Reserve Organization of America

Information Request For ROA Member:

Here's the ROA 10-Year Group Level Term Life Insurance information you requested.

Dear ROA Member,

Thank you for inquiring about the ROA Group Insurance Program. Enclosed you'll find the information you requested for the following policy: **10-Year Group Level Term Life Insurance**. Once your application is received and approved by the insurer, you will be sent your Certificate of Insurance.

With the ROA 10-Year Level Term Life Insurance, you can take advantage of flexible benefit amounts from $50,000 to $500,000, with specially negotiated group rates that are expected, although not guaranteed to remain the same for 10 years. And there's more...

Your membership in ROA, combined with the group purchasing power of ROA members, helped secure valuable benefits for you. These extra benefits are included in the 10-Year Group Level Term Life Insurance:

- **You get an exclusive Killed-In-Action Benefit.** Your loved ones will collect up to an extra $25,000 (or your benefit amount, whichever is less) if you're declared "killed in action" by the Department of Defense in a designated combat zone.
- **You pay no premiums if you're disabled.** Your coverage will continue at no cost to you if you become continuously totally disabled for at least nine consecutive months and if your disability occurs before age 60, as defined in the certificate.
- **Your spouse/Domestic Partner (DP) and dependent children may qualify for** coverage too**.** In fact, spouse-only coverage is also available. The ROA member does not have to have coverage in order for the spouse/(DP) to have coverage.

Please take a few minutes right now to complete your application. Then return it in the enclosed postage-paid envelope. Don't send any money now. Once your application is approved by the insurer, we will then send you a bill.

Apply today.

Sincerely,

David Chambers, Senior Vice President
Association Member Benefits Advisors, LLC
ROA Insurance Plans Administrator
Administrator License #1115788

Reserve Officers Association Insurance Trust d/b/a Reserve Organization of America

Group 10-Year Level Term Life Insurance

Negotiated For ROA Members And Their Families

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

To Apply:

Complete this form and return to:
ROA Group Insurance Program Administrator
P.O. Box 14536
Des Moines, IA 50306

Questions? 1-800-247-7988

Send No Money Now

Please print in ink or type all answers. Do not use correction fluid or gel pens. Initial and date any changes you make.
(Please make any necessary corrections to your full name and street address)

1 MEMBER INFORMATION

Name ____

Address ____

City ____ State ____ ZIP ____

Home Phone ( ) ____ **Work Phone** ( ) ____

Email ____ (For internal use only for important announcements, time-sensitive bulletins or member notifications. Neither ROA nor the Plan Administrator will sell or rent your email address under any circumstances.)

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widow(ed) ☐ Civil Union†
☐ Domestic Partner†

†Eligibility of Domestic Partner/Civil Union partner is determined by state law.

Are you presently insured under any Reserve Organization of America (ROA) Plans? ☐ Yes ☐ No

If "Yes," indicate which plan(s) and provide details (person insured and amount of insurance):
☐ Term Life ☐ 10-Year Level Term Life ☐ Joint Term Life ☐ SeniorTerm Life

Details ____

Do you or your spouse (if proposed for insurance) intend to reside outside the United States within the next 12 months?

Member: ☐ Yes, Country ____ For How Long? ____ ☐ No

Spouse: ☐ Yes, Country ____ For How Long? ____ ☐ No

		DATE OF BIRTH	HEIGHT	WEIGHT	SEX
MEMBER		MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
SPOUSE*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
CHILD(REN)*	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F
	(NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	MO/DAY/YR	FT. IN.	LBS.	☐ M ☐ F

*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.

G-31331-0

Please complete all pages and sign on page 4

2 MEMBERSHIP AFFILIATION

Are you now a member of the Reserve Organization of America (ROA)?

☐ Yes ☐ No

Membership # ____________

Expiration Date ____________

(Membership in ROA is required for participation in the plan. Affiliate members are not eligible.)

3 PAYMENT OPTION SELECTED

☐ **Electronic Funds Transfer (EFT):** I request and authorize the Administrator, ROA Member Group Insurance Program, to make ☐ monthly ☐ quarterly ☐ semiannual ☐ annual withdrawals against the account specified on the attached check or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions under this plan. (Enclose a VOIDED check.)

X ____________________________________ ____________

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

☐ **Periodic Billing: Quarterly**

4 TOBACCO/NICOTINE USE

Tobacco/Nicotine Use: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum or electronic cigarettes)?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

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

Member ________ MO/YR ____________ Product Spouse ________ MO/YR ____________ Product

5 INSURANCE REQUESTED (Refer to the enclosed brochure for eligibility, options and coverage description.)

I HEREBY APPLY FOR THE FOLLOWING COVERAGES ☐ Member (N/0_ _1) ☐ Spouse (N/0_ _5)

a. Initial Member Insurance Amount $____________________ $50,000 to $500,000 (use $25,000 increments)

☐ Member AD&D (A_ _1)

Initial Spouse Insurance Amount $____________________ $50,000 to $500,000 (use $25,000 increments)

☐ Spouse AD&D (A_ _5)

Initial Child Insurance Amount

Note: Member or Spouse coverage must be in force to request child coverage. ☐ $10,000 each eligible child (N0E7)

b. Increase Member Insurance Amount from $_____________ **to $**_____________

Increase Spouse Insurance Amount from $_____________ **to $**_____________

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. Insurance Replacement

RESIDENTS OF NEW YORK—IMPORTANT REPLACEMENT INFORMATION: 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 be 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?

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? Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

G-31331-0

Please complete all pages and sign on page 4

6 BENEFICIARY DESIGNATION

Death benefit will be paid to current beneficiary on file or if no one is designated, benefits will default to beneficiary designations as indicated in the certificate.

7 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:

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? ☐ Yes ☐ No

B. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No

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? ☐ Yes ☐ No

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? ☐ Yes ☐ No

E. Is any person to be insured now pregnant? ☐ Yes ☐ No

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, high blood pressure, pain or pressure in chest? ☐ Yes ☐ No
2. Arthritis, back trouble, bone or joint disorder? ☐ Yes ☐ No
3. Fainting spells, convulsions or epilepsy? ☐ Yes ☐ No
4. Sugar, blood, albumin or pus in urine? ☐ Yes ☐ No
5. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ Yes ☐ No
6. Disorder of the breasts or reproductive organs or functions? ☐ Yes ☐ No
7. Nervous or mental disorder, emotional condition or psychiatric care? ☐ Yes ☐ No
8. Cancer, tumor or cyst? ☐ Yes ☐ No
9. Varicose veins, hemorrhoids or hernia? ☐ Yes ☐ No
10. Disorder of eyes, ears, nose or sinuses? ☐ Yes ☐ No
11. Thyroid, liver or respiratory disorder? ☐ Yes ☐ No
12. Alcoholism or drug habit? ☐ Yes ☐ No
13. Disorder of the blood? ☐ Yes ☐ No
14. Other health or physical impairment including:
    a. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? ☐ Yes ☐ No
    b. Chronic cough, persistent diarrhea, enlarged lymph glands or chronic fatigue in the past five years? ☐ Yes ☐ No
    c. Any other impairment? ☐ Yes ☐ No

IF YOU HAVE ANSWERED "YES" TO ANY QUESTIONS, 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—Operation—Degree of Recovery and Date	Name and Address of Physicians or Other Practitioners and Hospitals Where Confined or Treated

8 AUTHORIZATION AND SIGNATURE

I understand that New York Life 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 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 and Fraud Notices enclosed, 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.

MEMBER'S SIGNATURE X ____________________ **DATE** __________

(PLEASE SIGN AND DATE IN INK.)

SPOUSE'S SIGNATURE X ____________________ **DATE** __________

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED. PLEASE SIGN AND DATE IN INK.)

OWNER'S SIGNATURE X ____________________ **DATE** __________

(NECESSARY ONLY IF MEMBER PREVIOUSLY TRANSFERRED OWNERSHIP OR HIS/HER GROUP TERM LIFE INSURANCE.)

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.

FRAUD NOTICES

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. **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.

RESIDENTS OF CA: 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.

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 and 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.

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for Group 10-Year Level 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, 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.

Reserve Organization of America

Group 10-Year Level Term Life Insurance

Underwritten by New York Life Insurance Company

For ROA Members and Their Families

10-YEAR LEVEL TERM LIFE INSURANCE FEATURES AND HIGHLIGHTS

Here is term life insurance you can depend on for a full **ten years**, with premiums expected but not guaranteed to remain level for the entire 10-year term period. You can renew coverage up to age 74, subject to all termination of coverage provisions.

Available to ROA members and lawful spouses (DP) under age 61, the Group 10-Year Level Term Life Insurance helps you protect your family from the financial burdens of you or your spouse's (DP's) premature death. Your spouse/(DP) can also have coverage even if you don't select coverage. Also, your dependent children age 14 days but less than 26 years of age are eligible for $10,000 in coverage.Your renewal is guaranteed until age 75, (See "When Coverage Ends"). You can select a coverage amount to help meet your needs, from $50,000 up to $500,000. The Policy features Smoker and Non-Smoker Rates.

ELIGIBILITY

Members of ROA under age 61 may request coverage for themselves, their lawful spouse (DP) under age 61 and their eligible child(ren). In order to become insured, individuals must provide satisfactory evidence of insurability and the required premium must be paid.

A dependent who is also a member is eligible for either member or dependent coverage, but not both. If both the member and spouse (DP) are covered as members, neither may insure the other as spouse (DP) and only one may insure any eligible children.

This coverage is available only for residents of the United States (excluding ME, NY, UT, WA and territories).

APPLY FOR UP TO $500,000 OF COVERAGE

Choose the amount of Group 10-Year Level Term Life Insurance you need to help protect you and your family for the next ten years.

At the end of your level term period, your amount of insurance will decrease to the lesser of 50% or $50,000 at age 70.

Amounts Of Insurance:

Member–$50,000 to $500,000 in $25,000 multiples

Spouse (DP)–$50,000 to $500,000 in $25,000 multiples

The total amount of coverage an individual may have under all group life insurance policies underwritten by New York Life Insurance Company may not exceed $1,000,000.

In addition, the total amount of coverage an individual may have under all group policies issued by New York Life Insurance Company to the Trustee of the Reserve Officers Association Insurance Trust d/b/a Reserve Organization of America may not exceed the maximum benefit option for any insured person.

FEATURES

Secure the policy's most beneficial rates if You're a Qualified Non-Smoker

Only Non-smokers will qualify for Non-smoker Rates. Smokers qualify for higher Smoker Rates, but still specially-negotiated rates.

Continuing Insurance After the 10-Year Term Ends

Premiums are expected but not guaranteed to remain level for the first ten years of coverage. At the end of the 10-year period, you may reapply for another 10-year level term, at the rate then in effect for a subsequent 10-year period, provided the insured person is under age 61 and otherwise eligible. If your application for a subsequent 10-year term is approved, your premium contribution will be based on the insured person's age, health and tobacco/nicotine use at the time coverage becomes effective for a new 10-year term.

If you and your spouse (DP) are not approved for a subsequent 10-year term or you do not apply for a subsequent 10-year term, coverage will continue in force on a non-guaranteed rate basis, under which premium contributions increase as the insured ages. Coverage will end earlier if the group policy ends, insurance for your class ends or you fail to pay the premium.

OTHER IMPORTANT INFORMATION

Valuable Living Benefit Provision "Accelerated Death Benefit". The "Accelerated Death Benefit" option is available to help terminally ill insureds during a difficult and often financially challenging time. Under this provision, you may request one advance payment equal to 50% or $100,000 of your (or an insured spouse's/DP's) in force life insurance to be paid while the terminally ill person is still alive. The amount of insurance payable after the insured's death will be reduced by this payment. (Premium contributions will not be reduced.)

This money can be used to help cover high prescription drug costs...medical bills...outstanding debts...to help pay for experimental treatments...the cost of modifications to your home...or for a family vacation-the choice is yours. To qualify, a terminally ill insured must provide New York Life Insurance Company with proof of terminal illness and anticipated life expectancy (12 months or less), as well as any other necessary medical information requested. For additional details and limitations, please see the Certificate of Insurance.

Please note that receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult with the appropriate social services agency and seek the advice of a qualified tax advisor.

Exclusions

Coverage is payable for death by any cause except death from suicide during the first year of coverage, whether sane or insane, for which the only benefit payable is the return of applicable premium contributions. The validity of any amount of your life insurance which has been in force for one year during an insured's lifetime will not be contested except for insurance eligibility provisions and non-payment of premium contributions.

You Name Your 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 owner's surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

Effective Date

Insurance will take effect on the date your application is approved by New York Life Insurance Company provided the initial contribution is paid when due (send no money now) and any person to be insured is actively performing the normal activities of a person in good health of like age (In NC: of like age) on the date 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, and the person is still eligible. Dependent insurance will not take effect unless the member or spouse is insured on a premium-paying basis.

When Coverage Ends

Coverage will end when the insured person reaches age 75. Coverage will end earlier if: (a) premium contributions are not paid when due; (b) membership in ROA ceases; (c) the group policy is terminated or modified by the Policyholder to end insurance for the group of insureds to which the member belongs; (d) if the insured requests to terminate insurance; (e) for the insured spouse, the last day of the insurance period during which the insured spouse ceases to be the lawful, married spouse of the insured member.

Renewal Payments And Claims

Once your application is approved, you will have a 31-day grace period for your payment of renewal premium contributions. When you want to submit a claim, call or write the Administrator for claim forms.

TO APPLY

Consider Your Eligibility

Before you request coverage, you must be a member in good standing of the ROA. If you have any questions regarding membership, please call the association directly at 1-800-247-7988.

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. New York Life Insurance Company relies on your answers and statements.

The Group 10-Year Level Term Life Insurance is medically underwritten based on the information provided by you on the 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 information may be required. If so, we will arrange for an independent professional paramedic to contact you to perform these simple tests at your convenience. The exam and blood test will be paid for by the policy.

1. Complete and sign the application. Be sure to indicate whether you are requesting coverage for your spouse.
2. Do not send any money until New York Life Insurance Company has approved your application and you are notified of the premium contribution due, based on the information you have provided.
3. Mail your completed application to:
   ROA Group Insurance Program
   P.O. BOX 14536
   Des Moines, IA 50306

Certificate Of Insurance

This information is only a brief description of the principal provisions including features, costs, eligibility, renewability, limitations and exclusions of the coverage. The complete terms and conditions are set forth in the group policy issued by New York Life Insurance Company to the Trustee of the Reserve Officers Association Insurance Trust d/b/a Reserve Organization of America.

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

ROA incurs costs in connection with this policy. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. ROA also receives a fee for the license of its name and logo for use in connection with this 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!

The Group 10-Year Level Term Life Insurance is Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-31331-0
on Policy Form GMR-FACE/G-31331-0

NEW YORK LIFE and the NEW YORK LIFE Box Logo are trademarks of New York Life Insurance Company.

The Group 10-Year Level Term Life Insurance is Administered by:

Association Member Benefits Advisors, LLC (AMBA)

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

AR Insurance License #100114462
CA Insurance License #0I96562
In CA d/b/a Association Member
Benefits & Insurance Agency

Questions?

Call: 1-800-247-7988

E-Mail: roa.service@getamba.com

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YOUR COST
Current 2026-2027 MONTHLY Rates

The cost of this life insurance is based upon the member or spouse's amount of insurance requested, usage of tobacco/nicotine products, health status, and attained age on the date coverage is issued. Only Non-smokers will qualify for Non-smoker Rates. Smokers may only qualify for Smoker Rates. Upon approval of your Application, you will be notified of the rate classification for each approved person.

	$100,000		$200,000	
Age	Non-Tobacco User	Tobacco User	Non-Tobacco User	Tobacco User
35	$4.60	$16.10	$9.20	$32.20
36	4.70	17.30	9.40	34.60
37	4.80	18.60	9.60	37.20
38	5.10	20.00	10.20	40.00
39	5.30	21.60	10.60	43.20
40	5.80	23.30	11.60	46.60
41	6.30	25.20	12.60	50.40
42	7.00	27.20	14.00	54.40
43	7.80	29.30	15.60	58.60
44	8.60	31.60	17.20	63.20
45	9.50	33.80	19.00	67.60
46	10.40	36.00	20.80	72.00
47	11.30	38.30	22.60	76.60
48	12.20	40.80	24.40	81.60
49	13.30	43.60	26.60	87.20
50	14.70	46.60	29.40	93.20
51	16.20	50.00	32.40	100.00
52	18.00	53.60	36.00	107.20
53	19.90	57.50	39.80	115.00
54	22.20	61.70	44.40	123.40
55	24.50	66.20	49.00	132.40
56	26.80	70.70	53.60	141.40
57	29.30	75.40	58.60	150.80
58	32.10	80.90	64.20	161.80
59	35.30	87.80	70.60	175.60
60	39.10	97.30	78.20	194.60

Coverage of $10,000 is also available for your children at a monthly rate of $2. One premium covers all eligible children 14 days but less than 26 years.

Other benefit amounts are available ($50,000 to $500,000). Please call the administrator at 1-800-247-7988 for ages or rates not listed.

Your individual premium contribution will be based on your entry age for the fixed 10 year term period. Premium rates are expected but not guaranteed to remain level for the first 10 years of coverage.

Coverage will not be reduced during your level term period. However, your amount of insurance will decrease to the lesser of 50% or $50,000 on the Group Policy Anniversary date on or after your 70th birthday.

Coverage terminates at age 75.

Accidental Death & Dismemberment (AD&D) Insurance Benefit Option

In addition, many people are seriously injured by accidents and sustain loss of limb or eyesight. For these reasons, the ROA Group Accidental Death & Dismemberment (AD&D) Insurance is an important addition to your benefit coverage. If you choose the optional Accidental Death & Dismemberment (AD&D) benefit, you will receive the same level of coverage as your 10-Year Level Term Life Insurance being applied for. The AD&D monthly rate is $0.03 per $1,000.

You will be billed quarterly. If applicable, an additional $2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option.