GEBA
Government Employees' Benefit Association

Complete this form and send to :
GEBA
1362 Mellon Road, #100, Hanover, MD 21076
For any questions, call (410) 567-8060 or (800) 826-1126
or email geba@geba.com

NEW YORK LIFE

Term Life Insurance Enrollment and Change Form

General Information:

Applicant's Name (First, MI, Last)

Social Security Number

Gender ☐ Male ☐ Female

Marital Status ☐ Married ☐ Domestic Partner ☐ Divorced ☐ Widow/Widower ☐ Single ☐ Separated

Date of Birth (mm/dd/yyyy)

Email Address

Address Line 1

Address Line 2

City

State

Zip Code

Home Phone

Cell Phone

Office Phone

By providing your email, 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 abut other GEBA products or services. We will not give your email address to another party to promote their products or services directly to you.

Type of Member:

☐ Active Employee — Agency/Department/Bureau — Hire Date

☐ Retiree — Agency/Department/Bureau — Retire Date

☐ Military — Branch of Service — Hire Date

☐ Surviving Spouse/Domestic Partner — Deceased GEBA Member Name

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

☐ Advertisement ☐ Brochure ☐ Information Table ☐ NSA Net

☐ Agency Announcement ☐ Email/Mailing ☐ Member Services Representative ☐ Seminar

☐ Briefing ☐ GEBA Website ☐ New Hire Orientation ☐ Word of Mouth

GEBA is a nonprofit, member-governed association dedicated to serving federal employees and retirees, and active and retired military. GEBA never charges a membership fee - membership comes from simply enrolling in any of GEBA's insurance or investment plans.

Group Term Life Application

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

Complete this form and send to:
GEBA
1362 Mellon Road, #100
Hanover, MD 210761

Member Information

First Name | MI | Last Name | Gender ☐ Male ☐ Female

Street Address | City | Apt. | State | Zip Code

Date of Birth (mm/dd/yyyy) | Social Security Number | Height | Weight | Daytime Phone | Evening Phone

Spouse/Domestic Partner information (Complete if applying or changing Spouse/Domestic Partner Coverage)

First Name | MI | Last Name | Gender ☐ Male ☐ Female

☐ Same Address as Member Address | If different, Address | City, State, Zip Code

Date of Birth (mm/dd/yyyy) | Social Security Number | Height | Weight | Daytime Phone | Evening Phone

Dependent Child(ren) Information (Complete if applying for or changing Dependent Child(ren) Coverage)

Add dependent child(ren) to my group insurance coverage.
Reason: ☐ Marriage ☐ Birth of Child ☐ Adoption ☐ Other (Explain)

1

First Name | MI | Last Name

☐ Same Address as Member Address | If different, Address | City, State, Zip Code

Telephone Number | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender ☐ Male ☐ Female | ☐ Disabled[1]

2

First Name | MI | Last Name

☐ Same Address as Member Address | If different, Address | City, State, Zip Code

Telephone Number | Date of Birth (mm/dd/yyyy) | Social Security Number | Gender ☐ Male ☐ Female | ☐ Disabled[1]

[1]***Continued Coverage for a Disabled Child:*** *This applies only to the Dependents Insurance you have for a child. The insurance for the child will not end on the date the age limit in the definition of Qualified Dependent is reached if both of these are true: (1) The child is then mentally or physically incapable of earning a living. New York Life must receive Proof of this within 31 days of their 26th birthday. (2) The child otherwise meets the definition of Qualified Dependent. If these conditions are met, the age limit will not cause the child to stop being a Qualified Dependent. This will apply as long as the child remains disabled. Please complete the "Statement of Dependent Eligibility" available at www.geba.com/forms.*

Applicant Name:

3			
First Name	MI	Last Name	
☐ Same Address as Member Address	If different, Address	City, State, Zip Code	
Telephone Number	Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female ☐ Disabled[1]

4			
First Name	MI	Last Name	
☐ Same Address as Member Address	If different, Address	City, State, Zip Code	
Telephone Number	Date of Birth (mm/dd/yyyy)	Social Security Number	Gender ☐ Male ☐ Female ☐ Disabled[1]

For additional children, attach a separate sheet.

Coverage Request* (Check and Complete all that Apply)

I hereby apply for the following coverage(s)

☐ Apply for **NEW** MEMBER Coverage: ☐ Apply to **INCREASE** MEMBER Coverage to:	☐ $600,000	☐ $400,000	☐ $200,000	☐ $80,000	
	☐ $550,000	☐ $350,000	☐ $150,000	☐ $70,000	
	☐ $500,000	☐ $300,000	☐ $100,000	☐ $60,000	
	☐ $450,000	☐ $250,000	☐ $90,000	☐ $50,000	
☐ Apply for **NEW** SPOUSE Coverage: ☐ Apply to **INCREASE** SPOUSE Coverage to: Cannot exceed the lesser of the member's coverage amount or $300,000.	☐ $300,000	☐ $200,000	☐ 100,000	☐ $80,000	☐ $60,000
	☐ $250,000	☐ $150,000	☐ $90,000	☐ $70,000	☐ $50,000
☐ Apply for **NEW** DEPENDENT Coverage: ☐ Apply to **INCREASE** DEPENDENT Coverage to: (Children are eligible dependents from birth to age 26.)	☐ $20,000				

*Refer to the brochure for eligibility and coverage descriptions.

	Member	Spouse
Do you have other life insurance in force? If "yes" total amount in all companies?	☐ Yes ☐ No $:	☐ Yes ☐ No $:
Do you have other life insurance applications pending? If "Yes" indicate amount and company:	☐ Yes ☐ No $: Company:	☐ Yes ☐ No $: Company:

Applicant Name:

Residents of New York - 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 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 insurance 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 the 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 decide whether the replacement is in your best interest.

RESIDENT OF NEW YORK: I have read the Important Replacement Information above.
Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

RESIDENT OF ALL OTHER STATES:
Is the insurance applied for intended to replace, discontinue, or change an existing policy?

Member ☐ Yes ☐ No Spouse ☐ Yes ☐ No

Statement of Health

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse/domestic partner to be insured. Please answer these questions by checking "Yes" or "No".

Health Questions	Member	Spouse (if applicable)
1. Are you or your spouse disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you or your spouse now ill, or receiving medical attention or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No
3. During the past five years, have you or your spouse 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 any illness, disease or injury?	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you or your spouse taking any kind of medication or so far as you know, in impaired physical or mental health?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you or your spouse now pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:	☐ Yes ☐ No	☐ Yes ☐ No
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐ Yes ☐ No	☐ Yes ☐ No
b. Arthritis, back trouble, bone or joint disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Fainting spells, convulsions or epilepsy?	☐ Yes ☐ No	☐ Yes ☐ No
d. Sugar, blood, albumin or pus in urine?	☐ Yes ☐ No	☐ Yes ☐ No
e. Diabetes, kidney trouble, ulcers or digestive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
f. Disorder of breast or reproductive organs or functions?	☐ Yes ☐ No	☐ Yes ☐ No
g. Nervous or mental disorder, emotional conditions or psychiatric care?	☐ Yes ☐ No	☐ Yes ☐ No
h. Cancer, tumor, or cyst?	☐ Yes ☐ No	☐ Yes ☐ No
i. Varicose veins, hemorrhoids or hernia?	☐ Yes ☐ No	☐ Yes ☐ No
j. Disorder of eyes, ears, nose or sinuses?	☐ Yes ☐ No	☐ Yes ☐ No
k. Thyroid, liver or respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
l. Alcoholism or drug habit?	☐ Yes ☐ No	☐ Yes ☐ No
m. Disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
n. (i). Other health or physical impairment including: Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
n. (ii). Other health or physical impairment including: Chronic cough persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	☐ Yes ☐ No	☐ Yes ☐ No
n. (iii). Other health or physical impairment including: Any other impairment?	☐ Yes ☐ No	☐ Yes ☐ No

Applicant Name:

If you answered "Yes" to any of the previous questions 1-6, please provide full details below.
(If more space is needed, please attach an additional sheet.)

Member	Spouse	Question No.	Date of Illness:	Date of Full Recovery	Details of nature of illness, number of attacks, duration, severity, treatments, and medications prescribed and taken.	Names, complete addresses, and phone numbers of physicians:
☐	☐					
☐	☐					
☐	☐					
☐	☐					

Primary Care Physician Information (For Member)

Name | Date Last Seen | Telephone Number

Address | City | State | Zip

Primary Care Physician Information (For Spouse/Domestic Partner)

Name | Date Last Seen | Telephone Number

Address | City | State | Zip

Authorization and Signature

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 hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, 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 drub records, maintained by physicians, pharmacy benefit managers, and other sources of 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, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid for a period of 24 months from the date signed, unless sooner revoked. The AUTHORIZATION may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

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 above and in the IMPORTANT NOTICE, including making a brief report of [my/our] protected health information to MIB, Inc.; and **attest** to having read the IMPORTANT NOTICE and Fraud Noticed indicated enclosed, including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Applicant Signature: ______________________ Date: ____________

Spouse/Domestic Partner Signature: ______________________ Date: ____________
(Necessary only if spouse/domestic partner coverage is requested)

Applicant Name:

Beneficiary Designation for Member Coverage

Member is automatically designated as the beneficiary for all dependent child and spousal coverage.

☐ Primary

First, MI, Last Name: | Relationship: | Date of Birth:

Beneficiary Address (Number, Street, City, State, Zip Code): | Social Security Number: | Telephone Number: | % of Benefit

☐ Primary
☐ Contingent

First, MI, Last Name: | Relationship: | Date of Birth:

Beneficiary Address (Number, Street, City, State, Zip Code): | Social Security Number: | Telephone Number: | % of Benefit

☐ Primary
☐ Contingent

First, MI, Last Name: | Relationship: | Date of Birth:

Beneficiary Address (Number, Street, City, State, Zip Code): | Social Security Number: | Telephone Number: | % of Benefit

☐ Primary
☐ Contingent

First, MI, Last Name: | Relationship: | Date of Birth:

Beneficiary Address (Number, Street, City, State, Zip Code): | Social Security Number: | Telephone Number: | % of Benefit

If additional room is required for beneficiary designation, use a separate sheet of paper.

Payment Options:

☐ Payroll Deduction (NSA & DIA Only)

☐ Automatic Debit (Complete the automatic debit section below.)

Automatic Debit Payment Information:

☐ Checking Account (Enclose a voided check) ☐ Savings Account

Bank Name:

Bank Routing Number: 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 any 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.

Applicant Name: ____________________

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.
Personalized Certificate of Coverage Page will be mailed to policyholder upon plan approval. Certificate of Insurance can be viewed, downloaded and printed at www.geba.com.

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

__________ (Initial Here) Instructions in this application supercede all past GEBA term life insurance coverage requests.[2]

Applicant Signature: ____________________ Date: __________

Signature of Spouse/Domestic Partner: ____________________ Date: __________
(if enrolling for dependent coverage)

FRAUD NOTICE - ***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 at, 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.
RESIDENTS OF D.C.: <u>WARNING:</u> 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.
RESIDNENTS 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 include imprisonment, fines or denial of insurance benefits.
RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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 NJ: <u>WARNING</u>: 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 stated value of claim for each such violation.
RESIDENTS OF OK: <u>WARNING:</u> 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 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.