

GEVBT GROUP TERM LIFE INSURANCE ENROLLMENT FORM

for USDA employees



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



Complete this form and return to:
 Mass Benefits Consultants, Inc
 USDA/ESRA Plan Administrator
 P.O. Box 828, Annandale, VA 22003
 Toll Free: 800-221-8083

MEMBER INFORMATION [PRINT IN INK OR TYPE ALL ANSWERS] **Group Policy: G-29165-0 Certificate No. _____**

Last Name _____ First _____ Initial _____ Social Security Number _____

Billing Address: Street _____ City _____ State/Province _____ Zip Code _____

Home Address: Street _____ City _____ State/Province _____ Zip Code _____

e-Mail Address _____ (____) _____ (____) _____ (____) _____
 Day Time Phone Number Evening Phone Number Day Fax Number

Date of Birth ____/____/____ Height ____ft____in. Weight ____lbs. Sex: Male Female
 (MM/DD/YYYY)

Marital Status Married.....Maiden Name _____ Divorced Single Widowed

Are you an employee of: the US Department of Agriculture? Yes No

Date of Employment: ____/____/____ Annual Income: _____
 (MM/DD/YYYY)

Are you presently insured by any USDA/ESRA sponsored Insurance Plan? Yes No

If yes, provide details _____

Do you intend to reside outside the U.S. or Canada in the next 12 months?

Member: Yes Country _____ No **Spouse:** Yes Country _____ No
 If yes, for how long? _____ If yes, for how long? _____

PAYMENT OPTION SELECTION: *Choose only one*

Periodic Billing Semi-Monthly Monthly Quarterly

DEPENDENT INFORMATION: If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 19, or 23 if a full time student.) *Attach separate sheet to provide additional dependent information.*

Dependent Full Name (First, Last, Middle Initial)	Date of Birth (mm/dd/yyyy)	Height (Ft., In)	Weight (Lbs.)	Male or Female
Spouse				<input type="checkbox"/> M <input type="checkbox"/> F
Child				<input type="checkbox"/> M <input type="checkbox"/> F
Child				<input type="checkbox"/> M <input type="checkbox"/> F

INSURANCE REQUESTED: (Refer to your certificate, the brochure or website for eligibility, options and coverage description)

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

NOTE: If you are increasing or altering present coverage in any way, indicate the Total Amount of Coverage, not just the increased amount - **COVERAGE AMOUNT:**

(Check **Member** Coverage: Available from \$10,000 to \$300,000 in \$10,000 increments:..... \$ _____
 to **Spouse** Coverage: Available from \$10,000 to \$300,000 in \$10,000 increments:..... \$ _____
 Apply) *Spouse Amount of coverage can not exceed Member Amount of coverage*

Dependent Child(ren) Coverage: \$3,000 per child

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INSURANCE REPLACEMENT

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 to 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.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above.

Is the life insurance applied for on page 1 of this application 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 on page 1 of this application intended to replace, discontinue or change an existing policy? **Member:** Yes No **Spouse:** Yes No

BENEFICIARY DESIGNATION: I make the following beneficiary designation with respect to all the insurance on my life under Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary 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, 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

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

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

STATEMENT OF HEALTH: To the best of my knowledge and belief:

		Yes	No
A.	Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
B.	During the past five years has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, unexplained weight loss, or other illness disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>
C.	During the past five years has any person been counseled, treated or hospitalized for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered yes to any of the above questions, please explain (attach a separate sheet if necessary, then sign and date it)

Name of Proposed Insured	Details

YOU MAY BE CONTACTED BY A SERVICE PROVIDER ON BEHALF OF NEW YORK LIFE TO ASK ADDITIONAL QUESTIONS ABOUT YOUR MEDICAL HISTORY

Best place and time to contact you: (Choose one of each)	PLACE <input type="checkbox"/> Residence <input type="checkbox"/> Business	DAY <input type="checkbox"/> Weekdays <input type="checkbox"/> Weekends	TIME 1Morning (7:00 – 12:00) 1Evening (5:00 – 8:00)	1Afternoon (12:00 – 5:00) 1Night (8:00 – 11:00)
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I request the group insurance shown on page (1) of this application. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. I understand that New York Life 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 and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

I understand that: (a) insurance (or additional insurance) will become effective on the first day of the month on or following the date approved by New York Life if the initial contribution is paid within 31 days after the date I am billed and I and any approved dependents are actively performing the normal activities of a person in good health of like age (or with respect to **NC residents**, I and any approved dependents health status continues to be the same as stated on this application) on the approval date; (b) any person who is not performing such normal duties/activities (for **NC Residents:** whose health status is not the same as stated on this application) as required will not become insured until the day he/she is performing such normal duties/activities, provided such 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

I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau).

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator (Mass Benefits Consultants) about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator (Mass Benefits Consultants.) with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application or any supplement to it.

I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law. New York Life may release information covered by this AUTHORIZATION to the plan administrator (Mass Benefits Consultants.), MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the plan administrator (Mass Benefits Consultants.) in writing at the address given on this form. My revocation will not be effective to the extent 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I, or my authorized agent, may request a copy of this signed AUTHORIZATION.

By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information to the providers noted, and I represent that I have read the Fraud Notices on the reverse of this page and that to the best of my knowledge and belief, the answers to the questions are true and complete

Member's Signature X

(PLEASE SIGN IN INK)

DATE

Spouse's Signature X

(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

DATE

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FRAUD NOTICE: 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 AR/LA: 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.

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., 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 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 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 PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

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.

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Questions? Call Toll Free: (800) 221-8083

Please visit www.massbenefits.com

or call for details of other plans available to USDA ESRA members.

Additional forms are also available.

BEFORE YOU MAIL THIS APPLICATION, IT WILL GREATLY SPEED ACTION ON YUR APPLICATION IF YOU REVIEW IT CAREFULLY.....

- DID YOU SIGN THE APPLICATION IN ALL REQUIRED PLACES?**
 - o MEMBER SIGNATURE
 - o SPOUSE SIGNATURE (IF APPLICABLE)
 - o ANY CORRECTIONS TO THE APPLICATION MUST BE INITIALED BY MEMBER
- HAVE ALL QUESTIONS BEEN ANSWERED?**
- HAVE YOU PROVIDED NAMES AND ADDRESSES OF ALL DOCTORS YOU HAVE CONSULTED (EVEN ROUTINELY)?**

RETURN APPLICATION TO:

Mass Benefits Consultants, Inc.

P.O. Box 828

Annandale, VA 22003

Residents of Puerto Rico should mail applications to:

Global Insurance Agency

P.O. Box 9023918

San Juan, Puerto Rico 00902-3918