



**1. MEMBER INFORMATION:** Please Print in Ink or Type (Be Sure to Complete the Reverse Side)

Rank: \_\_\_\_\_ AGR:  Yes  No NG Unit \_\_\_\_\_ Unit Location \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth MM / DD / YY Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mailing Address \_\_\_\_\_ Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs. Sex:  Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home: \_\_\_\_\_ Phone Number Work: \_\_\_\_\_ Phone Number

Email Address \_\_\_\_\_

**Spouse Information:**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth MM / DD / YY Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Mailing Address  Same as Member Height: \_\_\_\_ ft. \_\_\_\_ in. Weight: \_\_\_\_ lbs. Sex:  Male  Female

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Home: \_\_\_\_\_ Phone Number Work: \_\_\_\_\_ Phone Number

**Child Information:**

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth MM / DD / YY Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address  Same as Member City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Date of Birth MM / DD / YY Social Security Number \_\_\_\_\_ - \_\_\_\_ - \_\_\_\_

Address  Same as Member City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Insurance Replacement:** Is the insurance applied for intended to replace, discontinue or change any other existing policy? Member  Yes  No Spouse  Yes  No

**2. BENEFICIARY DESIGNATION:**

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Level Term Life Insurance Plan. The beneficiary for dependent coverage shall be the insured member as provided in the group policy.

Beneficiary Name _____	Relationship to Member _____	Social Sec. # _____	Date of Birth _____	% _____
Street Address <input type="checkbox"/> Same Address and Phone as Member _____	City _____	State _____ Zip _____	Phone # _____	
Beneficiary Name _____	Relationship to Member _____	Social Sec. # _____	Date of Birth _____	% _____
Street Address <input type="checkbox"/> Same Address and Phone as Member _____	City _____	State _____ Zip _____	Phone # _____	

**3. MEMBERSHIP AFFILIATION:**

I am a Member of the Massachusetts National Guard, and a Member or Associate Member of The National Guard Association of Massachusetts.  Yes  No

**4. INSURANCE REQUESTED:** Refer to Brochure for eligibility, options and coverage description.

I hereby apply for the following coverage(s) as indicated below:  New Coverage  Increase in Coverage

<u>Guard Member</u>				<u>Spouse</u>		<u>Children</u>	
Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*
<input type="checkbox"/> \$ 1,000 (no cost)**		<input type="checkbox"/> \$15,000 (\$5.33)		<input type="checkbox"/> \$ 5,000 (\$2.00)		<input type="checkbox"/> \$ 5,000 (\$1.50)	
<input type="checkbox"/> \$ 5,000 (\$2.00)		<input type="checkbox"/> \$20,000 (\$7.00)		<input type="checkbox"/> \$10,000 (\$3.66)		<input type="checkbox"/> \$10,000 (\$3.00)	
<input type="checkbox"/> \$10,000 (\$3.66)				<input type="checkbox"/> \$15,000 (\$5.33)		<input type="checkbox"/> \$15,000 (\$4.50)	
				<input type="checkbox"/> \$20,000 (\$7.00)			

Aggregate Plan maximum is \$21,000 per Member.

Note that children's coverage terminates with a conversion option at age 21 (or age 26, if a full-time student).

\*Premiums are not guaranteed. See Plan Brochure for complete rate details. \*\*No Cost Premium is paid by your National Guard Association.

**5. STATEMENT OF HEALTH:** Complete only if you are applying more than 120 days since you enlisted or if spouse coverage amount desired exceeds \$5,000.

(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 your spouse, if also to be insured.

- a. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?  YES  NO
- b. During the past 5 years has any person to be insured ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood 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
- c. During the past 5 years has any person to be insured been counseled, treated or hospitalized for the use of alcohol or drugs?  YES  NO

**IF YOU HAVE ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, PLEASE GIVE DETAILS BELOW.**

(Attach a separate sheet if necessary)

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

**FRAUD NOTICE** — 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.

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 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.

**READ & SIGN:** 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, and attest to having read the IMPORTANT NOTICE on the attached and Fraud Notice indicated above, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature x \_\_\_\_\_ Date \_\_\_\_\_  
*(Please sign and date in ink)*

TO REQUEST MIT TERM LIFE INSURANCE,  
 Complete this form in ink and mail to:

**MILITIA ADMINISTRATIVE SERVICES, INC.**  
**48 Main Street**  
**Sturbridge, MA 01566**

APPLY TODAY

FOR MORE INFORMATION 1-800-633-8333