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

Sponsored by: NEW YORK COUNCIL 66 WORKING CLASS HEROES

Administered by: PEARL® INSURANCE

Group Comprehensive Accident Insurance Plan

Please use blue or black ink only. Do not use gel pens, correction fluids, or tape. All fields are required and initial any corrections.

1. MEMBER INFORMATION

Last Name	First Name	Initial	Social Security #

Home Address	City	State/Province	Zip Code

Email Address	Date of Birth *(mm/dd/yyyy)*	Sex ☐ Male ☐ Female	Are you presently working? ☐ Yes ☐ No

2. SPOUSE INFORMATION

Last Name	First Name	Initial	Date of Birth *(mm/dd/yyyy)*	Sex ☐ Male ☐ Female

Home Address (☐ *Same as Member*)	City	State/Province	Zip Code

3. I HEREBY APPLY FOR THE FOLLOWING COVERAGE PLAN *(Choose only one.)*

☐ **Coverage for Member Only**

Plan Benefit Amounts Combined:
$100 Accidental Hospital Indemnity Daily Benefit
$50 Emergency Room Benefit
$1,000 Accident Only Disability Monthly Benefit
$100,000 Accidental Death Lump Sum Benefit
$9.09 per bi-weekly paycheck

☐ **Coverage for Member and Spouse**

Plan Benefit Amounts Combined:
$100 Accidental Hospital Indemnity Daily Benefit
$50 Emergency Room Benefit
$1,000 Accident Only Disability Monthly Benefit
$100,000 Accidental Death Lump Sum Benefit
$18.18 per bi-weekly paycheck

BENEFICIARY: Unless otherwise requested, your spouse, if living will be the beneficiary of your Accidental Death benefit, otherwise, the death benefit will be paid to your surviving relative(s) in the following order of survival: spouse, children equally, parents equally, brother or sisters equally, or your estate.

4. PAYMENT OPTION SELECTED *(Choose only one.)*

☐ **Option 1 (Periodic Billing):** ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ **Option 2 (Payroll Allotment):** ☐ Bi-weekly Payroll Allotment

I hereby authorize the necessary salary deductions for the premium once approved for coverage, to pay for insurance for the Comprehensive Accident Insurance Plan. This authority is to remain in effect until it is cancelled by written notice to the Plan Administrator.

I UNDERSTAND THAT THIS IS ACCIDENT-ONLY INSURANCE. IT DOES NOT PROVIDE COVERAGE FOR SICKNESS. 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.

READ AND SIGN:

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **attest** to having read the Fraud Notice on the back of this page, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature *(Required - Please sign and date in ink.)*	Date *(mm/dd/yyyy)*

Spouse's Signature	Date *(mm/dd/yyyy)*

FRAUD NOTICE – 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.

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