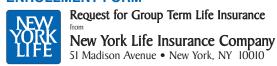
## **ENROLLMENT FORM**



## State Sponsored Life Insurance Guardian Group Term Life Insurance Plan FOR THE

National Guard Association of Illinois



1. MEMBER INFORMATION:  Please Print in Ink or Type (Be Sure to Complete the Reverse Side)										
Rank:	AGR: [	es No	NG Unit			Unit I	ocation			
Last Name Mailing Address		First		Initial	Height: ft.	in.	Social Security Weight:	lbs. Sex:		
City Email Address _		State	. Zip		Home:	Phone Number	Wor	k:Pho	ne Number	
Spouse Informati	ion:									
Last Name		First		Initial			Social Security Weight:			
Mailing Address	Same as Member									
City		State	Zip		F	Phone Number	Wor	Pho	ne Number	
Child Information	n:				Data of Birth	MM / DD / VV	Casial Casurity	Number		
Last Name		First		Initial	Date of Birth	VIIVI / DD / I I	Social Security	Number		
Address Same as	Member	City	Stat	e Zip	Date of Birth	Date of Birth MM / DD / YY Social Security Number				
Last Name		First		Initial	Date of Birtin					
Address Same as	Member	City	Stat	e Zip						
nsurance Replacemen	t: Is the insurance ap	pplied for inten	ided to replace, d	iscontinue or c	hange any other exi	isting policy?	Member Yes	□No Spou	se 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 Nan	ne			Relationship	o to Member	Soc	ial Sec. #	Date of Bir	th %	
Street Address	Same Address and Phon	ne as Member		City		Sta	te Zip	Pho	ne #	
Beneficiary Nan	пе			Relationship	o to Member	Soc	ial Sec. #	Date of Bird	th %	
	Same Address and Phon			City		Sta	te Zip	Pho	ne #	
3. MEMBERS	HIP AFFILIATI	ON:								
am a Member of the			a Member or A	Associate Mer	nber of The Natio	onal Guard A	ssociation of Illin	ois.	□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										
☐ I hereby	apply for the foll	lowing cover	rage(s) as indi	cated below:	: □New Covera	age 🗆 Incr	ease in Coverag	ge		
	Guard Member Current			Current	Spou	Current	<u>Childr</u>	Current		
	Coverage Amount	Monthly Premium*	Coverage Amount	Monthly Premium*	Coverage Amount	Monthly Premium*	Coverage Amount	Monthly Premium*		
	□ \$ 1,000 □ \$ 5,000 □ \$10,000	(\$2.00)	□ \$15,000 □ \$20,000	` ,	□ \$ 5,000 □ \$10,000 □ \$15,000 □ \$20,000	(\$3.66) (\$5.33)	□ \$ 5,000 □ \$10,000 □ \$15,000	` '		
Aggregate Plan maximum is \$21,000 per Member. Note that children's coverage terminates with a conversion option at age 26. Please note that Accelerated Death Benefits may be payable under this Plan. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable.										

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\*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: Co	omplete only if you are applying mor	e than 90 days since you e	enlisted or if spouse coverage amount desired exceeds \$5,000.							
(Please initial any changes you n they apply to you and your spous		of your knowledge ar	nd belief, answer the following questions as							
a. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?										
treated for: heart trouble, eleva or nervous disorder or psychot	ated blood pressure, gynecolog herapeutic treatment, epilepsy, or immunodeficiency disorder,	ical or genitourinary di , respiratory disorder, l thyroid disorder, bloo	nosed by a physician as having or been isorders, ulcers, cancer, diabetes, mental kidney or liver disorder (including hepaod disorder, albumin, blood or sugar in							
c. During the past 5 years has any	person to be insured been cour	nseled, treated or hospi	italized for the use of alcohol or drugs? $\Box$							
IF YOU HAVE ANSWERE		E QUESTIONS ABO ate sheet if necessary)	ove, please give details below. Yes no							
Name(s) of Proposed Insured	Illness or Condition-Date of Onse		Name and address of Physicians or other Medical Care							
Name(s) of Proposed insured	Operations-Degree of Rec	covery and Date	Practitioners and Hospitals where confined or treated							
misleading, information concerning may subject such person to crimical I understand that New York Life examination by a physician. I asto it, while considering this request and statements set forth above.  AUTHORIZATION: I authorize a related facility, laboratory, insuratedge of me or my health to releast benefit managers, and other sour or the plan administrator about the cant history, findings, diagnosis at A photocopy of this AUTHORIZATIZED agent or representative, or for a period of 24 months from the READ & SIGN: By signing and and any person proposed for in noted above and in the IMPORT	ng any fact material thereto inal and civil penalties.  Insurance Company has k New York Life to rely on est. I also understand that any licensed physician, mance company or other orgonices of information to New he physical and mental hand treatment, but excluding any request form significant to any request a copy of the date signed, unless so that and the application, the surance consent to auth and any request to auth and the and the application, the surance consent to auth any request and attest	the right to require all such statement the coverage afformation drug regarization, institution and prescription drug regarization drug regarization drug regarization drug regarization drug regarization drug persoding psychotherapy hall be as valid as a fithis AUTHORIZA coner revoked as some member requestiorize the disclosure to having read the	see information or conceals for the purpose of allent insurance act, which may be a crime and additional information and, if necessary, and any supplement orded will be in consideration of the answers of the present that has any records or knowled the cords, maintained by physicians, pharmaciance Company, its reinsurers, its subsidiaries on proposed for insurance, including signification of the all circumstances, my authoration. This AUTHORIZATION may be used stated in the IMPORTANT NOTICE.  Its the insurance indicated; and the member of information to and from the provider of IMPORTANT NOTICE on the attached and the life, the answers provided to the questions.							
Member's Signature x	Date									
(	,									
TO DECLIFOR MIT TERM LIFE IN	DUDANOE AULT									
TO REQUEST MIT TERM LIFE INS Complete this form in ink and mail	to: 48 M	Main Street Oridge, MA 0156	TIVE SERVICES, INC.							
	APPI	LY TODAY								
	FOR MORE INFORMA	ATION 1-800-63	3-8333							
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