ENROLLMENT FORM

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

State Sponsored Life Insurance
Guardian Group Term Life Insurance Plan
FOR THE
National Guard Association of Rhode Island

1. MEMBER INFORMATION:

Please Print in Ink or Type *(Be Sure to Complete the Reverse Side)*

Rank: _____ AGR: ☐ Yes ☐ No NG Unit _____ Unit Location _____

_____ Date of Birth MM / DD / YY Social Security Number _____-___-_____
Last Name First Initial

_____ Height: ___ ft. _____ in. Weight: ____ lbs. Sex: ☐ Male ☐ Female
Mailing Address

_____ Home: _____ Work: _____
City State Zip Phone Number Phone Number

Email Address _____

Spouse Information:

_____ Date of Birth MM / DD / YY Social Security Number _____-___-_____
Last Name First Initial

_____ Height: ___ ft. _____ in. Weight: ____ lbs. Sex: ☐ Male ☐ Female
Mailing Address ☐ Same as Member

_____ Home: _____ Work: _____
City State Zip Phone Number Phone Number

Child Information:

_____ Date of Birth MM / DD / YY Social Security Number _____-___-_____
Last Name First Initial

_____
Address ☐ Same as Member City State Zip

_____ Date of Birth MM / DD / YY Social Security Number _____-___-_____
Last Name First Initial

_____
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 ☐ Same Address and Phone as Member City State Zip Phone #

Beneficiary Name *Relationship to Member* *Social Sec. #* *Date of Birth* *%*

Street Address ☐ Same Address and Phone as Member City State Zip Phone #

3. MEMBERSHIP AFFILIATION:

I am a Member of the Rhode Island National Guard, and a Member or Associate Member of The National Guard Association of Rhode Island. ☐ 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

Guard Member				Spouse		Children	
Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*
☐ $ 1,000	(no cost)**	☐ $15,000	($5.33)	☐ $ 5,000	($2.00)	☐ $ 5,000	($1.50)
☐ $ 5,000	($2.00)	☐ $20,000	($7.00)	☐ $10,000	($3.66)	☐ $10,000	($3.00)
☐ $10,000	($3.66)			☐ $15,000	($5.33)	☐ $15,000	($4.50)
				☐ $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 23, 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 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.

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

G-14109-7

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