Application for GROUP SHORT TERM DISABILITY INCOME INSURANCE

for Members of the AMERICAN POSTAL WORKERS UNION (APWU)

SECTION C – STATEMENT OF HEALTH – To the best of your knowledge and belief: (Please initial any changes) _____

1.) Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ☐ Yes ☐ No

2.) During the past five years have you ever been medically diagnosed by a physician as having or been treated for:

a. back trouble/disorder, bone or joint disorder, arthritis	☐ Yes ☐ No		j. epilepsy	☐ Yes ☐ No	
b. enlarged lymph nodes or immunodeficiency disorder	☐ Yes ☐ No		k. liver disorder (including hepatitis)	☐ Yes ☐ No	
c. gynecological or genitourinary disorders	☐ Yes ☐ No		l. mental or nervous disorder or psychotherapeutic treatment	☐ Yes ☐ No	
d. heart or circulatory trouble, elevated blood pressure chest pain or pressure	☐ Yes ☐ No		m. ulcers	☐ Yes ☐ No	
e. albumin	☐ Yes ☐ No		n. kidney disorder	☐ Yes ☐ No	
f. blood disorder	☐ Yes ☐ No		o. respiratory disorder	☐ Yes ☐ No	
g. blood, pus or sugar in urine	☐ Yes ☐ No		p. thyroid disorder	☐ Yes ☐ No	
h. cancer	☐ Yes ☐ No		q. varicose veins	☐ Yes ☐ No	
i. diabetes	☐ Yes ☐ No		r. unexplained weight loss	☐ Yes ☐ No	

3.) During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs? ☐ Yes ☐ No

4.) Are you now pregnant? ☐ Yes ☐ No

5.) Are you now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance? ☐ Yes ☐ No

6.) *Except for the residents of Minnesota and Connecticut,* have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending? ☐ Yes ☐ No

For residents of Minnesota and Connecticut only, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years? ☐ Yes ☐ No

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

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 Insurance Company 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 LLC ("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 LLC, 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 Short Term Disability Income Policy underwritten by New York Life Insurance Company.

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

NOTE: *If you have made corrections or strikeouts on this application, the Member MUST initial them.*

Short Term Disability Income will be there to help you when you really need it the most.

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

Send no money… Review your certificate with no obligation first!

- Simply complete the provided **GROUP SHORT TERM DISABILITY APPLICATION** authorizing payroll deductions. Please make sure you complete all the information requested. An incomplete application will be returned, resulting in a delay in processing your application.
- Send no money.
- Return your application to:
  The Voluntary Benefits Plan
  P.O. Box 12009, Cheshire, CT 06410
- For a faster application decision, you can apply online at **vbp.nylinsure.com**.

PLEASE NOTE: You must notify the Voluntary Benefits Plan of any address change for you, your dependents and/or beneficiaries, and any 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.

Any questions?
Call 1-800-422-4492 or visit VoluntaryBenefitsPlan.com/DI

UNDERWRITTEN BY:

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

ADMINISTERED BY:

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

AIS Administrators, Inc.
DBA Accretive Insurance & Administrative Solutions
PO Box 12009, Cheshire, CT 06410

Group Short Term Disability Income Insurance

Can guarantee you a fixed monthly income for up to 12 months.

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

Group Short Term Disability Income Insurance

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

Collect up to $3,500 a Month.....$42,000 a Year

Receive a fixed monthly income if a covered disability keeps you from working. Benefits begin after a 30 day waiting period. Benefits can continue up to 12 months (6 weeks for pregnancy related disabilities). After 12 months, benefits may continue to be paid under the Voluntary Benefits Plan Long Term Disability Insurance Policy if you have that coverage. You can pay your insurance premiums through payroll deduction!

Eligibility

All active APWU members under age 65 working full time (at least 20 hours per week) for at least 90 consecutive days can apply for coverage. Full time work means the active performance for pay or profit of the regular duties of your normal occupation.

What does it mean to be Totally Disabled?

Total disability means a complete inability to perform the material duties of your regular occupation. The total disability must be a result of an injury or sickness, and you must be under the regular care of a doctor and not working at a gainful occupation.

What are the benefits?

You may select a monthly benefit amount from $500 to $3,500 in $100 increments. Benefits cannot exceed 66% of your Average Monthly Income when combined with all Other Income Benefits you receive from any other source. See the Other Income Benefits provision for more details. Average monthly income means your average monthly pay from the employer and does not include income from overtime, bonuses, or other extra compensation, income from any other source.

Other Income Benefits means the amount of monthly benefit selected is the maximum benefit you will receive under the group policy. The benefit will be reduced by any other benefits you are entitled to receive that month from an employer or self-employment, an employer retirement plan, the retirement system of any government agency, the Federal Social Security Act, the Railroad Retirement Act, the Canada Pension Plan or the Quebec Pension Plan, an employer benefit plan providing disability income benefits, if such benefits do not reduce the member's short term disability amount or if such plan is elected by the member, the Veterans Administration or any other government agency, a workers' compensation or similar law. In no event will the monthly benefit paid under the group policy exceed 66% of your average monthly salary or be less than $100. In addition, benefits are reduced by one-third upon attainment of age 60. Premiums do not reduce.

Benefit Duration

For all covered injuries and sicknesses other than pregnancy, benefits are payable up to 12 months after the 30-day waiting period. For disabilities that are the result of a pregnancy that begins after you are insured for at least 12 months following the certificate's effective date, benefits are payable for a maximum period of six weeks after the 30-day waiting period. The benefit period will end on the date you fail to give required proof of continuing total or partial disability; your total disability ends; the maximum benefit period ends; or you die.

Additional Survivor Benefits

If you are totally disabled for at least 90 consecutive days and die while receiving benefits for such disability, the monthly benefit will be paid for 2 more months to your spouse or children.

Premiums Waived

Once you qualify for total disability you will not be required to pay any premiums for the Short Term Disability coverage while you are receiving benefits. When the disability ends and you return to full-time work, you may keep the coverage in force by resuming premium payments.

Exhaustion of Benefits

Once you have received benefits under the policy for one disability, coverage will automatically terminate once the benefits are exhausted. Additional injuries or sickness contracted during the disability will not extend the coverage beyond the 12 month benefit period. You may reapply for coverage, once you have returned to active full-time employment for at least 30 days.

Exclusions

Disabilities are not covered if they result from: war or acts of war; intentionally self-inflicted injuries; mental, nervous or emotional disorders; committing a crime or an attempt to do so; or any impairment or disease specifically excluded from the insured's coverage. Disabilities resulting from pre-existing conditions* are not covered under this policy until the person has not incurred charges, received medical treatment, consulted a physician, or taken prescription drugs for such conditions, or any complication of it for 12 continuous months or the person stays insured under the policy for 24 continuous months.

When Coverage Begins

All coverage is subject to approval by New York Life Insurance Company. Once approved your coverage will become effective on the first payday the premium is deducted from your paycheck. You must be actively at work on that day, otherwise, coverage is effective the day you return to work.

When Coverage Ends

Your Short Term Disability Insurance Policy is renewable until you reach age 70 provided the group policy remains in force. Earlier termination can occur if (1) you fail to pay the required premium when due (2) you retire or cease to be actively engaged in full time employment of at least 20 hours per week in your profession for reasons other than total disability or (3) your disability benefits have been paid for 12 months.

Right to Change Benefits or Rates

Future benefits are subject to change by agreement between New York Life Insurance Company and the group policyholder. Rates can be changed by New York Life Insurance Company on any premium due date and on any date in which benefits are changed.

No Risk. No Obligation.

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 return it, without claim, and we'll send you a full refund of any premium paid during that period and your certificate will be considered never issued. Once your coverage is in effect, your monthly benefit amount will not automatically increase in the event that your basic monthly pay increases. You must apply for additional coverage amounts.

How to Determine Your Benefit Amount and Cost

1. To determine your maximum monthly benefit amount, multiply your basic monthly postal salary by .660 to equal $_____. Round this number down to the nearest $100.
2. From the rate chart at right, locate your current age and benefit amount from step 1 above. The corresponding amount will be your bi-weekly premium amount that will be deducted from your paycheck upon receipt and approval of your application. You may, of course, apply for an amount equal to or lower than the amount in step 1.
3. Complete and sign the application and return it in the postage paid envelope provided. It's that easy!

CURRENT 2025 SHORT TERM DISABILITY BI-WEEKLY PAY PERIOD RATES

Monthly Benefit Amount Selected	Less Than Age 30	Attained Age* 30 to 39	40 to 49	50 to 59	60 to 69** and Over
$3,500	$31.78	$38.12	$44.49	$63.53	$82.60
3,400	30.87	37.03	43.21	61.71	80.24
3,300	29.96	35.94	41.94	59.90	77.88
3,200	29.06	34.85	40.67	58.08	75.52
3,100	28.15	33.76	39.40	56.27	73.16
3,000	27.23	32.67	38.12	54.45	70.79
2,900	26.32	31.58	36.85	52.64	68.43
2,800	25.41	30.49	35.57	50.82	66.07
2,700	24.51	29.40	34.31	49.01	63.71
2,600	23.60	28.31	33.03	47.19	61.35
2,500	22.69	27.23	31.77	45.38	58.99
2,400	21.78	26.14	30.49	43.56	56.63
2,300	20.88	25.05	29.23	41.75	54.27
2,200	19.97	23.96	27.95	39.93	51.91
2,100	19.06	22.87	26.69	38.12	49.56
2,000	18.15	21.78	25.41	36.30	47.19
1,900	17.25	20.69	24.15	34.49	44.84
1,800	16.34	19.60	22.87	32.67	42.47
1,700	15.43	18.51	21.60	30.86	40.12
1,600	14.52	17.42	20.33	29.04	37.75
1,500	13.62	16.34	19.06	27.23	35.40
1,400	12.71	15.25	17.79	25.41	33.03
1,300	11.80	14.16	16.52	23.60	30.68
1,200	10.89	13.07	15.25	21.78	28.31
1,100	9.99	11.98	13.98	19.97	25.96
1,000	9.08	10.89	12.71	18.15	23.60
900	8.17	9.80	11.44	16.34	21.24
800	7.26	8.71	10.16	14.52	18.88
700	6.36	7.62	8.90	12.71	16.52
600	5.45	6.53	7.62	10.89	14.16
500	4.54	5.45	6.36	9.08	11.80

*Benefits are reduced by one-third upon attainment of age 60 and terminate at age 70. Premiums do not reduce. Note: The rate will increase as you attain a higher age bracket.

**Rates from 65-69 are for renewals only, members over 64 are not eligible to enroll

*Pre-existing conditions are defined as an injury or sickness for which a person incurred charges, received medical treatment, consulted a physician, or took prescribed drugs within 12 months prior to the date his or her insurance took effect.

The Voluntary Benefits Plan Group Short Term Disability Insurance Policy described is subject to the terms and conditions of Group Policy G-29315-1, issued by New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010 to the Voluntary Benefits Plan Insurance Trust (on Policy Form GMR-FACE/G-29315-1). Please refer to the Certificate of Insurance for details of your coverage. New York Life Insurance Company (NAIC#66915) is domiciled in New York and licensed/authorized to transact business in the 50 United States and the District of Columbia. Coverage may vary and not be available in all states. This material is not intended for use with residents of New Mexico.

Application for GROUP SHORT TERM DISABILITY INCOME INSURANCE

for Members of the AMERICAN POSTAL WORKERS UNION (APWU)

This is a request for Group Insurance from:
NEW YORK LIFE New York Life Insurance Company
51 Madison Avenue
New York, NY 10010

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

Group Policy G-29315-1 Certificate No.

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

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

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

Home Email Address: _____ Local: _____

Home Phone: (___) _____ Work Phone: (___) _____

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

OCCUPATIONAL STATUS: FULL-TIME WORK means actively performing the regular duties of your normal occupation for pay or profit on the basis of at least 20 hours each week at the place such duties are normally performed for the past 90 days with your present employer.

Are you now at FULL-TIME WORK? ☐ Yes ☐ No Gross Annual Basic Salary: $ _____ Date of Hire: ___/___/___ (MM/DD/YYYY)

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?

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 SHORT TERM DISABILITY INCOME:

a.) MONTHLY BENEFIT OPTION: $ _____ b.) Deduction per pay period _____

If you request a monthly benefit amount that exceeds the salary requirements the administrator will update the benefit amount to the maximum allowed for your salary.

c.) Do you now have or are you now applying for any other insurance which provides benefits if you are unable to work because of a disability? ☐ Yes ☐ No

(If "Yes", please provide the requested information below)

COMPANY	PLAN	MONTHLY BENEFIT	BENEFIT PERIOD