GEVBT Supplemental Hospital Indemnity Insurance Plan
SHIP Enrollment Form ♦ Guaranteed Acceptance

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
P.O. Box 828, Annandale, VA 22003-0828
Questions? Call Toll Free: **800-221-3083**

EMPLOYEE INFORMATION [PRINT IN INK OR TYPE ALL ANSWERS & INITIAL ANY CHANGES]

MEMBER'S / EMPLOYEE'S FULL NAME (Last, First, MI)		SOCIAL SECURITY NO.	GROUP POLICY **G-29162-0**
ADDRESS (Name & Number)			DATE OF BIRTH
CITY	STATE	ZIP CODE	OFFICE PHONE
FAX NUMBER	E-MAIL ADDRESS		HOME PHONE

MARITAL STATUS: ❐ Single ❐ Married ❐Divorced ❐Domestic Partner* ❐ Civil Union* *Eligibility is determined by State Law

Maiden Name_________________

FEDERAL AGENCY NAME
❐ VAEA ❐ USDA/ESRA ❐ UPMA ❐ Other ___________________

Are you currently enrolled in the Federal Employee Health Benefit Plan (FEHB): ❐ Yes ❐ No

Do you or your spouse intend to reside outside the U.S. or Canada in the next 12 Months? ❐ Yes ❐ No

EMPLOYEE: If Yes, Country ______________________How Long?________ **SPOUSE**: If Yes, Country _____________________How Long?_________

Payment Options: (*Choose Only One*)

❐ **Bi-Weekly Direct Deposit** (The Direct Deposit form is available on our website: www.massbenefits.com or call 1-800-221-3083

❐ **Monthly Check Service** (Contact the SHIP Administrator or visit our website for the monthly cost. Complete the form below)

❐ **Direct Bill** (*Choose one of the following*) ___Quarterly ____Semi-Annual ____Annual

DEPENDENT INFORMATION: IF DEPENDENT COVERAGE IS REQUIRED, LIST ELIGIBLE DEPENDENTS

Lawful spouse and unmarried dependent children (natural child, stepchild and adopted child) to age 26 *If more than 4 children, please list on separate sheet*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.		DATE OF BIRTH		❐ MALE ❐ FEMALE
Child (Name) 1.	Date of Birth / /	❐ MALE ❐ FEMALE	Child (Name) 3.	Date of Birth / /	❐ MALE ❐ FEMALE
Child (Name) 2.	Date of Birth / /	❐ MALE ❐ FEMALE	Child (Name) 4.	Date of Birth / /	❐ MALE ❐ FEMALE

INSURANCE REQUESTED: ***Check Appropriate Categories*** (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE: ❐ New Coverage ❐ Change in Coverage

INDICATE WHO IS TO BE COVERED: ❐ Member Only ❐ Member plus 1 dependent ❐ Member plus 2 or more dependents

SELECT THE DAILY PLAN YOU DESIRE: ❐ **Red** ❐ **White** ❐ **Blue*** *Blue Plan not available to residents of NY

I understand that insurance will not be effective until the acceptance of my enrollment form and receipt of the initial premium as indicated in the brochure. I further understand that any injury or sickness for which I, or any insured dependents, incurred charges, received medical treatment, consulted a physician or took prescribed drugs within the 12 (6 in FL, IN, NY) months prior to the effective date of coverage until after: 12 (6 in MS) consecutive months lapsing while insured and during which no treatment, care or advice was received for that condition; or if earlier 24 (12 in MT, NY & NC) consecutive months of coverage under the plan.

By signing and dating this enrollment form, the member **requests** the insurance indicated; and **attests** to having read the Fraud Notices indicated on the reverse side; and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

I HEREBY ATTEST THAT I AM PURCHASING THIS POLICY AS A SUPPLEMENT TO MY HEALTH COVERAGE, WHICH MEETS THE FEDERAL REQUIREMENTS OF MINIMUM ESSENTIAL COVERAGE.

Employee Signature ____ **Date** ______________________

Application continued on reverse side

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Fraud Notices ***For Residents of all states <u>except</u> those listed below:*** 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 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 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. **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 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. **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:** 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.

Request for Preauthorized Check

GEVBT Plan Administrator is hereby requested and authorized to present checks drawn on my checking account number ______________________________________ beginning on or about the 10th day of ___________ 20____ and on or about the same day of each month thereafter until this authorization is revoked. I understand that all advance premiums will be refunded to me if my coverage is not issued and that the effective date of my insurance will be the date stated on my certificate.
(NOTE your signature below the bank authorization portion will also apply to the above authorization)

IMPORTANT: Be sure to include a voided check for your bank checking account with this authorization
Print the Name and Address of your bank

Bank___________________________________Address____

AUTHORIZATION TO HONOR CHECKS DRAWN IN THE NAME OF GEVBT PLAN ADMINISTRATOR
As a convenience to me, the undersigned, I hereby request and authorize you to pay and charge to my account checks drawn on my account in the name of GEVBT Plan Administrator. This authorization will remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring such check.

I agree that your treatment of each check and your rights with respect to it shall be the same as if it were signed personally by me. I further agree that if any such check is dishonored, whether with our without cause, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

GEVBT Plan Administrator is instructed to forward this authorization to you:

X____ ___________ ___________________________ ___________________
SIGNATURE OF BANK DEPOSITOR – AS SHOWN ON BANK RECORDS ACCOUNT TO WHICH THIS AUTHORIZATION IS APPLICABLE | DATE | CHECKING ACCOUNT NUMBER | TRANSIT NUMBER

____ ____
PRINTED NAME OF DEPOSITOR | NAME OF BANK AND BRANCH NAME (IF ANY)