Application for GROUP LONG TERM DISABILITY INCOME INSURANCE

for Members of the AMERICAN POSTAL WORKERS UNION (APWU)

Complete this form and return to:
VOLUNTARY BENEFITS PLAN®
P.O. Box 12009
Cheshire, CT 06410

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

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

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

Group Policy G-29315-2 Certificate No._____

Member's Name: _____ Social Security Number:_____
Last Name First Middle Initial

Home Address: _____ _____ _____ _____
Street City State ZIP Code

Home E-mail Address: _____ Local: _____

Home Phone: (_____) _____ Work Phone: (_____) _____

Date of Birth: ____/___/_____ Height: ___ ft ___ in Weight: _____ lbs. Sex: ☐ Male ☐ Female
(MM/DD/YYYY)

Employment Status: ☐ Active ☐ PSE ☐ Associate

OCCUPATIONAL STATUS: FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed for the past 90 days with your present employer.

Are you now at FULL-TIME WORK? ☐ Yes ☐ No Gross Annual Basic Salary: $ _____ Date of Hire: ___/___/_____
(MM/DD/YYYY)

Are you presently insured with any other insurance products provided by the Voluntary Benefits Plan®? ☐ Yes ☐ No

If "Yes," which other coverage(s) from Voluntary Benefits Plan® do you have? _____

SECTION B – INSURANCE REQUESTED

(Refer to the brochure or your certificate for eligibility, options and coverage descriptions)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ☐ New ☐ Additional *NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage, instead indicate the TOTAL AMOUNT of coverage you are requesting.*

GROUP LONG TERM DISABILITY INCOME:

a.) MONTHLY BENEFIT OPTION: $ _____ b.) Deduction per pay period _____

NOTE: If you request a monthly benefit amount that exceeds the salary requirements, the administrator will update the benefit amount to the maximum allowed for your salary.

c.) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of disability? ☐ Yes ☐ No

(If "Yes", please provide the requested information below)

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD

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SECTION C – STATEMENT OF HEALTH – To the best of your knowledge and belief: (Please initial any changes)

1.) Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ☐ Yes ☐ No

2.) During the past five years have you ever been medically diagnosed by a physician as having or been treated for:

a. back trouble/disorder, bone or joint disorder, arthritis ☐ Yes ☐ No
b. enlarged lymph nodes or immunodeficiency disorder ☐ Yes ☐ No
c. gynecological or genitourinary disorders ☐ Yes ☐ No
d. heart or circulatory trouble, elevated blood pressure chest pain or pressure ☐ Yes ☐ No
e. albumin ☐ Yes ☐ No
f. blood disorder ☐ Yes ☐ No
g. blood or sugar in urine ☐ Yes ☐ No
h. cancer ☐ Yes ☐ No
i. diabetes ☐ Yes ☐ No
j. epilepsy ☐ Yes ☐ No
k. liver disorder (including hepatitis) ☐ Yes ☐ No
l. mental or nervous disorder or psychotherapeutic treatment ☐ Yes ☐ No
m. ulcers ☐ Yes ☐ No
n. kidney disorder ☐ Yes ☐ No
o. respiratory disorder ☐ Yes ☐ No
p. thyroid disorder ☐ Yes ☐ No
q. unexplained weight loss? ☐ Yes ☐ No

3.) During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs? ☐ Yes ☐ No

4.) Are you now pregnant? ☐ Yes ☐ No

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? ☐ Yes ☐ No

6.) **Except for the residents of Minnesota and Connecticut**, have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ☐ Yes ☐ No

For residents of Minnesota and Connecticut only, 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? ☐ Yes ☐ No

7.) If you have answered "Yes" to any of the questions above please give complete details below.

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:

NOTE: *(If you need to add more information, please attach a separate sheet if necessary, then sign and date it.)*

I understand that New York Life Insurance Company has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life Insurance Company 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, MIB, Inc. ("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, representative, 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 in the IMPORTANT NOTICE, including making a brief report of my protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices enclosed, including how my information is exchanged with MIB, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

I also hereby authorize the necessary salary deductions for the premium once approved for coverage, to pay for insurance for the APWU Group Long Term Disability Income Policy underwritten by New York Life Insurance Company.

Member Signature X *(Sign in ink)* ____ /__ /____ *Date*