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
On Policy Form GMR

ANY QUESTIONS?
Call 1-800-422-4492
VoluntaryBenefitsPlan.com

ADMINISTERED BY:
Voluntary Benefits Plan®
AIS Administrators, Inc.
DBA Accretive Insurance & Administrative Solutions
P.O. BOX 12009 • Cheshire, CT 06410

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

Voluntary Benefits Plan®

Benefits for Members of the
American Postal Workers Union

Group Retiree Term Life Insurance

Group Retiree Term Life Insurance

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

MEMBER/SPOUSE LIFE INSURANCE

You may apply for insurance in amounts of $25,000 to $100,000, in increments of $25,000. You may retain this coverage, provided you continue your APWU Retiree Department membership.

The Member must be enrolled in this benefit for the spouse to be eligible for coverage. Spouse coverage may not exceed member's amount of coverage.

RIGHT TO RENEW

Your Term Life Insurance protection is renewable provided the group policy remains in force. Earlier termination can occur if you (1) fail to pay a premium when due, or (2) are no longer a member of the APWU.

Spouse's coverage terminates when you cease membership or they are no longer eligible. For Spouses, insurance ends upon divorce or annulment of marriage.

EXCLUSIONS

Suicide: If a person commits suicide within 2 years from the effective date of coverage, New York Life's liability will be limited to the premiums paid, plus interest.

EFFECTIVE DATE

All coverage is subject to approval by the insurance company. Provided you are accepted based on your answers to the medical questions asked in your application, your insurance will be effective upon receipt of the first premium payment following the date approved. You must not be hospitalized on that day, otherwise this insurance policy goes into effect upon the day you are discharged from the hospital.

Applicable benefits for your Spouse will also become effective on that day, provided they are accepted and are not hospitalized on the date insurance is to take effect. If your Spouse is hospitalized, insurance will take effect on the day after (s)he is discharged.

WHO MAY APPLY FOR INSURANCE?

You are eligible if:

- You are a retired APWU Member in good standing
- You are Age 50 – 74

You may also apply to insure your Spouse.

ADVANTAGES TO YOU

- Select either $25,000, $50,000, $75,000 or $100,000 of Member or Spouse Life Insurance
- Insurance can be retained, providing you continue your APWU Retiree Department Membership
- Affordable APWU Rates

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

We've brought comfort to thousands of APWU members and their families for over 20 years.

YOU CHOOSE YOUR BENEFICIARY

You can choose anyone you want to receive your life insurance benefits. You may change your beneficiary at any time by writing to the Policy Administrator. The member is automatically the beneficiary for spouse coverage.

HOW TO FIGURE YOUR PREMIUM

For Member Coverage: Locate the rate that corresponds to your current age and the benefit level for which you are applying. (Example: $25,000, $50,000, $75,000 or $100,000)

For Spouse Coverage: Locate the rate that corresponds to your Spouse's age and the benefit level for which your Spouse is applying.

For Total Premium: If applying for Member and Spouse, add applicable amounts to determine your total premium.

CURRENT 2025 MONTHLY PREMIUM RETIREE TERM LIFE INSURANCE

Member or Spouse

Applicant's Age	Rate for $25,000	Rate for $50,000	Rate for $75,000	Rate for $100,000
50-54	17.71	35.42	53.13	70.84
55-59	27.30	54.60	81.90	109.20
60-64	37.15	74.30	111.45	148.60
65-69	43.05	86.10	129.15	172.20
70-74	84.44	168.88	253.32	337.76
75 & Over	152.10	304.20	456.30	608.40

Rates increase as you enter a higher age bracket. Benefits do not reduce.

YOUR CERTIFICATE OF INSURANCE

Once insured, you will receive a Certificate of Insurance evidencing coverage which is provided under Group Policy G-29315-6 / FACE (Policy Form GMR).

RIGHT TO CHANGE BENEFITS, RATES OR TERMINATE THE POLICY

Changes to the group policy are subject to agreement between New York Life and the Group Policyholder. Rates can be changed by New York Life on any premium due date and on any date in which benefits are changed.

Incontestability

The validity of any amount of insurance which has been in force for two years during the insured's life will not be contested except for non-payment of premium contributions.

Accelerated Death Benefit - This benefit is designed to provide you with the option to have a portion of your life insurance benefit paid to you while you are still alive if you become terminally ill while insured, up to age 70. You would then be free to use that money any way you wish.

To qualify for the Accelerated Death Benefit an individual must be insured under the APWU Retiree Term Life Insurance Policy and diagnosed as having a life expectancy of 24 months or less. Proof of terminal illness will consist of a statement from the insured's physician and any other medical information that New York Life believes necessary to confirm the insured's status.

If the insured qualifies, he or she will be paid, in a lump sum, 50% of the benefit in force on the date of approval of the request. Only one Accelerated Death Benefit will be made during the insured's lifetime and any benefit payable for loss of life will be reduced by the amount paid under the Accelerated Death Benefit.

Receipt of Accelerated Death Benefits may be taxable and may affect eligibility for public assistance programs. You should seek advice from a personal tax advisor.

CONVERSION PRIVILEGE

Once insured, you may convert your term coverage to any permanent policy offered by New York Life, regardless of any health conditions or history under conditions stated in your certificate. Conversion must be requested within 31 days of the date you became eligible for this provision. See Certificate for complete details.

SEND NO MONEY... REVIEW YOUR CERTIFICATE WITH NO OBLIGATION FIRST!

Once coverage is approved, you will receive a Certificate of Insurance. Take up to 30 days to review it. If it does not meet your expectations you may return it, without claim and we will refund any premiums paid back to the effective date.

1. Simply complete the provided **GROUP RETIREE TERM LIFE APPLICATION**. Please make sure you complete all the information requested. An incomplete application will be returned, resulting in a delay in processing your application.
2. Send no money.
3. Return your application to: **The Voluntary Benefits Plan**
   P.O. Box 12009
   Cheshire, CT 06410

ANY QUESTIONS?
Call
1-800-422-4492
VoluntaryBenefitsPlan.com

PLEASE NOTE: You must notify the Voluntary Benefits Plan of any address change, employment or union membership status change, life status change (i.e., marriage, divorce, beneficiary or name change) or benefit changes requested. Notice must be in writing.

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	☐ $75,000	☐ $100,000
☐ Spouse Amount	☐ $25,000	☐ $50,000	☐ $75,000	☐ $100,000

(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 _____

G-29315-6

GMA-EZ3