The Company You Keep®

Request for Group Insurance from
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue, New York, NY 10010

Complete this form and send to:
GEBA
P.O. Box 206
Annapolis Junction, MD 20701-0206

GEBA
GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION

Long Term Disability Insurance Enrollment Form

General Information:

Applicant's Name (First, MI, Last):			Social Security No.:		Gender ☐Male ☐Female
Marital Status: ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow/Widower ☐ Single ☐ Separated					
Street Address:			Date of Birth (mm/dd/yyyy):		Home Email Address:
City:	State:	Zip:	Home Phone No.:	Work Phone No.:	Cell Phone No:

By providing your email address to us, you expressly consent to receive emails from us. We may use email to communicate with you, to send information that you have requested, or to send information about other products or services developed or provided by us. We will not give your email address to another party to promote their products or services directly to you.

Type of Member:

☐ Active Employee	Hire Date:	Agency:
☐ Military	Hire Date:	Services:
☐ Contractor (Assigned to NSA-W)	Assignment Date:	Company:

How Did You Hear About GEBA's Long Term Disability Insurance Plan?

☐ Advertisement	☐ Brochure	☐ Information Table	☐ Agency Website
☐ Agency Announcement	☐ Email/Mailing	☐ Member Services Representative	☐ Seminar
☐ Briefing	☐ GEBA Website	☐ New Hire Orientation	☐ Word of Mouth

At GEBA, there are no membership fees required to be a member. After enrolling into at least one of GEBA's insurance or investment plans, you are considered a GEBA member. Continuing to pay your premium for at least one plan allows you to remain a GEBA member in good standing.

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Group Long Term Disability Application

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Complete this form and send to:
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Annapolis Junction, MD 20701-0206

GEBA GOVERNMENT EMPLOYEES' BENEFIT ASSOCIATION

A. General Information:

First Name	MI	Last Name	Occupation

Street Address	City:

State:	Zip Code:	Social Security Number	Email Address	Home Phone Number

Daytime Telephone	Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Height:	Weight:

Spouse/Domestic Partner Information (if applying)**:**

First Name	MI	Last Name	Occupation

Social Security Number	Date of Birth (mm/dd/yyyy)	Sex ☐ Male ☐ Female	Height:	Weight:

Daytime Phone Number	Home Phone Number

B. Coverage Requested:

	Self	Spouse/Domestic Partner
Monthly Benefit Amount**:	☐ $_____	☐ $_____
Waiting Period: *(Please see rate tables for benefit availability)*	☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days	☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ 180 Days ☐ 365 Days
☐ Change in Coverage	Member New Benefit Amount $_____	Spouse/Domestic Partner New Benefit Amount $_____

*** The Monthly Benefit Amount cannot exceed $7,500 or 67% of your gross monthly salary, whichever is less.*

	Self	Spouse/Domestic Partner
1. Have you been actively engaged in the full-time duties (at least 30 hours per week) of your occupation for the 90-day period immediately before the date of this application?	☐ Yes ☐ No	☐ Yes ☐ No
2. Does anyone proposed for coverage have any Disability Income Insurance in force or pending in this (New York Life) or any other company? If yes, give detail.	☐ Yes ☐ No	☐ Yes ☐ No
3. Is the Monthly Benefit Amount herein applied for equal to or less than 67% of your Basic Monthly Pay minus any Other Income Benefits?	☐ Yes ☐ No	☐ Yes ☐ No

Please fill out if answered yes to #2:

Name	Company	Monthly Benefit	Benefit Period	To Be Replaced?
		$_____		☐ Yes ☐ No

C. STATEMENT OF HEALTH: Complete This Section When Applying for a Monthly Benefit of $4,000 or LESS

To the best of your knowledge and belief, answer the following questions as they apply to you and your lawful spouse/domestic partner (if applying for coverage). [For CA Residents: California law prohibits an HIV test from being required or used by health insurance companies for obtaining health insurance coverage]

	Self	Spouse/Domestic Partner
1. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No
2. During the past five years has any person to be insured ever been medically diagnosed by a physician as having or been treated for: heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?	☐ Yes ☐ No	☐ Yes ☐ No
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
4. Is any person to be insured now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
5. Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐ Yes ☐ No	☐ Yes ☐ No

All applicants MUST provide their signature in Section F, Authorization.

D. STATEMENT OF HEALTH: Complete This Section When Applying for a Monthly Benefit of $4,001 or MORE

To the best of your knowledge and belief, answer the following questions as they apply to you and your lawful spouse/domestic partner (if applying for coverage). [For CA Residents: California law prohibits an HIV test from being required or used by health insurance companies for obtaining health insurance coverage]

	Self	Spouse/Domestic Partner
1. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No
2. During the past five years, has any person to be insured ever been medically diagnosed by a physician or other medical care practitioner as having or been treated for: a) heart or circulatory trouble, elevated blood pressure, chest pain or pressure, gynecological or genitourinary disorders, disorder of breast or reproductive organs or functions, ulcers or digestive disorders, cancer, tumor or cyst, diabetes, mental or nervous disorder, emotional conditions, psychiatric care or psychotherapeutic treatment, fainting spells, convulsions or epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood, pus or sugar in urine, back trouble/disorder, arthritis, bone or joint disorder, varicose veins, hemorrhoids or hernia, disorder of eyes, ears, nose or sinuses, unexplained weight loss or accidental injury? b) Other Health or physical impairment including: (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? (iii) Any other impairment?	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No	☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No
3. During the past five years has any person to be insured ever been counseled, treated or hospitalized for the use of alcohol or drugs?	☐ Yes ☐ No	☐ Yes ☐ No
4. Is any person to be insured now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
5. Is any person to be insured now disabled, or applied or applying for, or receiving any disability or Workers' Compensation benefits or on waiver of premium for life or health insurance?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the past two years, has any person to be insured participated in, or does any person plan to participate in: aircraft flying other than as passenger, scuba diving, ultra-light flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding,	☐ Yes ☐ No	☐ Yes ☐ No

parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?		
7. **Except for the residents of Minnesota and Connecticut,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	☐ Yes ☐ No	☐ Yes ☐ No
8. **For residents of Minnesota and Connecticut only,** has any person to be insured been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	☐ Yes ☐ No	☐ Yes ☐ No
9. Driver's License No.: Member _____Spouse/Domestic Partner_____ State in which issued: Member _____Spouse/Domestic Partner_____ During the past five years, has any person to be insured had his or her driver's license suspended, or revoked, or had any moving violations?	☐ Yes ☐ No	☐ Yes ☐ No

If You Answered Yes to Any of the Above Questions, Please Explain the Details (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:

Remember, no matter how you answer the questions in Sections C andD, you are guaranteed a Monthly Benefit of $1,600 if you apply during the New Hire and Open Enrollment Periods, and you are not currently insured under this Plan.

E. Authorization:

I understand that New York Life Insurance Company 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.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company MIB, Inc. ("MIB"), or other organization, institution or person, that has any records or knowledge of me or my health to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its reinsurers, 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, but excluding psychotherapy notes.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member requests the insurance indicated; and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and attest to having read the enclosed IMPORTANT NOTICE and Fraud Notices which are indicated above, including how our information is exchanged with MIB, and that to the best of our knowledge and belief, the answers provided to the questions are true and complete.

Applicant's Signature:	**Date:**
Spouse/Domestic Partner Signature: (Only if spouse/domestic partner coverage is requested):	**Date:**

Payment Options:

1. ☐ Payroll Deduction (NSA/DIA Only)	
2. ☐ Auto-Debit (Complete necessary portion below)	☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

AUTOMATIC DEBIT PAYMENT REQUEST

AUTO DEBIT PAYMENT FREQUENCY: ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Annually

DEBIT THE ACCOUNT BELOW (Check only one item):	**ACCOUNT INFORMATION (Complete all information below):**	
☐ Checking Account (Enclose a copy or voided check)	Bank Routing Number:	Bank Name:
☐ Savings Account (Complete account information)	Your Account Number:	

I hereby authorize Government Employees' Benefit Association, Inc. (GEBA) to debit my checking/savings account according to the published schedule. I understand that GEBA reserves the right, upon written notification, to terminate my participation in this payment option. If an automatic debit is returned for any reason including insufficient funds, closed or unauthorized account, GEBA will not be able to process payment. I understand that I may be subject to a $20 charge if payment is rejected, reversed, or refused by my financial institution. I may cancel participation in the GEBA Automatic Debit service with written notice 10 days prior to the premium due date.

Beneficiary Designation for Member Coverage

Member is automatically designated as the beneficiary for spousal coverage

First Name	Middle Initial	Last Name	Social Security No.
Address		City	State / Zip Code
Phone No.		Date of Birth	Relationship:

Please Read Everything Below This Line Before Signing

I hereby authorize GEBA to deduct from my wages or salary should I elect payroll allotment (NSA & DIA Employees Only) the amount of insurance premium, if any, required for all coverage requested. Personalize Certificate of Coverage page will be mailed to policy holder upon plan approval. Certificate of Insurance can be viewed, downloaded and printed at www.GEBA.com/forms.

By signing this document, I certify that I am an employee of the agency/employer denoted on page one of this application which entitles me to become a member of GEBA. _____ (Initial Here).

Applicant's Signature:	**Date:**
Spouse/Domestic Partner Signature: (Only if spouse/domestic partner coverage is requested):	**Date:**

FRAUD NOTICES:

For residents of all states <u>except</u> those listed below: 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 AL/AR/LA/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.

RESIDENTS OF CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully 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 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.