NEW YORK LIFE INSURANCE COMPANY
FINANCIAL STATEMENT

SUPPLEMENT TO REQUEST FOR GROUP INSURANCE
(PLEASE COMPLETE BOTH SIDES)
If any question does not apply, indicate "none"

APPLICANT'S NAME: _____
(please print)
NAME OF GROUP PLAN/POLICY NUMBER: _____

Please complete the following questions:

1. Are you self-employed? _____ If self-employed, complete the following:
   (If "no", go to question #4)
   (a) How Long? _____
   (b) What percentage of the business do you own? _____

2. If self-employed, are you working jointly with your spouse? _____ If "yes":
   (a) How many other employees in the business? _____
   (b) How many employees are relatives? _____

3. Are you working out of your home? _____ If "yes", is any work conducted outside the home? _____
   Please explain and/or provide details including average number of days per week clients are seen:
   _____
   _____
   _____

4. If not self-employed, how long are you employed at your current place of business? _____

5. If less than one year, how long were you employed with your previous employer? _____
   Please provide employer history (names/addresses) for the last five years:

6. How many hours per week are you working? _____

7. Describe your duties:

8. Do you earn income from other occupations? _____

9. a) Are you a permanent U.S. or Canadian resident? _____
   b) Do you intend to live or travel outside of the U.S. or Canada? _____
      If "yes", for how long? _____
   c) Have you lived or traveled outside the U.S. or Canada in the past two years? _____
      If "yes" please provide details:

FINANCIAL STATEMENT (continued)
CONFIDENTIAL FINANCIAL INFORMATION – (COMPLETE BOTH SIDES)
If any question does not apply, indicate "none"

I. TOTAL NET WORTH (Assets minus Liabilities): $ _____

II. TOTAL ANNUAL UNEARNED INCOME
(as reported to IRS-e.g., Interest, Dividends, Royalties, Rental Income, etc.) $ _____

III. IF SELF-EMPLOYED - Complete all sources of income:

A. SOLE PROPRIETOR OR PARTNER

Gross earned income (share of partnership income)
past 12 months of fiscal year ending _____
(Gross earnings before business expenses and taxes) $ _____

Total business expenses for above period (your share) (Minus) $ _____

Net earned income, before personal income tax $ _____

B. PROFESSIONAL CORPORATION

Annual salary drawn currently $ _____
Your share of S-Corp distribution, if any (Plus) $ _____
Your share of dividends (Plus) $_____
Payment of bonus (Plus) $ _____
Payment of commission (Plus) $ _____
(Was the bonus/commissions a one-time payment, or annual payment?) _____
Annual Cost of corporate-paid benefits (Plus) $ _____
(e.g. Life or Health Insurance premiums, pension or profit sharing trust contributions paid on your behalf):
Total annual earned income $ _____

IV. IF EMPLOYED –
Annual salary $ _____

V. DISABILITY INSURANCE IN FORCE – INCLUDE ANY GROUP DISABILITY BENEFITS

Company	Policy	Benefit	Elimination Period	Maximum Benefit Period

VI. DISABILITY INSURANCE APPLIED FOR WITH ANOTHER COMPANY/COMPANIES

_____

VII. Will coverage applied for with us replace any of the above? Yes ___ No ___
(If yes, indicate which, and date it will be terminated) _____

I understand that any insurance issued will be in consideration of the answers and statements provided on this form which supplements my request for group insurance and on any other form(s) or documents signed by me and made part of the certificate of insurance, if issued. I also understand insurance may be invalidated if New York Life finds that I have not answered the questions on this form truthfully and completely.

Signature of Applicant _____ Date _____

Signature of Accountant _____ Date _____
(optional unless requested)