

SPECIAL OFFER TO ELIGIBLE FEDERAL GOVERNMENT EMPLOYEES \$50,000 Group Term Life Insurance

New York Life Insurance Company¹, one of the largest and most respected life insurance companies in the nation known for its financial strength, has agreed to a \$50,000 Guaranteed Acceptance Offer to eligible² Federal employees.

If you are under age 50 and working full-time (more than 30 hours per week) for the federal government, you can enroll for \$50,000 of Group Term Life Insurance on a **GUARANTEED basis – No Health Questions Asked.**

This offer is for a short time only!

Complete the enclosed application and return it with the first payment after reviewing the plan features and costs. You will be issued a Certificate of Insurance and have 30 days to determine if the coverage is right for you. If it is not, you may cancel it for a full refund of any premium paid (without claim) – no questions asked.

If you are not eligible for this offer or desire higher amounts of protection (up to \$300,000) and/or coverage for your dependents, you can apply through age 74 on a fully underwritten basis. Visit www.massbenefits.com or call Mass Benefits for details and an application form.

Please give our office a call if you have any questions regarding this offer at 1-800-221-3083.

Sincerely yours,



Arthur S. Cranston, III
Vice President

¹ New York, NY 10010 is the underwriter of this coverage (policy form GMR)

² to be eligible you must be an active federal employee working full-time (30 hrs); a resident of the US (excluding ME, OR & SD) or Puerto Rico; not currently insured or have been declined by Group Life Insurance underwritten by New York Life.

GEVBP Group Term Life Insurance Plan Details

\$50,000 Guaranteed Acceptance Limited Time Offer

Underwritten by New York Life Insurance Company on policy form GMR

Who Can Apply for this limited time offer?

Active Federal employees under age 50, who are actively at work on a full-time basis (30 or more hours per week) and residing in the United States (excluding ME, OR & SD) or Puerto Rico are eligible to apply for this limited time offer. Applications must be received within 30 days from the last date this offer is made available online at www.massbenefits.com.

Current 2015 Quarterly Rates for \$50,000

<u>AGE</u>	<u>Premium</u>
Under 30	\$12.00
30 – 34	\$12.45
35 – 39	\$15.45
40 – 44	\$21.60
45 – 49	\$33.90

Notes:

- "Age" means attained age at the time of application
- Premiums increase as the insured enters a new age bracket
- Premiums for all ages can be obtained by contacting the plan administrator
- Upon attainment of age 70, benefits will reduce 50% - premiums do not reduce
- Coverage terminates at age 75 if you are no longer at full-time work
- An administrative fee of \$2.00 will be added to each account quarterly billing cycle (contact Mass Benefits for billing options that do not contain this fee)

Renewable to age 75 or your date of retirement if later

As long as you make your payments on time and the master policy is in force, you can keep renewing your insurance until age 75 (or date of retirement if later).

Group Conversion Privilege

If your insurance ends for a reason other than your request, non-payment of premium before age 75, or receipt of an Accelerated Death Benefit, you have the privilege of converting your group coverage to an individual policy of permanent life insurance (other than term) from New York Life during the conversion period without further evidence of insurability as will be described in your Certificate of Insurance.

Waiver of Premium

If an insured member becomes totally disabled prior to age 60, all premiums after six months of continuous disability will be waived and the insurance will continue in effect. Complete details will be available in your Certificate of Insurance.

An Accelerated Death Benefit*

This attractive benefits provision is available to insureds under the age of 70. If you are diagnosed by a physician to be terminally ill, and have 12 months** or less to live, you may elect to receive up to 50% of your group life insurance benefit. The remaining benefit then becomes payable to your beneficiary after your death. Complete details will be available in the Certificate of Insurance. Receipt of this benefit may affect eligibility for public assistance programs and may be taxable. Prior to applying you should consult with the appropriate social services agency and your tax advisor.

* Not available to Residents of Massachusetts ** 24 months for Residents of Illinois.

Effective Date

The \$50,000 Guaranteed Acceptance coverage will be effective on the first of the month following receipt of your completed application provided the full premium for the insurance is received and you are actively working full-time (30 hours) on such date.

Benefits and Exclusions

New York Life will pay the amount of your insurance to your beneficiary if you die from any cause anywhere in the world. The only exclusions are for misrepresentation of facts on your application and for suicide in the first two years of coverage. Residents of Missouri: Benefits will not be paid for suicide within the first two years if New York Life can show that suicide was intended at the time of application. You name your beneficiary. You are the automatic beneficiary for dependent coverage.

Right to change benefits, rates or terminate the plan

Changes to the group policy are subject to agreement between New York Life and the Policyholder. Rates may be changed by New York Life on any premium due date and on any date which benefits are changed, but only on a class-wide basis (for example a class is a group of insureds with the same age and gender). The Policyholder or New York Life may terminate the plan on any premium due date by giving 60 days advance notice.

You can apply now with no risk - You will have a 30-day FREE look

When your Certificate of Insurance arrives, please examine it carefully. If you are not completely satisfied, simply return it within 30 days for a complete refund (without claim), no questions asked.

Please Contact Us with any questions, or learn more about applying to GEVBP Group Term Life at www.massbenefits.com if you are ready to get started!

Brokered and Administered by:

Mass Benefits Consultants, Inc.
P.O. Box 828
Annandale, VA 22003-0828
Call Toll-Free: 1-800-221-3083

Underwritten by:

New York Life Insurance Company
51 Madison Avenue
New York, New York 10010
on policy form GMR

This plan summary briefly describes the important features of the plan and is not a contract. Terms and conditions of coverage are set forth in group policy G-29293-0/GMR-FACE issued by New York Life to the Government Employees Voluntary Benefits Trust. Additional information is contained in the Certificate of Insurance issued to persons who become insured under the plan.

New York Life Insurance Company has received the highest possible ratings for financial strength currently awarded to any life insurer from the leading rating services: A.M. Best A++ (Superior), Fitch Ratings (AAA), Moody's Investors Service (Aaa) and Standard and Poors (AA+).*

*Source: Individual Third Party Rating Reports (as of 03/16/2015)



Limited Time Offer

\$50,000 Guaranteed Acceptance Application Form Group Term Life Insurance



Complete this form and return to:

Mass Benefits Consultants, Inc ♦ P.O. Box 828 ♦ Annandale, VA 22003-0828 ♦ Phone: 1-800-221-3083

PLEASE PRINT IN INK OR TYPE ALL ANSWERS AND INITIAL ANY CHANGES

Request for Group Insurance From New York Life Insurance Company 51 Madison Avenue • New York, NY 10010		GROUP POLICY G-29293-0	CERTIFICATE NO. (OFFICE USE ONLY)	
		SOCIAL SECURITY NO.		DATE OF BIRTH MM / DD / YYYY
EMPLOYEE'S FULL NAME		MARITAL STATUS: <input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Domestic Partner <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed Maiden Name _____		
MAILING ADDRESS			SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	
CITY	STATE	ZIP CODE	OFFICE PHONE	
FAX NUMBER	E-MAIL ADDRESS		HOME PHONE	
Are you presently insured by any insurance Plan Administered by Mass Benefits Consultants? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, details:				
OCCUPATIONAL STATUS				
Are you a federal employee actively-at-work full-time (30 or more hours per week)? <input type="checkbox"/> Yes <input type="checkbox"/> No		DATE OF HIRE	AGENCY	
I HEREBY APPLY FOR THE FOLLOWING COVERAGE: To be ELIGIBLE you must be a Federal Employee under age 50, actively working full-time (30 hours per week), residing in the United States or Puerto Rico (excluding ME, OR, & SD) and not currently insured and never been declined for Group Life Insurance coverage underwritten by New York Life Insurance Company.				
<input type="checkbox"/> \$50,000 Group Term Life Insurance				
INSURANCE QUESTION (Must Be Completed)				
Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Residents of New York: I have read the Important Replacement Information on the reverse side. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No				
BENEFICIARY DESIGNATION (If necessary, attach separate signed and dated sheet to provide additional beneficiary information)				
I hereby make the following beneficiary designation with respect to all the insurance on my life under the Group Term Life Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. 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 NAME <input type="checkbox"/> Primary <input type="checkbox"/> Contingent		RELATIONSHIP	BENEFICIARY'S SOCIAL SECURITY #	
BENEFICIARY STREET ADDRESS				
CITY	STATE	ZIP CODE	% OF BENEFITS	
BENEFICIARY NAME <input type="checkbox"/> Primary <input type="checkbox"/> Contingent		RELATIONSHIP	BENEFICIARY'S SOCIAL SECURITY #	
BENEFICIARY STREET ADDRESS				
CITY	STATE	ZIP CODE	% OF BENEFITS	

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Application continued – see following page

G-29293-0
50KGA 0615 (WEB)
Page 1

Complete all questions on the application form, sign and date page 2 and return it to the GEVBP Plan administrator at the address listed on the reverse side.

IMPORTANT REPLACEMENT INFORMATION RESIDENTS OF NEW YORK

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 a 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 you decide whether the replacement is in your best interest.

FRAUD NOTICE – For Residents of all states except those listed below and New York: 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 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.

RESIDENTS OF AR/LA/MD/RI: 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 CA:** 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer. **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 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 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.

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.

I request the group insurance shown on page 1. 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 insurance will become effective on the first of the month following receipt of this application provided (a) the application is received by the Plan Administrator within the "limited time offer" period; (b) the initial contribution is paid; and (c) I am a federal employee actively working full-time (at least 30 hours per week) on the day insurance would become effective.

By signing and dating this application, I **request** the insurance indicated; **attest** to having read the Fraud Notices, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Signature _____ **Date** _____

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Once completed and dated, this form should be submitted at once to the GEVBP Plan Administrator: Page 2
Mass Benefits Consultants, Inc ♦ P.O. Box 828 ♦ Annandale, VA 22003-0828 ♦ Phone: 1-800-221-3083

Residents of Puerto Rico should mail applications to:
Global Insurance Agency ♦ P.O. Box 9023918 ♦ San Juan, Puerto Rico 00902-3918