

USDA Employees Services and Recreation Association (USDA/ESRA) Sponsored GEVBT Group Accidental Death and Dismemberment Guarantee Issue Enrollment Form

COMPLETE THIS FORM AND RETURN TO:
GEVBT PLAN Administrator
 P.O. Box 828
 Annandale, VA 22003-0828

Request for Group Insurance from:
 New York Life Insurance Company
 51 Madison Avenue
 New York, New York 10010

PLEASE PRINT IN INK

Group Policy: G-29171-0

1. Member Information:

Last Name	First	Initial	Certificate/Membership Number
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Home Address	Street	City	State/Province	Zip Code
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Social Security No.	Home Phone Number	Office Phone Number	Fax Number
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Date of Birth ____/____/____ Gender: Male Female Marital Status: Married Divorced Single

Are you a member of the USDA Employee Services and Recreation Association? Yes No

2. PAYMENT OPTION SELECTED: (Choose only one) Semi-Annual Annual

3. DEPENDENT INFORMATION: If dependent coverage is requested, list eligible dependents (ie. Lawful spouse and unmarried, dependent children under age 19, or 25 if a full time student)

Full Name (Last, First, Middle Initial)	Date of Birth (mo/day/year)
Spouse:	
Child:	
Child:	
Child:	

4. INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Additional

NOTE: If you are increasing or altering present coverage in any way, indicate in line (a) & (b) the Total Amount of Coverage, not just the increased amount

a) Total **Member** Amount Desired:

\$25,000 \$50,000 \$100,000 \$150,000 \$200,000 \$250,000

b) Total **Spouse** Amount Desired:

50% Member Amount 100% Member Amount

c) Total **Child(ren)** Amount Desired:

10% Member Amount

G-29171-0

Please read Additional Information, and sign, on reverse side of this request form...

GMA-GI

5. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Accidental Death and Dismemberment Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Beneficiary's Name: _____ Relationship to Member _____ Social Security # _____

Beneficiary's Address: _____ Street _____ City _____ State/Province _____ Zip Code _____

I request the group insurance shown on the reverse side. To the best of my knowledge and belief: (a) I am under age 70 and eligible for such insurance; and (b) the statements I have made are true and complete.

I understand that: (a) insurance will become effective on the first day of the month following the date approved by New York Life if the initial contribution is paid and I and any approved dependents are actively performing the normal activities of a person in good health of like age on the day insurance is effective; (b) any person who is not performing his/her normal activities on the day insurance would otherwise become effective, will not become insured until the first day of the month following the date he or she is performing such activities, provided such a date is within three months of the date insurance would have been effective and the person is still eligible for insurance; and (c) any dividend apportioned to the group policy will be paid to the Group Policyholder.

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 is a crime and subjects such person to criminal and civil penalties.

FOR 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.

FOR RESIDENTS OF D.C., the following also applies: 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 LA: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in a application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

RESIDENTS OF NY: Any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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.

Member's Signature X _____
(PLEASE SIGN IN INK) _____ DATE _____

To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Spouse's Signature X _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) _____ DATE _____

Owner's Signature X _____
(NECESSARY ONLY IF OWNER HAS TRANSFERRED OWNERSHIP OF HIS/HER AD&D INSURANCE) _____ DATE _____

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