



**4. PAYMENT OPTION** (Choose only one)

**PERIODIC BILLING:**  Annual  Semiannual

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

**I HEREBY APPLY FOR THE FOLLOWING COVERAGES:**

a) **For Applicants and Spouses Not Currently Insured under this Group Term Life Insurance Plan:**

- I request Term Life Insurance in the INITIAL amount of \$\_\_\_\_\_ \* for myself;
- I request Term Life Insurance in the INITIAL amount of \$\_\_\_\_\_ \* for my spouse\*.
- For my eligible child(ren)
- I request Accidental Death and Dismemberment Insurance for Myself in the INITIAL amount of \$\_\_\_\_\_\*\*

b) **For Applicants and Spouses Currently Insured under this Group Term Life Insurance Plan:**

- I request to INCREASE amounts of insurance as follows: From \$\_\_\_\_\_ to \$\_\_\_\_\_ \*for myself;
- I request to INCREASE amounts of insurance as follows: From \$\_\_\_\_\_ to \$\_\_\_\_\_ \*for my spouse;
- I request to INCREASE my Accidental Death and Dismemberment Insurance: From \$\_\_\_\_\_ to \$\_\_\_\_\_\*\*;

\*Amounts must be in multiples of \$25,000.

\*\*You may only request Accidental Death and Dismemberment insurance if requesting Term Life insurance, and only for an amount not to exceed the Term Life amount.

c.) **Tobacco/Nicotine Use:** Have you and/or your spouse (if proposed for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 months?

Applicant:  Yes  No Spouse:  Yes  No

If yes, when did such person last use tobacco or nicotine products? Applicant: \_\_\_\_/\_\_\_\_ Spouse: \_\_\_\_/\_\_\_\_  
MONTH/YEAR MONTH/YEAR

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forfeited, assigned, terminated, changed or modified into paid-up or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or 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 any part of an existing insurance or annuity?

Applicant:  Yes  No Spouse:  Yes  No If yes, complete below:

RESIDENTS OF OTHER STATES:

Is the Insurance applied for intended to replace, discontinue or change an existing policy?

Applicant:  Yes  No Spouse:  Yes  No

ALL RESIDENTS:

Do you have other life insurance in force? Applicant:  Yes  No Spouse:  Yes  No

If "yes", total amount and company:

Applicant: \$\_\_\_\_\_ Company \_\_\_\_\_ Spouse: \$\_\_\_\_\_ Company \_\_\_\_\_

Do you have other life insurance pending? Applicant:  Yes  No Spouse:  Yes  No

If "yes", total amount and company:

Applicant: \$\_\_\_\_\_ Company \_\_\_\_\_ Spouse: \$\_\_\_\_\_ Company \_\_\_\_\_

**6. BENEFICIARY DESIGNATION:**

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured Applicant as provided in the Group Policy. (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

|                      |        |       |                |              |                   |
|----------------------|--------|-------|----------------|--------------|-------------------|
| Beneficiary Name:    | Last   | First | Middle Initial | Relationship | Social Security # |
| Beneficiary Address: | Street | City  | State          | Zip Code     |                   |

**7. STATEMENT OF HEALTH:** (Please initial any changes you make on this form.) Answer the following questions as they apply to you and all dependents to be insured.

- |   | YES                      | NO                       |  | YES                      | NO                       |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 1. Are you or any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver or premium for life or health insurance?  | <input type="checkbox"/> | <input type="checkbox"/> | d. Sugar, blood, albumin or pus in urine?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any person to be insured now ill, or receiving medical attention or surgical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | e. Diabetes, kidney trouble, ulcers or digestive disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. During the past five years, has any person to be insured consulted any physician or 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? | <input type="checkbox"/> | <input type="checkbox"/> | f. Disorder of breasts or reproductive organs or functions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Are you or any person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?   | <input type="checkbox"/> | <input type="checkbox"/> | g. Nervous or mental disorder, emotional condition or psychiatric care?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person to be insured now pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> | h. Cancer, tumor or cyst?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having been treated for:  |                          |                          | i. Varicose veins, hemorrhoids or hernia?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?  | <input type="checkbox"/> | <input type="checkbox"/> | j. Disorder of eyes, ears, nose or sinuses?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Arthritis, back trouble, bone or joint disorder?   | <input type="checkbox"/> | <input type="checkbox"/> | k. Thyroid, liver or respiratory disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Fainting spells, convulsions or epilepsy?  | <input type="checkbox"/> | <input type="checkbox"/> | l. Alcoholism or drug habit?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | m. Disorder of the blood?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | n. Other health or physical impairment including:  |                          |                          |
|   |                          |                          | (i) Being medically diagnosed by a physician as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, or chronic fatigue, in the past five years?                      | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | (iii) Any other impairment?  | <input type="checkbox"/> | <input type="checkbox"/> |

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

| Item | Name(s) of Proposed Insured | 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: |
|------|-----------------------------|---|---|
|      |                             |   |   |
|      |                             |   |   |
|      |                             |   |   |
|      |                             |   |   |

G-29212-0

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

GMA-PR1

**7. DECLARATIONS**

**I request** the group insurance shown above. 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 I and any approved dependents are performing the normal activities of a person in good health of like age [*for MD and NC residents: I and any approved spouse's health status continues to be the same as stated on this application*] on the approval date; (b) any person who is not performing such normal activities [*for MD and NC residents: whose health status is not the same as stated on this application*] as required will not become insured until the day he/she is performing such normal activities [*for MD and NC residents: I and any approved spouse's health status continues to be the same as stated on this application*], provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the Insurance Plan.

**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.**

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

**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.**

**Spouse's Signature X** \_\_\_\_\_ **DATE** \_\_\_\_\_  
(Necessary only if spouse coverage is requested)

G-29212-0

4/09 ed.

GMA-PR1

**Owner Information (required if owner is other than Applicant)**

Name: Last First Middle Initial Relationship to Proposed Insured Daytime Phone

Mailing Address: Street City State Zip Code

\_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth Social Security Number Tax ID#

**Owner's Signature X** \_\_\_\_\_ **Date** \_\_\_\_\_  
(Necessary only if other than Applicant)

### **FRAUD NOTICES**

**EXCEPT RESIDENTS OF NY:** 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 AR/LA:** 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 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.

**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.