

Information Request For ROA Member:

Here's the ROA Group Term Life Insurance information you requested.

Dear ROA Member,

Thank you for requesting information on ROA's Group Term Life Insurance. I'm pleased to send the information you requested.

As you would expect, ROA won't sponsor a product that doesn't have exclusively priced GROUP rates. There's never been a better time to consider ROA Group Term Life Insurance.

For example, a 49-year-old non-tobacco-using ROA Member will have the following monthly rates: \$10.45 for \$50,000 coverage and \$20.90 for \$100,000 coverage.

And your spouse/Domestic Partner (DP) and dependent children can be covered, too. In fact, many members are already taking advantage of these exclusively priced rates to cover their dependents. Spouses can apply for coverage and can even apply if the Member does not have coverage.

And there's more...

Your membership in ROA, combined with the group purchasing power of ROA, helped secure valuable benefits for you and your family. These benefits are automatically included in your ROA Group Term Life Insurance – at no extra cost to you!

- **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 can collect up to 50% of your ROA Group Term Life benefit** (or \$100,000, whichever is less) if you become terminally ill as defined in your Certificate with less than six months to live. You can use this "living benefit" any way you want. To qualify for this benefit, a person must be insured under his policy and diagnosed as having a life expectancy of 6 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 deems necessary to confirm the person's status. Your beneficiary will then receive the remainder of your life insurance benefit at your death. Receipt of the accelerated benefit may be taxable, or may adversely affect your eligibility for Medicaid or other government benefits. You should consult your personal tax advisor to assess the impact of this benefit.
- **You're covered 365 days a year, wherever you are.** The only exclusion is suicide within the first year of the date your insurance or increase in insurance starts. The Accelerated Life Benefit and AD&D benefit are subject to additional exclusions.
- **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.

Please take a few minutes right now to review and complete the enclosed application. Don't send any money now. Once your application is approved by the insurer, we will then send you a bill.

Sincerely,



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

P.S. Member-only group rates are just one of the reasons many ROA members and their families have taken advantage of ROA Group Term Life. Please look over the enclosed information to see what your fellow members have to say.

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

	MEMBER	DATE OF BIRTH	HEIGHT	WEIGHT	SEX
MEMBER	<input type="text"/>	<input type="text"/> MO/DAY/YR	<input type="text"/> FT. IN.	<input type="text"/> LBS.	<input type="checkbox"/> M <input type="checkbox"/> F
SPOUSE*	<input type="text"/> (NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	<input type="text"/> MO/DAY/YR	<input type="text"/> FT. IN.	<input type="text"/> LBS.	<input type="checkbox"/> M <input type="checkbox"/> F
CHILD(REN)*	<input type="text"/> (NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	<input type="text"/> MO/DAY/YR	<input type="text"/> FT. IN.	<input type="text"/> LBS.	<input type="checkbox"/> M <input type="checkbox"/> F
	<input type="text"/> (NAME IF PROPOSED FOR INSURANCE) FIRST / MI / LAST	<input type="text"/> MO/DAY/YR	<input type="text"/> FT. IN.	<input type="text"/> LBS.	<input type="checkbox"/> M <input type="checkbox"/> 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.

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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.)

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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.)

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

Periodic Billing: Quarterly

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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 Spouse
MO/YR Product MO/YR Product

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

I HEREBY APPLY FOR THE FOLLOWING COVERAGES Member (N/S__1) Spouse (N/S__5)

a. Initial Member Insurance Amount

Member AD&D (A__1)

\$
up to \$500,000 (use \$25,000 increments)

Initial Spouse Insurance Amount

Spouse AD&D (A__5)

\$
up to \$500,000 (use \$25,000 increments)

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

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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.

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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

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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 DATE
(PLEASE SIGN AND DATE IN INK.)

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

OWNER'S SIGNATURE 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 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 PERSONS¹ have a right of access to certain CONFIDENTIAL ABUSE INFORMATION² 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.

¹PROTECTED 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.

²CONFIDENTIAL 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.

Group Term Life Insurance

Underwritten by New York Life Insurance Company

For ROA Members and Their Families

WHY YOU MAY NEED TO ORGANIZE YOUR FAMILY'S FINANCIAL SECURITY

Many families go without the life insurance coverage they really need because they think it is going to be too expensive. But the simple fact is, life insurance doesn't have to be expensive. The ROA Group Term Life Insurance designed for and available to members of ROA has proven just that.

Feel free to compare the costs and benefits of this policy sponsored by ROA with any other now available. You'll probably find that this Group Term Life Insurance is one of your best choices in terms of quality, service, reliability, and value.

WHO IS ELIGIBLE?

ROA members under age 60 are eligible to apply for coverage for themselves, their lawful spouses/Domestic Partner (DP) under age 60, and unmarried dependent children ages 14 days through 25 years. In order to become insured, satisfactory evidence of insurability must be provided and the required premium contribution must be paid.

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

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

WHAT YOU CAN CHOOSE

FOR MEMBER

Options up to \$500,000 (in multiples of \$25,000)

FOR SPOUSE

Options up to \$500,000 (in multiples of \$25,000)

FOR EACH ELIGIBLE DEPENDENT CHILD

\$10,000 for 14 days through 25 years. One premium of \$2.00 covers all eligible children.

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

The total amount of coverage an individual may have under all group policies issued by New York Life Insurance Company to the Trustees 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.

Non-Smoker Discount

Reduced rates are available for qualified non-smokers.

Exclusions

Benefits for a covered person's death due to suicide, attempted suicide or intentionally self-inflicted injury during the first 12 months of coverage will be limited to a return of premium contributions.

Incontestability

The validity of any amount of your insurance which has been in force for two years during your lifetime will not be contested except for insurance eligibility provisions or 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, to the surviving relatives in the following order of survival: spouse; children equally; parents equally; or brothers and sisters equally.

When Coverage Ends

Insurance for you/your spouse can remain in force to age 75, and for your insured dependents as long as they remain otherwise eligible, provided: (a) you continue to pay premium contributions when due; (b) you remain a member of ROA; and (c) the group policy is not terminated or modified by the Policyholder or New York Life Insurance Company to end insurance for the group of insureds to which you belong. Upon your death, coverage for insured dependents may continue as described in the Certificate of Insurance.

Coverage for dependent children terminates upon their attainment of age 26.

Group Conversion Privilege

This policy provides conversion privileges under certain circumstances of involuntary termination as described in the Certificate of Insurance.

AMOUNTS OF INSURANCE AT MEMBER AGES 70

The amount of life insurance for you is based on your age and the amount of life insurance for your spouse is based on your spouse's age at last birthday and, depending upon the applicable option. Your amount of insurance will decrease to the lesser of 50% or \$50,000 on the Policy Anniversary date on or after your 70th birthday.

Coverage terminates at age 75.

EFFECTIVE DATE

You and your dependents will become insured on the date specified by New York Life Insurance Company provided the initial premium contribution is paid within 31 days after the date you are billed (send no money now), satisfactory evidence of insurability has been submitted, and you and your dependents are performing the normal activities of a person in good health of like age on that date. Coverage for any person who is not performing his or her normal activities on the date coverage would otherwise become effective will not become effective until the date he or she is performing such activities, provided such date is within three months of the date insurance would have been effective and the person is still eligible for 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 Insurance Company.)

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 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.

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 your application is approved, 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 ROA. Please wait until your application for ROA membership is accepted before initiating insurance request. If you have any questions regarding membership, please contact ROA 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.

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 Two Easy Steps

1. Refer to the 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.

If your state of residence mandates recognition of a Domestic Partner as an eligible spouse, contact the Administrator for a Declaration of Domestic Partnership form: call 1-800-247-7988, email roa.service@getamba.com, or go to www.roainsure.com to download the form.

2. Mail your completed application to:

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

If you have questions about your eligibility or the features of this policy, call a Customer Service Representative toll-free at 1-800-247-7988.

**This Group Term Life Insurance is
Underwritten by:**



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

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
under Group Policy No. G-31330-0
on Policy Form G-31330-0/GMR-FACE

**This Group Term Life Insurance is
Administered by:**



Association Member Benefits Advisors, LLC (AMBA)

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

Questions?

Call: 1-800-247-7988

E-Mail: roa.service@getamba.com

AR Insurance License #100114462

CA Insurance License #0196562

In CA d/b/a Association Member

Benefits & Insurance Agency

The Reserve Officers Association Insurance Trust d/b/a Reserve Organization of America incurs costs in connection with this sponsored policy. To provide and maintain this valuable membership benefit, it is reimbursed for these costs. ROA may also may receive a fee for the license of its name and logo for use in connection with this policy.

YOUR COST

Current 2026-2027 Monthly Premium Contributions

The initial cost of insurance for you and your lawful spouse is based on your/your spouse's attained age when insurance becomes effective, the amount selected, and on the member's/spouse's tobacco/nicotine use. The cost increases as the member/spouse grow older. Premium contributions will vary depending upon the options chosen.

NON-TOBACCO USER									
BENEFIT		Under 30	30-34	35-39	40-44	45-49	50-54	55-59	*60-64
\$ 25,000	Member	\$0.95	\$1.43	\$1.90	\$2.85	\$5.23	\$8.55	\$14.02	\$20.90
	Spouse	0.72	1.19	1.67	2.38	4.28	7.13	11.88	17.58
\$ 50,000	Member	1.90	2.85	3.80	5.70	10.45	17.10	28.03	41.80
	Spouse	1.43	2.38	3.33	4.75	8.55	14.25	23.75	35.15
\$100,000	Member	3.80	5.70	7.60	11.40	20.90	34.20	56.07	83.60
	Spouse	2.87	4.77	6.67	9.50	17.10	28.50	47.50	70.30
TOBACCO USER									
BENEFIT		Under 30	30-34	35-39	40-44	45-49	50-54	55-59	*60-64
\$ 25,000	Member	\$0.95	\$1.67	\$2.14	\$3.33	\$5.94	\$9.74	\$16.15	\$24.23
	Spouse	0.95	1.19	1.90	2.85	4.99	8.32	13.54	20.19
\$ 50,000	Member	1.90	3.33	4.28	6.65	11.88	19.48	32.30	48.45
	Spouse	1.90	2.38	3.80	5.70	9.98	16.63	27.08	40.38
\$100,000	Member	3.80	6.67	8.57	13.30	23.77	38.97	64.60	96.90
	Spouse	3.80	4.77	7.60	11.40	19.97	33.27	54.17	80.77

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.

Coverage of \$10,000 is available for your children at a monthly rate of \$2.00. One premium covers all eligible children age 14 days but less than 26 years of age.

*Renewal rates only. Members and/or Spouses ages 59 and under can only apply.

Other benefit amounts are available. Please call administrator for other rates not listed.

Premiums are based on age at date of issue and increase on renewal dates as indicated above. Rates will not change unless they are changed for all insureds in your classification.

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 for member/spouse 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 Term Life Insurance being applied for. The AD&D monthly rate is \$0.03 per \$1,000.

The premium contributions shown reflect the current rates 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 option amounts are not guaranteed and are subject to change by agreement between New York Life Insurance Company and the Trustees of the Reserve Officers Association Insurance Trust d/b/a Reserve Organization of America.