

# GEVBT 10-Year Level Term GROUP LIFE ENROLLMENT FORM



**Complete this form and return to:**  
 Mass Benefits Consultants, Inc.  
 P.O. Box 828  
 Annandale, VA 22003



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

**PLEASE PRINT IN INK OR TYPE ALL ANSWERS**

GROUP POLICY: **G-29164-0**

## 1. MEMBER INFORMATION

Last Name		First	Initial	Social Security No.		Certificate Number	
<b>BILLING ADDRESS</b> Street						Height	Weight
						____ft. ____in.	____ lbs.
City			State/Province		Zip Code	Date of Birth	<input type="checkbox"/> Male
						____/____/____	<input type="checkbox"/> Female
<b>HOME ADDRESS</b> Street						Marital Status	
						____ Married ____ Divorced ____ Single	
City			State/Province		Zip Code	Date of Marriage:	
						____/____/____	
Home Phone Number			Office Phone Number		Fax Number	Maiden Name:	

**SEND CORRESPONDENCE TO:** \_\_\_\_\_ Home Address \_\_\_\_\_ Billing Address

I am an Employee of the U.S. Department of Agriculture \_\_\_\_\_  
 Date of Employment: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Home Email Address: \_\_\_\_\_ Work Email Address: \_\_\_\_\_  
 Are you presently insured by any Government Employee Voluntary Benefits Trust (GEVBT) plan? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 If yes, provide details. \_\_\_\_\_

In the past two years, has any person proposed for insurance traveled or resided outside the U.S. or Canada for more than six weeks per year or intend to do so within the next 12 months?

Member:  No  Yes - Country \_\_\_\_\_  
 Spouse:  No  Yes - Country \_\_\_\_\_

## 2. PAYMENT OPTION SELECTION:

**PERIODIC BILLING:** *Choose only one*

Quarterly  Semi-Annual  Annual

## 3. DEPENDENT INFORMATION:

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under 19 or 23 if full time student).  
 Attach a separate sheet to provide additional dependent information.

Spouse's Full Name (First, Last, Middle Initial)	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
	____/____/____		____ft. ____in.	____ lbs.
Child's Full Name	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
	____/____/____		____ft. ____in.	____ lbs.
Child's Full Name	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
	____/____/____		____ft. ____in.	____ lbs.
Child's Full Name	Date of Birth	<input type="checkbox"/> Male <input type="checkbox"/> Female	Height	Weight
	____/____/____		____ft. ____in.	____ lbs.

## 4. INSURANCE REQUESTED: (Refer to the brochure for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S):  New  Additional

**NOTE:** If you are increasing or altering present coverage in any way, do not indicate on line (a) below just the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

### Group Life Insurance:

a) Total Member Amount Desired \$ \_\_\_\_\_  
 (from \$100,000 to \$1,000,000 in \$10,000 increments)

b) Total Spouse Amount\* Desired \$ \_\_\_\_\_  
 (from \$100,000 to \$1,000,000 in \$10,000 increments)  
 \*Spouse coverage cannot exceed member coverage

c) Total Child Amount Desired \$ \_\_\_\_\_  
 (\$3,000 per child)

#### 4. INSURANCE REQUESTED: *Continued.*

d) Have you or your spouse (if applying for coverage) used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 months?

Member \_\_\_ Yes \_\_\_ No Spouse \_\_\_ Yes \_\_\_ No

If yes, when did you last use tobacco or nicotine products?

Member \_\_\_\_\_ Mo/Yr Spouse \_\_\_\_\_ Mo/Yr

e) Financial Data: Member: Annual Earned Income: \$ \_\_\_\_\_ Spouse: Annual Earned Income: \$ \_\_\_\_\_

Member: Net worth: \$ \_\_\_\_\_ Spouse: Net Worth: \$ \_\_\_\_\_

f) Present occupation and duties: Member: \_\_\_\_\_

Spouse: \_\_\_\_\_

#### g) Insurance Replacement

##### RESIDENTS OF NEW YORK:

I have read the Important Replacement Information below. Is the Life Insurance applied for intended to replace in whole or in any part of an existing insurance or annuity?

Member \_\_\_ Yes \_\_\_ No Spouse \_\_\_ Yes \_\_\_ No

##### RESIDENTS OF ALL OTHER STATES

Is the Insurance applied for intended to replace, discontinue or change an existing policy?

Member \_\_\_ Yes \_\_\_ No Spouse \_\_\_ Yes \_\_\_ No

#### 5. BENEFICIARY DESIGNATION :

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life 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. *(If you wish to name a different beneficiary for spouse coverage, contact the administrator.)* 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 1:	Last	First	Middle Initial	Relationship
Beneficiary Address:	Street	City	State/Province	Zip Code
				Social Security No.
Beneficiary Name 2:	Last	First	Middle Initial	Relationship
Beneficiary Address:	Street	City	State/Province	Zip Code
				Social Security No.

#### 6. STATEMENT OF HEALTH:

(Please initial any changes you make on this form.) To the best of your knowledge and belief answer the following questions as they apply to you and all dependents to be insured.

1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 25 or more hours per week at your usual place of business? **YES** **NO**
2. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? **YES** **NO**

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*Continued. . .*

GMA-PRS1

##### **For NY Residents Only—Important Replacement Information**

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 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.

**6. STATEMENT OF HEALTH:** *Continued. . .*

	YES	NO		YES	NO
3. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	(ii) Any other disorder of the immune system?	<input type="checkbox"/>	<input type="checkbox"/>
4. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>	(iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue?	<input type="checkbox"/>	<input type="checkbox"/>
5. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>	(iv) Any other impairment ?	<input type="checkbox"/>	<input type="checkbox"/>
6. Is any person to be insured now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	8. Has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuromuscular or mental illness?	<input type="checkbox"/>	<input type="checkbox"/>
7. During the past five years has any person to be insured ever been medically diagnosed by a physician as having or been treated for:			<i>Genetic /family history question not applicable to Maryland residents</i>		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>	9. Within the past two years have you or your spouse participated in, or do either of you plan to participate in: aircraft flying other than as passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	<input type="checkbox"/>	<input type="checkbox"/>
b. Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>	10. Driver's License No.:		
c. Fainting spells, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	Member _____		
d. Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>	Spouse _____		
e. Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>	State in which issued:		
f. Disorder of breast or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>	Member _____		
g. Nervous or mental disorder, emotional condition or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>	Spouse _____		
h. Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>	Have you or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years?	<input type="checkbox"/>	<input type="checkbox"/>
i. Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>	11. In the last 15 years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	<input type="checkbox"/>	<input type="checkbox"/>
j. Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>			
k. Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
l. Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>			
m. Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>			
n. Other Health or physical impairment including:					
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex?	<input type="checkbox"/>	<input type="checkbox"/>			

**If you have answered Question 1 "No" or any other Questions "Yes" give complete details below.**

*(Attach a separate sheet if necessary, then sign and date it).*

Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated

**I request** the group insurance shown above. 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 New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy.

**I understand** that: (a) insurance will become effective on the first day of the month on or following the date approved by New York Life if I and any approved dependents are alive on that date and the initial contribution is paid within 31 days after the date I am billed, and (b) any dividend appoyoned to the group policy will be paid to the Group Policyholder.

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.

**FOR 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.

**FOR RESIDENTS OF D.C.**, the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by 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 LA** 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 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 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 authorize** disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE which describes how New York Life underwrites this request for coverage, including how information is exchanged with MIB (Medical Information Bureau).

**AUTHORIZATION**: I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or the MIB to release information to New York Life, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. MIB and other insurance companies may also furnish to New York Life, its subsidiaries or the plan administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). New York Life may release information covered by this AUTHORIZATION to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Administrator in writing at the address given on this form. My revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I or my authorized agent may request a copy of this signed AUTHORIZATION.

Member Signature **X** \_\_\_\_\_  
 (PLEASE SIGN AND DATE IN INK) DATE

**To the best of my knowledge and belief, the statements made regarding my health are true and complete.**

Spouse's Signature **X** \_\_\_\_\_ (Necessary only if spouse coverage is requested)  
 (PLEASE SIGN AND DATE IN INK) DATE

**Owner Information (required if owner is other than member)**

Last Name	First	Initial	Social Security No.	Relationship to Proposed Insured
<b>MAILING ADDRESS</b> Street				Tax ID Number:
City	State/Province		Zip Code	Date of Birth <input type="checkbox"/> Male ____/____/____ <input type="checkbox"/> Female
Signature			Date	Daytime Phone