Application for GROUP HOSPITAL INDEMNITY 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-29315-3 Certificate No._____

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

Home Address: _____ (Street) _____ (City) _____ (State) _____ (Zip Code)

Home E-mail Address: _____ Local: _____

Daytime Phone: (_____) _____

Date of Birth: ____/____/_____ (MM/DD/YYYY) Sex: ☐ Male ☐ Female

Marital Status: ☐ Married... Maiden Name:_____ Date of Marriage: ____/____/____ (MM/DD/YYYY) ☐ Divorced ☐ Single ☐ Widowed

Are you an eligible APWU Member working 20 or more hours per week? ☐ Yes ☐ No

Employment Status: ☐ Active ☐ PSE ☐ Retired ☐ Associate

Are you presently insured under any other benefit plans provided by the Voluntary Benefits Plan®? ☐ Yes ☐ No

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

If **DEPENDENT** coverage is requested, list eligible dependents *(Lawful spouse and unmarried dependent children under age 26.)*

SPOUSE'S FULL NAME (Last, First, Mid. Init.)			Social Security Number	Date of Birth / /	☐ Male ☐ Female
1. (Child Name)	Date of Birth / /	☐ Male ☐ Female	3. (Child Name)	Date of Birth / /	☐ Male ☐ Female
2. (Child Name)	Date of Birth / /	☐ Male ☐ Female	4. (Child Name)	Date of Birth / /	☐ Male ☐ Female

NOTE: *If both parents are members, child(ren) can only be covered by one parent. Attach separate sheet to provide additional dependent information.*

PAYMENT AUTHORIZATION: By signing and dating this enrollment form, I hereby authorize the necessary salary deductions for the premium, once approved for coverage, to pay for insurance in the Voluntary Benefits Plan Group Hospital Indemnity Plan underwritten by New York Life Insurance Company.

SECTION B – INSURANCE REQUESTED

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

I HEREBY APPLY FOR THE FOLLOWING GROUP HOSPITAL INDEMNITY COVERAGE: *(Choose one from line (a) and (b))*

MN residents must be insured under a qualified major medical plan in order to request HIP coverage.

(a) PLAN THAT PROVIDES: ☐ $200 per day ☐ $100 per day ☐ $75 per day ☐ $50 per day

(b) COVERAGE FOR: ☐ Member ☐ Member & Spouse ☐ Member, Spouse & Child(ren) ☐ Member & Child(ren)

I understand that insurance will not be effective until acceptance of my enrollment form and receipt of the initial premium. I further understand that any condition for which I, or any insured dependents, incurred charges, received medical treatment, consulted a physician or took prescribed drugs within the 12 months prior to the effective date of insurance will not be covered until insurance has been in force for 12 continuous months. I understand that the total amount of benefits payable under this plan and any other plan may not exceed $500 per day. If a person is hospitalized on the date insurance is to take effect, such insurance will take effect after the date of discharge.

By signing and dating this enrollment form, the member **requests** the insurance indicated; **authorizes** the necessary salary deductions for the premium; and the member and any person proposed for insurance **attest** to having read the Fraud Notices enclosed; and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

_____ ____/____/____ _____ ____/____/____

Member Signature X *(Sign in ink)* *Date* **Spouse's Signature X** *(Necessary only if Spouse coverage is requested)* *Date*

FRAUD NOTICES

FRAUD NOTICE – (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 AL/AR/LA/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 CA:** 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **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 MD:** Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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:** For accident and health insurance only, 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.

7.2013 ed. GMA-GI L/H1 GMA-PR1 GMA-DI-EZ4 GPA-DI-EZ-3

UNDERWRITTEN BY:

New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

BROKERED AND ADMINISTERED BY:

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

www.VoluntaryBenefitsPlan.com
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