Application for GROUP RETIREE 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-29315-4 Certificate No._____

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

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

Home E-mail Address: _____

Daytime Phone: (____) _____ Evening Phone: (____) _____ Fax: (____) _____

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

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

☐ Divorced ☐ Widowed ☐ Domestic Partner* Submit a completed Declaration of Domestic Partnership form. (Not applicable in OR).

☐ Single ☐ Civil Union*

*Eligibility of Domestic Partner/Civil Union is determined by state law.

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 application and once approved for coverage I agree to pay for insurance in the Voluntary Benefits Plan Group Retiree Hospital Indemnity Insurance Plan underwritten by New York Life Insurance Company.

PREMIUM PAYMENT INFORMATION: *(Check one)* ☐ ANNUAL ☐ QUARTERLY ☐ MONTHLY *(Monthly election requires Electronic Funds Transfer Method)*

SECTION B – INSURANCE REQUESTED

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

I HEREBY APPLY FOR THE FOLLOWING GROUP RETIREE HOSPITAL INDEMNITY COVERAGE THAT PROVIDES $50 PER DAY: *(Choose one)*

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 on the day after the date of discharge.

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

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

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

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