Application for Group Term Life Insurance for Members of The American Postal Workers Union

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

1. Is any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? ☐ Yes ☐ No
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? ☐ Yes ☐ No
3. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination or checkup, or been hospitalized or had an operation or had any illness, disease or injury? ☐ Yes ☐ No
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? ☐ Yes ☐ No
5. Is any person to be insured now pregnant? ☐ Yes ☐ No
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:

a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐ Yes	☐ No	
b. Arthritis, back trouble, bone or joint disorder?	☐ Yes	☐ No	
c. Fainting spells, convulsions or epilepsy?	☐ Yes	☐ No	
d. Sugar, blood, albumin or pus in urine?	☐ Yes	☐ No	
e. Diabetes, kidney trouble, ulcers or digestive disorder?	☐ Yes	☐ No	
f. Disorder of breast or reproductive organs or functions?	☐ Yes	☐ No	
g. Nervous or mental disorder, emotional conditions or psychiatric care?	☐ Yes	☐ No	
h. Cancer, tumor or cyst?	☐ Yes	☐ No	
i. Varicose veins, hemorrhoids or hernia?	☐ Yes	☐ No	
j. Disorder of eyes, ears, nose or sinuses?	☐ Yes	☐ No	
k. Thyroid, liver or respiratory disorder?	☐ Yes	☐ No	
l. Alcoholism or drug habit?	☐ Yes	☐ No	
m. Disorder of the blood?	☐ Yes	☐ No	
n. Other Health or physical impairment including: (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes	☐ No	
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	☐ Yes	☐ No	
(iii) Any other impairment?	☐ Yes	☐ No	

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

Name(s) of Proposed Insured	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 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 Term Life Insurance underwritten by New York Life Insurance Company.

Member Signature X *(Sign 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.

Get a feeling of greater security with the Voluntary Benefits Plan Group Term Life Insurance

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.

- ☑ Simply complete the provided **GROUP TERM LIFE 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/Life

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

Agency Insurance License Numbers: AR: 245147, CA: 0791700 FN38516D-7 10M 10/24

Group Term Life Insurance

Insurance protection when you really need it most.

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

Group 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 $10,000 to $500,000, in increments of $10,000. You may retain this coverage when you retire.

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.

The amount of life insurance for you or your spouse who is now 65 or older or when you attain age 65 will be reduced by 35%. The original amount will be further reduced at age 70 by 75%. Full premiums continue to be payable.

CHILDREN'S LIFE INSURANCE

You may apply to insure your Unmarried Dependent Children (age 15 days but under age 26).

WHEN COVERAGE ENDS

Your Term Life Insurance protection is renewable provided the group policy remains in force and premiums are paid when due.

Spouse and Children's coverage terminates when 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 (12 months for Missouri residents), 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 on the first pay day the premium is deducted from your paycheck following the date approved. You must be actively at work on that day, otherwise insurance is effective the day you return to work.

Applicable benefits for your Spouse and Children will also become effective on that pay day, provided they are accepted and are not hospitalized on the date insurance is to take effect. If your Spouse or Child(ren) 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 an active APWU Member in good standing
- You are working 20 or more hours per week

You may also apply to insure your Spouse and Unmarried Dependent Children at least 15 days but under age 26.

ADVANTAGES TO YOU

- Up to $500,000 of Member or Spouse Life Insurance
- Insurance can be retained when you retire
- Dependent children may also be insured
- You can pay your premiums through payroll deduction

We've brought comfort to thousands of APWU family members for over 20 years.

HOW TO FIGURE YOUR PAYROLL DEDUCTION

For Member Coverage: Locate the rate that corresponds to your current age. Multiply that rate by the number of $10,000 increments for which you are applying (Example: $100,000 = 10, $150,000 = 15).

For Spouse Coverage: Locate the rate that corresponds to your Spouse's age. Multiply that rate by the number of $10,000 increments for which your Spouse is applying.

For Children Coverage: Add the flat rate shown in the Children's column. One rate covers all of your eligible Children.

For Total Deduction: Add all of the applicable amounts to determine your total per pay period deduction.

YOUR CERTIFICATE OF INSURANCE

Once insured, you will receive a Certificate of Insurance evidencing coverage which is provided under Group Policy G-29315-0 / FACE (Policy Form GMR). This information is only a brief description of the principal provisions and features of the Policy. The complete terms and conditions are set forth in the group policy.

CURRENT 2025 DEDUCTION PER BI-WEEKLY PAY PERIOD TERM LIFE INSURANCE

Member or Spouse

Applicant's Age	Rate Per $10,000
Under 30	.42
30-34	.46
35-39	.81
40-44	1.31
45-49	2.08
50-54	3.27
55-59	5.04
60-64	7.62
*65-69	5.74
**70-74	4.33
**75 & Over	7.80

All Children are insured for $0.31 per bi-weekly pay period

* Benefits reduced by 35% of the original benefit at age 65. Premiums do not reduce.
** Benefits reduced by 75% of the original benefit at age 70. Premiums do not reduce.

Note: Rates will increase as you attain a higher age bracket.

Children age 15 days but less than 6 months may receive $1,000 insurance, 6 months and over may receive $2,000 insurance.

Child(ren)'s insurance ends when eligibility ends. Insurance issued at $1,000 will increase automatically to $2,000 after the eligible Child reaches 6 months of age.

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 BENEFITS

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.

Receipt of Accelerated Death Benefits may affect your eligibility for public assistance programs and may be taxable. Prior to applying to receive such benefits, you should consult with the appropriate social service agency and seek the advice of a qualified tax advisor.

CONVERSION PRIVILEGE

The Policy provides conversion privileges under certain circumstances of involuntary termination, as described in the Certificate of Insurance.

Application for GROUP 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

VoluntaryBenefits 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

Group Policy G-29315-0 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 E-mail Address: _____ Local: _____

Home Phone: (____) _____ Work 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 ☐ Single ☐ Widowed

I am an APWU Member currently working 20 or more hours per week ☐ Yes ☐ No Annual Income _____

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? _____

If DEPENDENT coverage is requested, list eligible dependents
(lawful spouse under age 65 and/or unmarried dependent children at least 15 days but under age 26)

SPOUSE'S FULL NAME (Last, First, Mid. Init.)	Social Security Number	Date of Birth ____/____/____	☐ Male ☐ Female	Height ft in	Weight lbs.
1. (Child Name)		Date of Birth ____/____/____	☐ Male ☐ Female		
2. (Child Name)		Date of Birth ____/____/____	☐ Male ☐ Female		
3. (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.*

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 LIFE INSURANCE:

☐ Member Amount (from $10,000 to $500,000 in $10,000 increments) $ _____

☐ Spouse Amount (from $10,000 to $500,000 in $10,000 increments) $ _____ *(Spouse amount cannot exceed member amount)*

☐ Child(ren) $2,000 for each eligible child; ($1,000 age 15 days to 6 months)

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 Life Term Insurance Policy, and if I am already covered under the policy, 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 _____ Complete Address _____ Relationship _____ Social Security # _____

Beneficiary's Name _____ Complete Address _____ Relationship _____ Social Security # _____