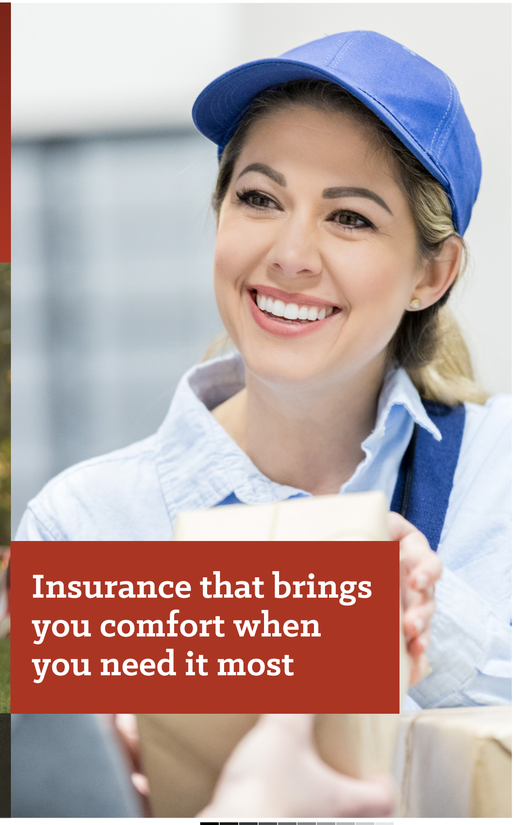
Offers 24-hour Group Accidental Death & Dismemberment Insurance to help protect against covered accidents anywhere in the world, on or off the job, on business, vacation, or at home.

As an APWU member in good standing, you are eligible to enroll for Group Accidental Death & Dismemberment Insurance in amounts of $30,000 to $300,000, in increments of $30,000.

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Any questions? **Call 1-800-422-4492 or visit VoluntaryBenefitsPlan.com**



Insurance that brings you comfort when you need it most

Send no money…

Once coverage is effective, you will receive a Certificate of Insurance. Take up to 30 days to review it. If it does not meet your expectations you may request a refund of any premiums paid and a termination of your coverage back to the effective date, unless a claim is incurred.

- ☑ Simply complete the provided **GROUP ACCIDENTAL DEATH & DISMEMBERMENT APPLICATION** authorizing payroll deductions. Please make sure you complete all the information requested. An incomplete application will be returned, resulting in a delay in processing your application.
- ☑ Send no money.
- ☑ Return your application to:
  The Voluntary Benefits Plan, P.O. Box 12009, Cheshire, CT 06410

PLEASE NOTE: You must notify the Voluntary Benefits Plan of any address change for you, your dependents and/or beneficiaries, and any employment or union membership status change, life status change (i.e., marriage, divorce, beneficiary or name change) or benefit changes requested. Notice must be in writing.

THIS INSURANCE ADVERTISED IS A GROUP ACCIDENT ONLY POLICY. IT DOES NOT PAY BENEFITS FOR LOSS CAUSED BY SICKNESS.

Terms and conditions of coverage are set forth in group policy number G-39315-0 on policy form GMR issued in IL to the Voluntary Benefits Plan Insurance Trust, a copy of which may be obtained from Alliant Services Houston listed within. For a full description of benefits, please review the Certificate of Insurance that is issued to persons who have purchased the coverage. This material is for illustrative purposes only and provides a brief description of the benefits available. It is not a contract. If there are any differences between the information provided in this material and the Group Policy, the information in the Group Policy will prevail. No one can be covered more than once under this policy. Policy provisions and availability may vary by state. Availability of this offer may change. Coverage may not be available in all states. Premiums are subject to change. This material is not intended for use with residents of New Mexico.

Any questions?
Call 1-800-422-4492 or visit VoluntaryBenefitsPlan.com

UNDERWRITTEN BY:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

ADMINISTERED BY:
Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Alliant Services Houston, Inc. P.O. BOX 12009, Cheshire, CT 06410

Agency Insurance License Numbers: AR: 245147, CA: 0791700

FN38516E-7 10M 1/22

Group Accidental Death & Dismemberment Insurance

Insurance protection when you really need it most.

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Group Accidental Death & Dismemberment Insurance

Voluntary Benefits Plan® for members of the American Postal Workers Union

BENEFIT AMOUNTS AVAILABLE

As an APWU member in good standing and between the age of 18 and 80, you are eligible to enroll for Group Accidental Death & Dismemberment insurance in amounts of $30,000 to $300,000, in increments of $30,000.

FEATURES AT NO ADDITIONAL COST!

Speech and/or Hearing. In addition to insurance protection for accidental loss of life, hand, foot, sight, thumb and index finger and movement of limbs, you are also covered for loss of speech and/or hearing. You receive the full Benefit Amount for the loss of both, and half the Benefit Amount for the loss of one or the other.

Seat Belt Benefit. The amount of the seat belt benefit will be the lesser of $30,000 or 10% of the Loss of Life benefit if you and/or an insured family member dies within 365 days as a result of a covered accident while driving or riding in a private passenger car (excluding public transport) equipped with seat belts and the seat belt was in actual use and properly fastened at the time of the accident, as certified in the police accident report.

MEMBER ONLY COVERAGE

You select your Benefit Amount from the "Coverage Selection and Cost" table. You are eligible regardless of your health history.

FAMILY COVERAGE

If you wish to insure your eligible spouse (under age 80) and/or dependent child/ren, the amount of insurance applicable to members of the family is based on the composition of the family at the time of loss and is expressed as a percentage of your Benefit Amount as follows:

1. At time of loss the family consists of Member & Spouse AND Dependent Child/ren		2. At time of loss the family consists of Member and Spouse but NO Dependent Child/ren		3. At time of loss the family consists of Member and Dependent Child/ren but NO Spouse	
Member	100%	Member	100%	Member	100%
Spouse	40%	Spouse	50%	Each Child	15%
Each Child	10%				

Example: The Member selects $150,000 coverage under the Family Plan. The family consists of the Member, Spouse and Children.

Member	$150,000
Spouse	$60,000
Each Child	$15,000

THE COVERAGE

The policy offers 24-hour insurance protection against covered accidents anywhere in the world, on or off the job, on business, vacation or at home. While covered, bodily injuries suffered by the insured must be as a direct result and from no other cause than from the covered accident that results in loss of life. Please be sure to review the enclosed materials for more information on what is and is not covered.

THE BENEFIT

If injuries caused by a covered accident result in death or dismemberment, within 365 days from the date of a covered accident, which occurs while you are insured, the policy will pay as follows:

SCHEDULE OF COVERED LOSSES

Covered Loss	Benefit (% of the Principal Sum)
Loss of Life	100%
Loss of Two or More Hands or Feet	100%
Loss of Sight of Both Eyes	100%
Loss of Speech and Hearing (in both ears)	100%
Quadriplegia	100%
Paraplegia	75%
Hemiplegia	50%
Uniplegia	25%
Loss of One Hand or Foot	50%
Loss of Sight in One Eye	50%
Loss of Speech	50%
Loss of Hearing (in both ears)	50%
Loss of Thumb and Index Finger of the Same Hand	25%

Loss of a Hand or Foot means complete Severance through or above the wrist or ankle joint.
Loss of Sight means the total, permanent loss of all vision in one eye which is irrecoverable by natural, surgical or artificial means.
Loss of Speech means total and permanent loss of audible communication which is irrecoverable by natural, surgical or artificial means.
Loss of Hearing means total and permanent loss of ability to hear any sound in both ears which is irrecoverable by natural, surgical or artificial means.
Loss of a Thumb and Index Finger of the Same Hand or four Fingers of the Same Hand means complete severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
Loss of Toes means complete Severance through the metatarsophalangeal joint.
Paralysis or Paralyzed means total loss of use of a limb. A Physician must determine the loss of use to be complete and irreversible.
Quadriplegia means total Paralysis of both upper and lower limbs.
Hemiplegia means total Paralysis of the upper and lower limbs on one side of the body.
Paraplegia means total Paralysis of both lower limbs or both upper limbs.
Uniplegia means total Paralysis of one upper or one lower limb.
Severance means the complete and permanent separation and dismemberment of the part of the body.

EXCLUSIONS

BENEFITS WILL NOT BE PAID FOR A LOSS CAUSED BY THE FOLLOWING:

Air Travel - A loss that occurs during or is a direct result of the Covered Person's travel in, travel on, fall from or descent from any aircraft while such aircraft is in flight, unless the Covered Person is traveling solely as a passenger.

Crime/Illegal Occupation/Illegal Activity - A loss that: (a) occurs during; (b) is due to; or (c) is related to; the Covered Person's active participation in or incarceration resulting from any of the following in a role other than as a victim: (a) the commission of a felony; (b) an illegal occupation or activity; (c) an insurrection; or (d) a riot.

Disease/Infirmity - A loss that is due to or related to: (a) disease or bodily infirmity of mind or body; (b) medical or surgical treatment of such disease or bodily infirmity; or (c) bacterial infections, except infections which occur as the result of an: (1) accidental cut or wound; or (2) accidental ingestion of contaminated material.

Drugs - A loss that: (a) occurs during; (b) is due to; or (c) is related to; the Covered Person's: (1) use of drugs, intoxicants, narcotics, barbiturates or hallucinogenic agents, unless such use is as prescribed by a doctor or if the loss results from purely accidental and unforeseen circumstances; or (2) legal intoxication.

Hazardous Activities - A loss that occurs during: (a) bungee jumping; (b) parachuting; (c) skydiving; (d) parasailing; or (e) hang-gliding.

Military Service - A loss that: (a) occurs during; (b) is due to; or (c) is related to; the Covered Person's duty in the military, naval or air services of any country.

Self-Inflicted Injury/Suicide - A loss that: (a) is due to or is related to: (1) suicide; (2) an attempt at suicide; or (3) an intentionally self-inflicted injury; (b) occurs during an attempt at suicide; or (c) occurs while intentionally injuring oneself; while the Covered Person is sane or insane.

Treatment - A loss that: (a) occurs during; (b) is due to; or (c) is related to; any medical, dental or surgical treatment unrelated to the accident which would otherwise entitle the Covered Person to benefits.

War Conditions - A loss that: (a) occurs during; (b) is due to; or (c) is related to; the Covered Person's engagement in any of the following in a role other than as a victim: (a) in war, (b) an act of war, or (c) an armed conflict which involves the armed forces of one or more countries.

2022 COVERAGE SELECTION AND COST

BI-WEEKLY COST FOR MEMBERS UNDER AGE 80*

Benefit Amount	Member Only	Family Plan
$ 30,000	$ .52	$ .75
60,000	1.04	1.50
90,000	1.56	2.25
120,000	2.08	3.00
150,000	2.60	3.75
180,000	3.12	4.50
210,000	3.64	5.25
240,000	4.16	6.00
270,000	4.68	6.75
300,000	5.20	7.50

*Coverage terminates at age 80. New York Life reserves the right to change rates on any premium due date and on any date which benefits change.

WHEN COVERAGE ENDS

The insurance on a Covered Person will end on the earliest date below:
1. the date this Policy or insurance for a Covered Class is terminated;
2. the date this Policy ends;
3. the next premium due date after the date the Covered Person is no longer in a Covered Class or satisfies eligibility requirements under this Policy;
4. the last day of the last period for which premium is paid;
5. the next premium due date after the Covered Person attains the maximum age for insurance under this Policy;
6. with respect to a Spouse or Dependent Child, the date of the death of the covered Member or the date of divorce from the Covered Member.

WHO MAY APPLY FOR THE COVERAGE?

You are eligible if:

You are an active APWU Member in good standing under age 80.

You may also apply to insure your eligible lawful spouse (under age 80) and unmarried dependent children (under age 26; subject to any state variations).

When Coverage Begins

Your coverage will become effective on the first payday following written notification the premium is deducted from your paycheck during your lifetime. You must be actively at work on that day, otherwise coverage is effective the day you return to work. Applicable benefits for your eligible Spouse and Children will also become effective on that payday.

ANY QUESTIONS?

1-800-422-4492

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

Application for GROUP ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE for Members of the AMERICAN POSTAL WORKERS UNION (APWU)

This is a request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

Complete this form and return to:
VOLUNTARY BENEFITS PLAN ®
P.O. Box 1 2009
Cheshire, CT 06410

Voluntary Benefits Plan®
Benefits for Members of the
American Postal Workers Union

MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

1. APPLICANT

Last Name _____ First Name _____ Middle Initial _____
Address _____
City _____ State _____ ZIP _____
Phone Number _____
Local Number _____
Email _____

2. ADDITIONAL INFORMATION

Union Status: ☐ Active ☐ PSE ☐ Retiree ☐ Associate
Date of Birth: ____/____/____
Sex: ☐ M ☐ F
Soc. Sec. #: _____

3. NAME YOUR BENEFICIARY

Name _____ Relationship _____
Address _____
City _____ State _____ ZIP _____
☐ Address is the same as Member's
Phone Number _____ _____ %
Name _____ Relationship _____
Address _____
City _____ State _____ ZIP _____
☐ Address is the same as Member's
Phone Number _____ _____ %

4. INSURANCE REQUESTED:

(Refer to the brochure for eligibility and coverage description.)

I hereby apply for the following:

CHOOSE THE TYPE OF COVERAGE THAT BEST MEETS YOUR NEEDS.
☐ Member-only plan
☐ Family Plan
Coverage for FAMILY includes Member, Spouse and/or eligible Children

AMOUNT: ☐ $30,000 ☐ $180,000
☐ $60,000 ☐ $210,000
☐ $90,000 ☐ $240,000
☐ $120,000 ☐ $270,000
☐ $150,000 ☐ $300,000

Please complete the following if you will be selecting the Family Plan:

NAME OF COVERED FAMILY MEMBER (Last, First, Middle Initial)	DATE OF BIRTH (MM / DD / YYYY)	SEX	SOCIAL SECURITY NUMBER
Spouse	/ /	☐ M ☐ F	
Child	/ /	☐ M ☐ F	
Child	/ /	☐ M ☐ F	

5. SIGN AND MAIL THIS FORM TODAY By signing and dating this application, the member attests to being under age 80 and an active APWU member, requests the insurance indicated; and the member and any person proposed for insurance attest to having read the Fraud Notices indicated enclosed, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete. I understand that the insurance shall become effective on the first payday after the premium is deducted from my paycheck and the completed enrollment form is received by the administrator, for covered accidents occurring after the effective date stated in my certificate. I authorize my employer to deduct the insurance premiums from my earnings.

Signature (Member) _____ Date ____/____/____
(One signature only, please)

QUESTIONS? CALL TOLL-FREE
1-800-422-4492

Group Policy # G-39315-0