GEVBT (GEVBP) GROUP AD&D INSURANCE ENROLLMENT FORM

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
Toll Free: 800-221-3083

EMPLOYEE INFORMATION [PRINT IN INK OR TYPE ALL ANSWERS] **Group Policy: G-29293-1 Certificate No._____**

Last Name _____ First _____ Initial _____ Social Security Number _____

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

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

Date of Birth ____/____/_____ *(mm/dd/yyyy)* Sex: ❒ Male ❒ Female

Marital Status: ❒ Married ❒ Divorced ❒ Domestic Partner*(Submit a completed Declaration of Domestic Partnership Form – Not Applicable in Oregon)
Maiden Name_____ ❒ Single ❒ Civil Union* *Eligibility is determined by State Law

I am an *(check one)* ❒ Active ❒ Retired employee of the Federal Government. Agency Name:_____

If Active, are you actively performing the duties of your position on a full time basis (30 or more hours per week)? ❒Yes ❒ No

Are you presently insured by any insurance Plan Administered by Mass Benefits Consultants? ❒Yes ❒ No If yes, details: _____

Do you intend to reside outside the U.S. or Canada in the next 12 months? Employee: ❒ Yes ❒ No Spouse: ❒ Yes ❒ No

Employee: If yes, Country _____ How Long?_____ **Spouse:** If yes, Country _____ How Long?_____

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.*

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

I HEREBY APPLY FOR THE FOLLOWING GROUP AD&D COVERAGE(S): NOTE: If you are increasing or altering present coverage in any way, indicate the Total Amount of Coverage, not just the increased amount ❒ New Coverage ❒ Additional Coverage

COVERAGE AMOUNT: *(choose only one):* ❒ $50,000* ❒ $100,000 **Maximum Coverage Amount for Retired Members*

PLAN *(choose only one):* ❒ Member ❒ Member & Spouse ❒ Member, Spouse & Child(ren) ❒ Member & Child(ren)

BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group AD&D 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. *(Attach a separate sheet if necessary)*

Beneficiary's Name:	Complete Address	Relationship	Social Security #	%
Beneficiary's Name:	Complete Address	Relationship	Social Security #	%

I understand that insurance will not be effective until the first day of the month on or following acceptance of my enrollment form and receipt of the initial premium. If a person is hospitalized on the date insurance is to take effect, such insurance will take effect after the date of discharge.

By signing and dating this enrollment form, the member **requests** the insurance indicated; the member and any person proposed for insurance attest to having read the Fraud Notices indicated on the reverse side; and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete

Employee Signature X _____
(PLEASE SIGN AND DATE IN INK) DATE

G-29293-1

Fraud Notices

Please read before signing the enrollment form

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.

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 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.

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Questions? Call Toll Free: (800) 221-3083

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

- ❑ **DID YOU SIGN THE APPLICATION IN ALL REQUIRED PLACES?**
  - o EMPLOYEE SIGNATURE
  - o SPOUSE SIGNATURE (IF APPLICABLE)
  - o ANY CORRECTIONS TO THE APPLICATION MUST BE INITIALED BY EMPLOYEE
- ❑ **HAVE ALL QUESTIONS BEEN ANSWERED?**

Return the completed enrollment form to the GEVBP Plan Administrator:

Mass Benefits Consultants, Inc.
P.O. Box 828
Annandale, VA 22003-0828

Residents of Puerto Rico should mail applications to:

Global Insurance Agency
P.O. Box 9023918
San Juan, Puerto Rico 00902-3918