



**5. BENEFICIARY DESIGNATION –Complete *only* if selecting the optional AD&D coverage**

I hereby make the following beneficiary designation with respect to any benefits payable following the covered loss of my life under the AD&D portion of this coverage. (Please print person’s name, address, relationship and Soc Sec #):

**6. STATEMENT OF HEALTH:** (Refer to the brochure for eligibility, options and coverage description)

To the best of your knowledge and belief, please answer these questions as they apply to you.

[For CA residents: California law prohibits an HIV test form being required or used by health insurance companies as a condition for obtaining health insurance.] YES NO

1. Are you now ill or taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?
2. During the past five years, have you ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for:
  - a) heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury?
  - b) Other Health or physical impairment including:
    - (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC) ?
    - (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?
    - (iii) Any other impairment?
3. During the past have you ever been counseled, treated or hospitalized for the use of alcohol or drugs?
4. Are you now pregnant?
5. Are you now disabled, or applied or applying for, or receiving any disability or Workers’ Compensation benefits or on waiver of premium for life or health insurance?
6. During the past two years, have you participated in, or plan to participate in: aircraft flying other than as passenger, scuba diving, ultra light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang-gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?
7. Driver’s License No.: \_\_\_\_\_ State in which issued: \_\_\_\_\_
8. During the past five years, have you had his or her driver’s license suspended, or revoked, or had any moving violations?
9. **Except for Residents of CT and MN:** Have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?    
**Residents of CT and MN:** Have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?

**If you have answered "Yes" to any of the Questions above, give complete details below.** (Attach a separate sheet if necessary, then sign and date it).

Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

**7. DECLARATIONS:** (Refer to the brochure for eligibility, options and coverage description)

**I request** the insurance shown on the reverse side. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

**I understand** that: (a) insurance will become effective on the first day of the month following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I am at FULL-TIME WORK, as defined, on the approval date, and; (b) if I am not at FULL-TIME WORK, I will not become insured until the day I am at FULL-TIME WORK, provided such date is within three months of the date insurance would have been effective and I am still eligible for insurance. I also understand that any dividend available under this policy will be payable to me, provided the policy is then in force, and all premiums have then been paid.

**FRAUD NOTICES:**

**For residents of all states except those listed below:** 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 AR/LA/MD/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.

**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 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 NY:** Any person who knowingly and with intent to defraud any insurance company or any other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

**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.

G-29445-0

**BE SURE TO COMPLETE ALL PAGES AND SIGN THE LAST PAGE**

GMA-DI-FMU

**AUTHORIZATION:**I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau). My request for coverage will not be accepted unless this AUTHORIZATION is signed. ■ I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratories, or insurance company to release prescription drug records and related information maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. ■ New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS). ■ This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. My 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

**By signing and dating this application, I request the insurance indicated, understand the effective date criteria, consent to authorize the disclosure of information to the providers noted, and attest that I have read the Fraud Notices indicated on the attached, and that to the best of my knowledge and belief, the statements made regarding my health are true and complete.**

Member's Signature X \_\_\_\_\_  
(PLEASE SIGN AND DATE IN INK)

\_\_\_\_\_  
DATE

G-29445-0

GMA-DI-FMU

10/10 ed.