Application for GROUP TERM LIFE 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-29315-0 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: _____

Home Phone: (____) _____ Work Phone: (____) _____ Fax: (____) _____

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

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

I am an APWU Member currently working 20 or more hours per week ☐ Yes ☐ No Annual Income _____

Employment Status: ☐ Active ☐ PSE ☐ Associate

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? _____

If **DEPENDENT** coverage is requested, list eligible dependents
(lawful spouse under age 65 and/or unmarried dependent children at least 15 days but under age 26)

SPOUSE'S FULL NAME (Last, First, Mid. Init.)	Social Security Number	Date of Birth / /	☐ Male ☐ Female	Height ft in	Weight lbs.

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.*

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 LIFE INSURANCE:

☐ Member Amount (from $10,000 to $500,000 in $10,000 increments) $_____

☐ Spouse Amount (from $10,000 to $500,000 in $10,000 increments) $_____ *(Spouse amount cannot exceed member amount)*

☐ Child(ren) $2,000 for each eligible child; ($1,000 age 15 days to 6 months)

INSURANCE REPLACEMENT – RESIDENTS OF NEW YORK: I have read the Important Replacement Information on the reverse side of this application. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Member: ☐Yes ☐No Spouse: ☐Yes ☐No

RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue or change an existing policy? Member: ☐Yes ☐No Spouse: ☐Yes ☐No

SECTION C – BENEFICIARY DESIGNATION

(Attach a separate sheet signed and dated to provide additional beneficiary information)

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Term Insurance Policy, and if I am already covered under the policy, I hereby revoke any prior beneficiary designation. The beneficiary for spouse and dependent coverage shall be the insured member as provided in the Group Policy.

Beneficiary's Name	Complete Address	Relationship	Social Security #
Beneficiary's Name	Complete Address	Relationship	Social Security #

SECTION D – STATEMENT OF HEALTH

To the best of your knowledge and belief: *(Please initial any changes)*

1. Is any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? ☐ Yes ☐ No
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No
3. During the past five years, has any person to be insured consulted any physician or other 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? ☐ Yes ☐ No
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ Yes ☐ No
5. Is any person to be insured now pregnant? ☐ Yes ☐ No
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? ☐ Yes ☐ No
b. Arthritis, back trouble, bone or joint disorder? ☐ Yes ☐ No
c. Fainting spells, convulsions or epilepsy? ☐ Yes ☐ No
d. Sugar, blood, albumin or pus in urine? ☐ Yes ☐ No
e. Diabetes, kidney trouble, ulcers or digestive disorder? ☐ Yes ☐ No
f. Disorder of breast or reproductive organs or functions? ☐ Yes ☐ No
g. Nervous or mental disorder, emotional conditions or psychiatric care? ☐ Yes ☐ No
h. Cancer, tumor or cyst? ☐ Yes ☐ No
i. Varicose veins, hemorrhoids or hernia? ☐ Yes ☐ No
j. Disorder of eyes, ears, nose or sinuses? ☐ Yes ☐ No
k. Thyroid, liver or respiratory disorder? ☐ Yes ☐ No
l. Alcoholism or drug habit? ☐ Yes ☐ No
m. Disorder of the blood? ☐ Yes ☐ No
n. Other Health or physical impairment including:
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? ☐ Yes ☐ No
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? ☐ Yes ☐ No
(iii) Any other impairment? ☐ Yes ☐ No

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

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:

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 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 Term Life Plan underwritten by New York Life Insurance Company.

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

Spouse's Signature X *(Necessary only if Spouse coverage is requested)* ____ /___ /_____ *Date*

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 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 insurance 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 decide whether the replacement is in your best interest.

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