, disease, bodily or mental infirmity, or medical or surgical treatment thereof or bacterial or viral infection, regardless of how contracted. This does not include bacterial infection that is the natural and foreseeable result of an accidental external cut or wound, or accidental food poisoning.

Rate Schedule

Accidental Death and Dismemberment
Annual Premium Schedule

Under Age 65		
Principal Sum*	**Insured Only**	**Insured & Family**
25,000	31.25	45.00
50,000	62.50	90.00
100,000	125.00	180.00
150,000	187.50	270.00
200,000	250.00	360.00
250,000	312.50	450.00
Age 65 Until Age 70		
Principal Sum*	**Insured Only**	**Insured & Family**
25,000	46.25	67.50
50,000	92.50	135.00
100,000	185.00	270.00
150,000	277.50	405.00
200,000	370.00	540.00
250,000	462.50	675.00

***** See the section labeled "**Selection of Your Principal Sum**" to determine the Principal Sum you are eligible to apply for.

If your terminating Principal Sum is not shown in the schedule above you can calculate your premium using the instructions under "To Calculate Your Premium" section.

To Calculate Your Premium

Example: If the Principal Sum on your terminating group accident policy is $75,000,

Under Age 65

Insured Only: $75,000 divided by 1,000=75. 75 multiplied by **$1.25 per year****=$93.75 of annual premium.
Insured & Family: $75,000 divided by 1,000=75. 75 multiplied by **$1.80 per year****=$135.00 of annual premium.

Age 65 Until Age 70

Insured Only: $75,000 divided by 1,000=75. 75 multiplied by **$1.85 per year****=$138.75 of annual premium.
Insured & Family: $75,000 divided by 1,000=75. 75 multiplied by **$2.70 per year****=$202.50 of annual premium.

**Rate per $1,000 per year.

If you wish to pay the premium semi-annually or quarterly, please note:

For a Principal Sum of $50,000 or more, you may pay the premium semi-annually by dividing the annual premium by 2.

For a Principal Sum of $100,000 or more, you may pay the premium quarterly by dividing the annual premium by 4.

Example: If your Principal Sum is $100,000, you have the family coverage, and your attained age is 55, your total quarterly premium for you and your family equals $45.00.

How Do I Apply and/or Ask Questions?

The application is located on the following pages. The completed application and premium must be sent to the address below by the deadline stated in your certificate of insurance.

Please note that the application includes a section that should be completed by your employer. This may have been filled out by your employer before it was given to you. If it is blank, please go ahead and submit the application and note that this may cause a delay in processing your application.

If you received a cover letter from any NYL GBS customer service center, or your former employer, please provide that letter instead.

Complete this application and mail along with your check and employer verification page or coverage verification letter to:

Life Insurance Company of North America
(Please make checks payable to LINA)
P.O. Box 786020
Philadelphia, PA 19178-6020

Overnight Address only:
Lockbox Services-6020
Life Insurance Company of North America
2005 Market Street, 5th Floor
Philadelphia, PA 19103-7042

If you have any questions or need assistance in completing the application, please call our toll-free number 1-800-441-1832, Monday through Friday, 8:00 am to 4:30 pm (CST).

CLEAR FORM

Application for Conversion of Accidental Loss of Life, Limb or Sight Coverage to an Individual Policy

Life Insurance Company of North America
New York Life Group Insurance Company of NY

The following information must be completed by the Insured or the Owner of this coverage, if coverage was previously assigned. If your basic and voluntary group policies were issued under two separate group policy numbers and you wish to convert both, two separate applications must be completed. Copies of this form are acceptable.

Section A - Insured Information

Employer Name			**Group Policy Number**
Insured/Owner Name (Last)	(First)	(Middle)	**Relationship to Employee**
Address (Street)	(City)	(State)	(Zip Code)
Date of Birth (Month/Day/Year)	**Telephone Number**		**Social Security Number**

Section B - Coverage Elections

- **Total amount of Accidental Death and Dismemberment Coverage you wish to convert*: $** $90,000.00
  Family Coverage** ☐ **Yes** ☐ **No**
  *Please note: this amount cannot exceed the amount you had under the Group Policy, to a maximum of $250,000.00.
  **Family coverage can only be elected by the Employee or the Spouse. It cannot be elected by both.
- **I wish to pay premiums:** ☐ **Annually** ☐ **Semi-annually** ☐ **Quarterly**
- **Amount of payment submitted with this application (minimum is quarterly) $** _____, **check number** _____

Section C - Beneficiary Information

This section is to be completed by the Applicant or Owner. Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

Beneficiary Name	**Percentage** *Must equal 100%*	**Social Security Number**	**Date of Birth** *Month/Day/Year*	**Relationship**
	%			
	%			
Contingent Beneficiary Name	**Percentage** *Must equal 100%*	**Social Security Number**	**Date of Birth** *Month/Day/Year*	**Relationship**
	%			
	%			

If you need additional space for your beneficiaries - sign, date, and attach a separate sheet of paper using the above format.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, payments of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

Spouse's Signature: _____ **Date:** (Month/Day/Year) _____

Standard (AD&D)
874445 Revised 12/2024

Section D - Agreement & Authorization

I have read the above statements and agree that they are accurate and complete to the best of my knowledge and belief. I understand that this insurance will be issued on reliance upon such statements. I further agree that while my application to convert under the terms of the group policy is being reviewed, the Insurance Company may deposit the payment submitted with the application. If I am later determined not to be eligible to convert my group insurance, the sole obligation of the Insurance Company shall be to refund the premiums paid.

Caution: Any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for Accident and health insurance; or statement of claim for Accident and health insurance containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, commits a fraudulent insurance act. For residents of the following states, please see the last page of this form: ***California, Colorado, District of Columbia, Florida, Kansas, Kentucky, Louisiana, Maryland, Minnesota, New Jersey, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, Tennessee, Texas, Vermont, Virginia or Washington.***

Applicant/Owner's Signature: _____ **Date:** (Month/Day/Year) _____

Employer Verification Page

Life Insurance Company of North America
New York Life Group Insurance Company of NY

This page must be completed by the Employer/Policyholder

Employer Name	**Basic Group Policy Number**	**Group Class Number**
Name of Employee	**Voluntary Group Policy Number**	**Group Class Number**
Date of Hire (month/day/year)	**Last Date Worked**	**Salary** (as of Last Date Worked)
Employment Termination Date	**Coverage End Date**	**Effective Date of Salary**
Reason for Termination of Coverage ☐ Termination of Employment ☐ FMLA ☐ Other (Describe):		

Amount of Terminated Group Accident Insurance Coverage Eligible for Conversion

	Voluntary	Basic
Group Coverage Effective Date (month/day/year)		
Premium Paid Through Date (month/day/year)		
Employee Coverage Amounts	$	$
Spouse Coverage Amounts	$	$
Child Coverage Amounts	$	$
Employee and Family	☐ Yes ☐ No	☐ Yes ☐ No

**If your group policy provided dependent spouse/child coverage under a Family Plan, please indicate the applicable benefit percentage in effect as of the coverage term date. (Example: 50%, 100%)*

Verification of the Information Above was provided by:	
Employer/Policyholder Signature:	**Date:** (Month/Day/Year)
Email Address:	Telephone Number:

Important Information to Employer/Policyholder:

1. Has an assignment been recorded on any of these coverages? ☐ Yes ☐ No
   a. If an assignment has been recorded for the coverage, you will need to provide notice to the assignee and not the employee
2. Make a copy of this form for your file. This is for your own protection to ensure proper notification has been given.
3. This form must be completed in its entirety. If any portion is incomplete or incorrect, it could result in delays or rejection of this valuable coverage for the employee and/or his/her dependents.

CLICK TO PRINT

Important State Specific Fraud Warning Notice

California Residents: 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.

Colorado Residents: It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the Department of Regulatory Agencies.

District of Columbia Residents: **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.

Florida Residents: 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.

Kansas Residents: Any person who knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any material fact thereto, may be guilty of insurance fraud determined by a court of law.

Kentucky Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

Louisiana Residents: 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.

Maryland Residents: 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.

Minnesota Residents: A person who files a claim with intent to defraud or helps commit a fraud against an insurer is guilty of a crime.

New Jersey Residents: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

Oklahoma Residents: **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.

Oregon Residents: Any person who includes any false or misleading information on an application for an insurance policy, may be guilty of fraud and may be subject to civil or criminal penalties if intentional and material to the risk assumed.

Pennsylvania Residents: 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.

Puerto Rico Residents: **Caution:** Any person who knowingly and with the intention of defrauding presents false information in an insurance application, or presents, helps, or causes the presentation of a fraudulent claim for the payment of a loss or any other benefit, or presents more than one claim for the same damage or loss, shall incur a felony and, upon conviction, shall be sanctioned for each violation by a fine of not less than five thousand dollars ($5,000) and not more than ten thousand dollars ($10,000), or a fixed term of imprisonment for three (3) years, or both penalties. Should aggravating circumstances be present, the penalty thus established may be increased to a maximum of five (5) years, if extenuating circumstances are present, it may be reduced to a minimum of two (2) years.

Rhode Island Residents: 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.

Tennessee Residents: 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.

Texas Residents: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Vermont Residents: Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Virginia Residents: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits application or files a claim containing a false or deceptive statement may have violated state law.

Washington Residents*:* 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.