REQUEST FOR GROUP TERM LIFE INSURANCE

4S

FROM NEW YORK LIFE INSURANCE COMPANY

51 Madison Avenue, New York, NY 10010

Please complete this form online, print and mail to:

Forrest T. Jones & Company, Inc., PO Box 418131, Kansas City, MO 64141-9131

PLEASE PROVIDE PERSONAL INFORMATION

I enclose my check for $_____ for ☐ quarterly ☐ semiannual ☐ annual contribution.
(Make check payable to Forrest T. Jones & Company, Inc.)

Name _____ Social Security No. _____

Address (Street) _____ Telephone No. _____

City _____ Country _____ State _____ ZIP _____

☐ Married ☐ Single Number of children at home_____

I am now a member of _____

PLEASE INDICATE COVERAGE DESIRED

1. INSURANCE REQUESTED (Refer to information for eligibility, amounts of insurance and coverage description.) Please note that receipt of accelerated death benefits may affect eligibility for public assistance programs. (Residents of MA are not eligible for Accelerated Death Benefit.)

a. For Members not currently insured:
I request group term insurance in the initial coverage amount of:
$_____ for Myself $_____ for my Spouse $_____ for my eligible Child(ren)

b. For Members currently insured:
I wish to increase coverage amounts of insurance as follows: from $_____ to _____ for Myself
from $_____ to _____ for my Spouse
from $_____ to _____ for my Child(ren)

I wish to *add* dependent coverage as follows: for my Spouse, in the initial amount of $_____
for my Child(ren), in the initial amount of $_____

2. a. **RESIDENTS OF NY:** I have read the Important Replacement Information that accompanied this application.
Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? ☐Yes ☐No

b. **RESIDENTS OF ALL OTHER STATES:**
Is the insurance applied for intended to replace, discontinue or change an existing policy? ☐Yes ☐No

3. MEMBER/SPOUSE BENEFICIARY DESIGNATION

I hereby make the following beneficiary designation (insert name, relationship, Social Security No., address) with respect to all the insurance on my life, and if I am already covered under the Group Life Insurance Plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent child coverage shall be the insured member as provided in the group policy.

Member's Beneficiary _____
(To be completed by Member) Name Relationship Social Security No.

Spouse's Beneficiary _____
(To be completed by Spouse) Name Relationship Social Security No.

PLEASE ANSWER ALL QUESTIONS

4. STATEMENT OF HEALTH

	Name of Proposed Insureds	Age	Sex	Birth Date	Height	Weight	Birthplace
Myself							
Spouse							
Child							
Child							
Child							

(If more than three children, attach a separate sheet.)

a. Are you now disabled or eligible for any disability benefits, workers' compensation benefits or waiver of premium for life or health insurance?..... ☐Yes ☐No

b. Is any person proposed for insurance now ill, taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? ..... ☐Yes ☐No

c. During the past ten years has any person proposed for insurance ever had: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, tuberculosis, liver disorder (including hepatitis), asthma or emphysema, enlarged lymph nodes or immunodeficiency disorder, albumin, blood or sugar in urine, back trouble/ disorder, unexplained weight loss, or any other illness, disease or injury? ..... ☐Yes ☐No

d. During the past five years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs? ..... ☐Yes ☐No

e. During the past five years has any person proposed for insurance had any illness, disease or injury, consulted any physician, chiropractor, medical care practitioner other than for a routine physical examination or checkup, or been confined or treated in any hospital, rest home or similar institution? ..... ☐Yes ☐No

f. If consultation with a physician was for a routine or annual examination or checkup, were there any symptoms or adverse findings? ..... ☐Yes ☐No

g. In the past 24 months have you or any person proposed for insurance used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum? ..... Member Yes No Spouse ☐Yes ☐No

Please complete the second page.

IF ANY QUESTIONS IN ITEMS 4A THROUGH 4G ARE ANSWERED "YES" GIVE FULL DETAILS BELOW. Please provide specific information. Avoid the use of terms such as "etc.," "various" and "miscellaneous". If you need more space, attach a separate sheet.

Question	Person to whom it applies	Names and addresses of physicians and hospitals (if any)	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results.

PLEASE BE SURE TO SIGN AND DATE BELOW

I HEREBY REQUEST the group insurance indicated on the reverse side. I understand that insurance will become effective on the first of the month on or immediately following the day this request is approved by New York Life, provided the initial contribution is paid within 31 days after such date and, on the day coverage would otherwise take effect, I and any approved dependents are alive, not confined in a hospital or other medical institution, and not incapacitated so as to be unable to perform all normal daily activities. I understand that any person who is confined or incapacitated will not become insured until the day he or she is no longer so confined or incapacitated, provided such date is within three months of the date insurance would have been effective and the person is still eligible for insurance. I understand that any dividend apportioned to the group policy will be paid to the Trustee for the Trust for Insuring Educators for the benefit of the insureds.

TO THE BEST OF MY KNOWLEDGE AND BELIEF, I am eligible for insurance and the statements I have made are true and complete. I understand that New York Life may: (a) require more information and a medical exam; and (b) invalidate coverage if it finds that I am not eligible or have not answered any of the above questions truthfully and completely. I declare (certify if I am a VA resident) that I have read (or had read to me) this completed application and understand that any false statement or misrepresentation may result in loss of coverage under the group policy. In order to determine insurability, I ask New York Life to rely on all statements made on this form, and any supplements to it, and I authorize disclosure of the types of information detailed in the AUTHORIZATION below. I have read the IMPORTANT NOTICE which describes how New York Life underwrites this request.

Member's Signature: _____ Date_____
(Please sign in ink)
To the best of my knowledge and belief, the statements made regarding my health are true and complete.

Spouse's Signature: _____ Date_____

Signature of Owner: _____Date _____
(necessary only if member previously transferred ownership of his/her group term life insurance)

Form GPA-L39
G-6300-0 7/00 ed

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical or medically related facility, insurance company or MIB to release information to New York Life Insurance Company, its subsidiaries or the plan administrator, about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment. MIB and other insurance companies may also furnish New York Life, its subsidiaries or the plan administrator with nonmedical 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 and its subsidiaries may release to the plan administrator, MIB, other insurance companies and to others whom I authorize in writing, information covered by this AUTHORIZATION. However, this will not be done in connection with information relating to the Acquired Immune Deficiency Syndrome (AIDS) virus. This AUTHORIZATION may be used for a period of 24 months from either the date signed above or the effective date of coverage, whichever is later. A photocopy of this request form shall be as valid as the original. I know that I or my authorized agent may request a copy of this AUTHORIZATION. Premium payment for Insurance does not mean there is any coverage in force before the effective date as specified by New York Life. **For Residents of AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH and PA** 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 subjects such person to criminal and civil penalties. **CO Residents**, 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. **DC Residents**, the following also applies: An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant. **For 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.

The Master Policy is Held by the Trust for Insuring Educators
Administered by: Forrest T. Jones & Co., Inc., 3130 Broadway, Kansas City, Missouri 64111.

Print

Print on 8.5 x 14 paper