Application for GROUP RETIREE 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-29315-6 Certificate No._____

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

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

Home E-mail Address: _____

Home Phone: (____) _____ Cell 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 ☐ Widowed ☐ Domestic Partner
☐ Single ☐ Civil Union

I am a Member of the APWU Retiree Department ☐ Yes ☐ No

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 **SPOUSE** coverage is requested *(lawful spouse of APWU Retiree)*

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

NOTE: *If both Applicant and Spouse are members, the Spouse can only be covered by applying directly. Attach separate sheet to provide additional 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 Term Life 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 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 RETIREE TERM LIFE INSURANCE: *(Check only one box per Member or Spouse)*

☐ Member Amount ☐ $25,000 ☐ $50,000
☐ Spouse Amount ☐ $25,000 ☐ $50,000
(Spouse Amount cannot exceed member amount)

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 Retiree Life Term Insurance Plan, and if I am already covered under the plan, 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 _____ Address _____ City _____ State _____ Zip _____
Relationship _____ Social Security # _____ Home Phone _____ Cell Phone _____

Beneficiary's Name _____ Address _____ City _____ State _____ Zip _____
Relationship _____ Social Security # _____ Home Phone _____ Cell Phone _____

SECTION D – STATEMENT OF HEALTH

(Please initial any changes you make on this form.)
To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured.

	Member	Spouse
1. Is any person proposed for insurance now ill, receiving or considering medical attention or treatment, or considering surgery?	☐ Yes ☐ No	☐ Yes ☐ No
2. Within the last five years, has any person proposed for insurance been counseled, hospitalized or treated for: (a) using alcohol or drugs; or (b) mental, emotional or nervous disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the last five years, has any person proposed for insurance been diagnosed by a physician as having, or been treated for: heart trouble, elevated blood pressure, cancer, diabetes, epilepsy, neurological or respiratory disorder, kidney or liver disorder, pancreas disorder, enlarged lymph nodes or tumors, disorder of the circulatory or digestive system, gynecological or genitourinary disorders, immunodeficiency or blood disorder, or unexplained weight loss?	☐ Yes ☐ No	☐ Yes ☐ No

If you answered "yes" to any of the questions above, please give details below and on additional sheets if needed.

Question Number	Name of Proposed Insured	Nature of Illness, Injury or Operation, Dates of Treatment, Duration & Degree of Recovery	Name & Address of Doctors/Hospitals

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 above and 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.

_____ ___/___/_____ _____ ___/___/_____

Member Signature X *(Please sign and date 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.

G-29315-6

IMPORTANT NOTICE: How New York Life Obtains Information and Underwrites Your Request For Group Term Insurance

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify for insurance, we will rely on the medical information you provide, and on the information you AUTHORIZE us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage or a claim for benefits is submitted to an MIB member company, medical or non-medical information may be given to MIB and such information may then be furnished by MIB, upon request, to a member company.

MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: ***PROTECTED PERSONS*** [1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION*** [2] *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1] ***PROTECTED PERSON*** *means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.*

[2] ***CONFIDENTIAL ABUSE INFORMATION*** *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*

New York Life Insurance Company 7.15 ed.

IMPORTANT FRAUD NOTICES

FRAUD NOTICE – (For Residents of all states except those listed below and New York): 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 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 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.

GMA-EZ3 7.13 ed.

UNDERWRITTEN BY:

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

ANY QUESTIONS?

Call 1-800-422-4492

www.VoluntaryBenefitsPlan.com

BROKERED AND ADMINISTERED BY:

Voluntary Benefits Plan®

Alliant Services Houston, Inc.

P.O. BOX 12009 • Cheshire, CT 06410

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

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