LD — 107674

APPLICATION — PART I — TO NEW YORK LIFE INSURANCE COMPANY

1. PROPOSED INSURED? { Print full name } | DATE OF BIRTH? Mo: ..... Day: ..... Yr: ..... | AGE nearest Birthday? | Male? ☐ Fem.? ☐

Single? ☐ Married? ☐ Sep.? ☐ Div.? ☐ Wid.? ☐ | Place of Birth? (State or Prov. and Country)

ADDRESS? Number St. or Rt. City or Town County State or Province | Time at Address? | FIRM OR EMPLOYER?

Residence ..... Yrs:.....Mos:.....

Business ..... Yrs:.....Mos:.....

Mailing Address? Res. ☐ Bus. ☐ Other .....

If in Military Service, Pay Grade and Permanent Mailing Address?

Present Occupation(s)? | Duties of Occupation(s)?

Previous Occupation(s) within last 2 years? | Previous Address(es) within last 2 years? Residence: ..... Business: .....

2. LIFE PLAN and AMOUNT?

W.P. Yes ☐ No ☐
P.P.O. Yes ☐ No ☐
C.P.B. Yes ☐ No ☐ A.D.B. $..... F. Inc. (.....Yr.) $.....Mo.
P.P.B. Yes ☐ No ☐ Term (.....Yr.) $..... M.P. (.....Yr.) .....Units

APL? Yes ☐ No ☐
LIFE Dividend option? Cash ☐ Add'n ☐ Prem. ☐ Dep. ☐ Dep. & 1 Y. T. Opt. ☐

LIFE Policy to be dated? Later date of Parts I and II ☐ Date policy written ☐ Other ..... 19.....

4. PREMIUM MODE?

LIFE	HEALTH
☐	C-O-M ☐
☐	Nyl-a ☐
☐	Mthly ☐
☐	Qrtly ☐
☐	Semi ☐
☐	Ann'l ☐
☐	Gov't
☐	S.P.

3. HEALTH PLAN and AMOUNT?

Monthly Disability Income $.....; Day Benefits Commence: Accident ..... Sickness .....
Daily Hospital Benefit $.....; Deductible Amount $.....
Maximum Major Medical Benefit $.....; Deductible Amount $.....

HEALTH Policy to be dated? Later date of Parts I and II ☐ Date policy written ☐ Other ..... 19.....

5. BENEFICIARY, subject to change. Full Name & Relationship to Proposed Insured?

LIFE .....

HEALTH .....

6. LIFE Policy Owner? Proposed Insured ☐ Other ☐ (If "Other" complete question 15)

7. CASH PAID subject to terms of receipt below? (If none paid, say "none")

LIFE Policy $.....

HEALTH Policy $.....

8. Has any person proposed for coverage (see Question 14):

(a) ever been declined for issue, reinstatement, or renewal of any type of Life or Health insurance, or been offered a policy on issue, reinstatement or renewal which was different from that applied for? Yes ☐ No ☐ (If "Yes", give name of person, companies and other details below.)

(b) flown within last 5 years, or intend to fly, as a pilot or other crew member of any kind of aircraft? Yes ☐ No ☐ (If "Yes", complete aviation blank, Form 5794, as part of this application.)

(c) resided within last 5 years, or intend to reside, outside the United States and Canada? (If "Yes", state where, when and how long.) Yes ☐ No ☐

(d) engaged in within last 5 years, or intend to engage in, skin diving, motor vehicle racing, sky diving, or any other hazardous sport or hobby? (If "Yes", complete Form 7663.) Yes ☐ No ☐

9. Is the policy(s) applied for intended to replace, in whole or in part, Life or Health insurance in force in this or any other company? Yes ☐ No ☐ (If "Yes", give name of company, replacement date, amount of benefit replaced, plan and policy number, if known.)

10. Insurance in force or pending on Proposed Insured? (If none, say "none")

(a) If life policy being applied for, total amount of life insurance In Force ..... Pending .....

(b) If health policy being applied for, amount of health insurance

Mthly Inc. (Disability)	Daily Ben. (Hospital)	Max. Ben. (Maj. Med.)	In Force	Pending	Company or Organization

11. Amendments and Corrections (for completion at Home Office; this space will not be used where not allowed by Statute or Insurance Department Regulations)

IT IS MUTUALLY AGREED THAT:

1. Except as provided in a receipt, the terms of which are mutually acceptable, given for cash and bearing the same date and number as Part I of this application, no policy applied for herein shall go into force or take effect unless and until it is delivered to the Applicant and the first premium for it is paid in full during the lifetime of the person or persons proposed for coverage under it, and then only if the written representations made in the entire application for insurance would be, without material change, at time of delivery of the policy, true and complete representations of the state, at that time, of those matters inquired about in such application.
2. No field underwriter or other agent of the Company, nor any medical examiner, is authorized to accept risks, pass upon insurability, make or modify contracts, or waive any of the Company's rights or requirements.
3. The Applicant agrees that the written representations made in such application are correctly recorded, complete and true and that the Company, believing them to be true, shall rely and act upon them accordingly. The Applicant confirms all agreements included in such application and agrees that acceptance of any policy issued thereon shall constitute ratification of such agreements and of any amendments and corrections which the Company has made under item 11 above.

Dated at ..... on ..... 19 .....

Witnessed by ..... Field Underwriter

Countersigned by .....
Licensed resident agent where required by statute or regulation.

Applicant .....

Proposed Insured* if other than Applicant .....

Proposed Insured's Spouse if proposed for life coverage .....

*"Name" instead of "Signature" if Proposed Insured is a child who cannot write

963-500 Printed in U.S.A.

NEW YORK LIFE INSURANCE COMPANY

Received from ..... *this* ..... *day of* ..... 19.....

the sum of ..... *Dollars ($* ..... *),*
on account of the first premium for the policy (or policies) applied for in Part I of an application to New York Life Insurance Company, corresponding in date and number with this receipt, as specified in Question 7. This payment is received subject to the provisions of this receipt and the conditions printed on the reverse side hereof.

The applicant, after 60 days from the date of this receipt, may demand the refund of the conditional payment made with respect to any policy applied for in such application if the Company has not offered to deliver such policy prior to such demand. Surrender of the receipt for such payment will be required when any such refund is made.

Any check tendered is to be drawn to the order of New York Life Insurance Company and will be received subject to collection. This receipt is not transferable.

.....
Field Underwriter

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(please see conditions on reverse side)

PART I CONTINUED

Questions 12 to 16 are to be completed, if applicable. Otherwise Questions 12 to 16 are not a part of this Application and will be removed by the Company.

Answer Question 12 if a Family Policy (Life or Health) is applied for:

12. (a) PROPOSED COVERED FAMILY MEMBERS other than Proposed Insured? (Please print and include, in parentheses, maiden name of wife if a proposed covered family member.)

Relationship to Proposed Insured?	Date of Birth? Mo. Day Yr.	Sex? M or F

(b) If a Major Medical or Hospital Expense policy is applied for:

Is coverage being applied for on the Proposed Insured? Yes ☐ No ☐

(If "Yes", Proposed Insured is also a proposed covered family member.
If "No", explain why such coverage is not being applied for.)

Has the name of any other person eligible to be a proposed covered family member been omitted? (If "Yes", give name and relationship to Proposed Insured and explain why omitted.) Yes ☐ No ☐

Is any Major Medical or Hospital Expense insurance in force or pending on any proposed covered family member (other than Proposed Insured)? (If "Yes", give details requested below.) Yes ☐ No ☐

Name of Family Member	Daily Ben. (Hospital)	Max. Ben. (Maj. Med.)	In Force	Pending	Company or Organization

Answer Question 13 if Applicant for Life Policy is not the Proposed Insured

13. APPLICANT? (Print full name and relationship to Proposed Insured.) | Applicant's date of birth? Mo:.....Day:.....Yr:..... | Male? ☐ Fem.? ☐

Address? No. St. or Rt. City or Town Co. State or Prov. Time at Address?

Residence..... Yrs:..... Mos:.....

Business..... Yrs:..... Mos:.....

Firm or Employer? | Applicant's Occupation(s) and Duties?

Total Life insurance in force on life of Applicant? (If none, say "none") $.....

Answer Question 14 if Family Policy (Life or Health), C.P.B. or P.P.B. is Applied For

14. Have Questions 8 and 9 been answered with respect to:
All proposed covered family members, if Family policy applied for? Yes ☐ No ☐
Applicant (other than Proposed Insured), if C.P.B. or P.P.B. applied for? Yes ☐ No ☐

Answer Question 15 if Proposed Insured under Life Policy is not to be Owner, whether or not Applicant is to be Owner

15. OWNER of Life Policy? (Other than Proposed Insured)

Applicant ☐

Applicant before policy anniversary when Proposed Insured's age nearest birthday is 21, then Proposed Insured. ☐

Other (Print full name and relationship to Proposed Insured)

OWNER'S DESIGNEE?

Proposed Insured ☐ No Designee ☐

Other (Print full name and relationship to Proposed Insured)

Owner's Date of Birth? Mo: .....Day:.....Yr:.....

Owner's Mailing Address?

Answer Question 16 if Applicant or Owner of Life Policy is a corporation or trustee

16. If Applicant or Owner is (i) a corporation or (ii) a trustee, give:
(i) Place where, and year, incorporated? .....
(ii) Name of applicable trust instrument and date of such instrument and the last amendment thereto, if any? .....
Copy of trust instrument should be furnished to the Company. Has this been done? Yes ☐ No ☐

NAMES AND RESIDENCES OF THREE FRIENDS

1. .....

2. .....

3. .....

FIELD UNDERWRITER'S STATEMENT

with Reference to Application on Other Side Hereof.

This Statement is Not Part of the Application

Office "Date Received" Stamp (#76) here.

IMPORTANT: Obtain information for questions 4, 5, 6, 9, 11 and 12 below when filling in the application.

1 INDICATE HOW WELL YOU KNOW

	(a) Proposed Insured	(b) Applicant, if other than Proposed Insured
Known well for	..... Yrs.	..... Yrs.
Known slightly for	..... Yrs.	..... Yrs.
Met on solicitation	☐	☐
Related by blood or marriage	☐	☐

(If related by blood or marriage, state relationship)

2 (a) DID YOU ASK EACH QUESTION in Part I and the non-medical Part II, if any, of the application exactly as set forth? Yes ☐ No ☐

(b) ARE THE ANSWERS TO THE QUESTIONS in Part I and the non-medical Part II, if any, of the application recorded exactly as made to you? ..... Yes ☐ No ☐

(If no, explain)

(c) WERE PART I AND THE NON-MEDICAL PART II, if any, of the application filled out and signed in your presence? ..... Yes ☐ No ☐

(If no, explain)

(**Note:** If non-medical Part II is submitted, Field Underwriter must see Proposed Insured when such Part II is completed.)

3 ARE YOU AWARE OF ANY INFORMATION not disclosed in the application (including any non-medical Part II) which might have a bearing on the insurability (including health, occupation, avocations, habits or reputation) of any person proposed for coverage? ..... Yes ☐ No ☐

(If "Yes" or if Applicant approached you for this insurance, explain here or in separate letter.)

4 IF PROPOSED INSURED IS A WOMAN and married, widowed, separated or divorced, give full maiden name *(Please print)*

5 WHO WILL PAY THE PREMIUM ON ANY LIFE POLICY APPLIED FOR?

(a) Owner ..... ☐

(b) Applicant (if other than Owner) ..... ☐

(c) If not (a) or (b), give:
Premium-Payer's full name and relationship to Proposed Insured *(Please print)*

6 IF ANY LIFE POLICY APPLIED FOR IS FOR MORE THAN $25,000 AND IS FOR BUSINESS PURPOSES, give full information below or by separate letter regarding the purpose of the insurance and the amounts of all life insurance either in force or pending on other members of the organization for this purpose.

7 (a) IS MEDICAL EXAMINATION(S) REQUIRED? Yes ☐ No ☐
If yes, give name(s) of person(s) to be medically examined.

(b) HAVE ARRANGEMENTS BEEN MADE for such examination? Yes ☐ No ☐

8 WHAT WAS THE AMOUNT COLLECTED WITH APPLICATION? *(If none, say "none")*

LIFE $..... HEALTH $.....

9 IF APPLICATION IS FOR MORE THAN $25,000 OF LIFE INSURANCE:

(a) Give the following information regarding all life insurance either in force or pending, in New York Life and any other Company, on the Proposed Insured at the present time.

Company	Amount In Force	Amount Pending	Amount in Force or Pending With Accidental Death Benefit	Amount in Force or Pending With W. P. or other Dis. Ben.	Beneficiary

(b) Give your best estimate as to:

	Net Worth	Annual Earned Income	Income from Other Sources
Proposed Insured	$.....	$.....	$
Premium-Payer (If an individual other than Proposed Insured)	$.....	$.....	$

PLEASE ALSO ANSWER QUESTIONS 10, 11 AND 12 IF HEALTH POLICY IS APPLIED FOR.

10 Premium $..... A ☐ S ☐ Q ☐ M ☐ C-O-M ☐ Nyl-A ☐

Occupational Classification (If Monthly Income policy applied for)

(Premium and Occupational Classification subject to Home Office confirmation.)

11 (a) Does any person proposed for coverage intend to travel outside the United States and Canada? ..... Yes ☐ No ☐

(If "Yes", where and for how long?)

(b) If Proposed Insured was born elsewhere, how long has he resided in the United States or Canada? ..... years ..... mos.

12 (a) If Monthly Income policy is applied for, approximate annual earned income of Proposed Insured? ..... $.....

(b) If Major Medical Insurance is applied for, approximate total annual income, from all sources, of Proposed Insured and his family? $.....

I HEREBY DECLARE that the application was secured by me personally, and that I have no understanding or agreement with any other person, directly or indirectly, as to commissions or compensation thereon, except as follows: *(See special rules for Health insurance.)*

Commissions to be shared with..... ; .....
(If no one shares the commission, write "no one") *(Share of Commission)*

I FURTHER DECLARE that I have not paid or allowed, and I agree that I will not hereafter pay or allow, either directly or indirectly, any compensation or commission other than the above, or any rebate of premium in any manner whatsoever to the Applicant or to any other person.

I HEREWITH SUBMIT the amount collected as stated under 8 above.

DATE..... 19.....

(If commissions are to be shared with a person not an authorized Field Underwriter of New York Life, Form 4625 must be filled out and attached to this form.)

Signature of Field Underwriter .....

Signature of any other person sharing commission .....

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The sum paid with respect to any policy, in exchange for this receipt, is referred to herein as the "conditional payment" for such policy. Any reference in this receipt to the "conditional date" shall mean the later of:

a) the date that the application, including any Part II, or other written representation forming a part of the application, for such policy is completed, or

b) the date of such policy, as elected in Part I.

If the conditional payment for such policy is $10 or more and equals at least a monthly premium for such policy, and if the Company is satisfied from evidence received by it that every person proposed for coverage under such policy was, at the time of completion of the application for it, acceptable under the Company's rules for such policy, without any restrictive indorsement or rider if a health insurance policy, either as a standard risk or as an extra risk solely because of occupation or aviation activities, the Company will be bound, as of the conditional date, for the insurance that would be made available under the provisions of such policy, subject to the following conditions:

1. If such conditional payment for the policy was equal to the full first premium for it, such policy shall be deemed to be in force as of the date of such policy, as elected in Part I of the application.
2. If such conditional payment for the policy was less than the full first premium for it, the balance of such premium can be paid, regardless of any change in insurability, within 60 days after the conditional date and, if such balance is paid within such 60 day period, the policy shall be deemed to be in force as of the date of such policy, as elected in Part I of the application. If, at the end of such 60 day period, such balance has not been paid, any such coverage will terminate upon expiration of (i) such 60 day period, or (ii) a period equal to such proportionate part of the first premium interval as the conditional payment for such policy bears to the full first premium for the policy, whichever is the longer period, measured in either case from the conditional date.
3. Any coverage provided in accordance with this receipt is subject to payment of any unpaid balance of the premiums that would have been payable for such policy, if it had become effective, where any claim for policy benefits arises.

Otherwise the Company will not be bound, and no coverage will be provided.

Under no circumstances will the Company be bound, or coverage be provided, before the conditional date.