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 _____

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