



Request for Group Insurance from
New York Life Insurance Company
51 Madison Avenue
New York, NY 10010
The Company You Keep®

Sponsored by:



Administered by:



Group Disability Income Insurance Plan Guaranteed Issue Application

1. MEMBER NAME AND INFORMATION:

LAST: _____ FIRST: _____ MIDDLE: _____ SEX: MALE FEMALE
 ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____
 SSN: _____ CELL PHONE#: (____) _____ WORK PHONE#: (____) _____
 EMAIL: _____ DATE OF BIRTH: ____/____/____
MM DD YYYY

2. MEMBER AFFILIATION / OCCUPATION:

- A. Are you now a member of Council 66? YES NO
- B. Work address: _____ Date employed? _____
- C. Are you presently performing all the duties of your occupation according to your regular schedule? YES NO
- D. Are you solely engaged in office or clerical work? YES NO
- E. What is your annual salary? \$ _____
- F. Describe your occupation/duties: _____

3. INSURANCE REQUESTED:

I hereby apply for the coverage indicated below based upon all my statements made in this application.
You may choose any Monthly Benefit from \$300 to \$1,200 per month (\$1,500 per month for clerical workers) provided it does not exceed the benefit amount based on your current salary.

- A. Monthly Benefit: \$ _____
- B. Waiting Period in Days: 0 Accident/7 Sickness 30 Accident/30 Sickness
- C. Maximum Benefit Period: 6 Months
- D. Optional Accidental Death and Dismemberment Benefit: \$10,000 \$30,000 \$50,000 \$100,000
- E. Optional Spouse Accident Disability Only Coverage: \$500 Monthly Benefit \$1,000 Monthly Benefit
 (maximum 6 month benefit duration) Spouse Name: _____ Spouse DOB: _____

BENEFICIARY DESIGNATION: Unless otherwise requested, your spouse, if living will be the beneficiary of your AD&D 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, brothers or sisters equally, or your estate.

By signing and dating this application, the member **requests** the insurance indicated; and the member **attests** to having read the Fraud Notice indicated below and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

I understand that benefits will not be payable for any condition for which medical advice was given, or treatment was recommended by or received from a physician during the 6 month period before my effective date, until my coverage has been continuously in force for 12 months.

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 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.

Signature of Member: X _____ Date: _____

PLEASE SIGN AND DATE IN INK

11628-Basic

Assuming the Hospital & Home Care Recovery (HHCR) Group Policy remains in effect, a new retiree would be eligible to automatically become insured for the HHCR Guaranteed Issue benefit. The HHCR Group Policy will include a 10% rate discount and a waiver of the Preexisting Condition provision.

Do you wish to automatically enroll for the HHCR plan provided the HHCR Group Policy remains in effect? Yes No

10/16 ed

AGENT#	SOURCE CODE:	APP #:	APPROVED BY:
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