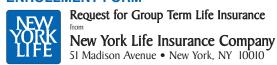
ENROLLMENT FORM



State Sponsored Life Insurance Guardian Group Term Life Insurance Plan

Wyoming National Guard Association



Rank:AGR:No NG Unit							
Height: _ftin. Weight: _lbs. Sex: Male Femal Home:							
City State Zip Phone Number Phone Number Spouse Information:							
Spouse Information: Last Name First Initial Height: _ftin. Weight: _lbs. Sex:Male Female							
Last Name First Initial Height: _ftin. Weight:lbs. Sex: Male Femal							
Home: Work: Phone Number Phone Number Phone Number Phone Number							
Child Information: Last Name First Initial Address							
Last Name First Initial Address							
Last Name 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 Yes No Spouse Yes Yes No Spouse Yes Yes No Spouse Yes Yes No Spouse Yes No Spouse Yes No Spouse Yes Yes No Spouse Yes No Spouse Yes No Spouse Yes Yes No Spouse Yes No Spo							
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 Spouse Yes No Spouse Hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Level Term Life Insurance							
nsurance Replacement: Is the insurance applied for intended to replace, discontinue or change any other existing policy? Member Yes No Spouse							
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							
I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Level Term Life Insurance							
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:							
am a Member of the Wyoming National Guard, and a Member or Associate Member of The Wyoming National Guard Association.							
4. INSURANCE REQUESTED: Refer to Brochure for eligibility, options and coverage description.							
Tiefer to brochare 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 following coverage(s) as indicated below: ☐ New Coverage ☐ Increase in Coverage ☐ Guard Member ☐ Current ☐ Current ☐ Coverage Monthly Coverage Monthly ☐ Coverage ☐ Increase in Coverage ☐ Coverag							
☐ I hereby apply for the following coverage(s) as indicated below: ☐ New Coverage ☐ Increase in Coverage Guard Member Current Current Current Current Current Current							

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

G14109-7

5. STATEMENT OF HEALTH: Co	mplete only if you are applyin	ig more than 90 da	ys since you er	nlisted or if spouse cover	rage amount desired exce	eds \$5,000.	
(Please initial any changes you n they apply to you and your spous		e best of your ki	nowledge an	d belief, answer the	following questions a	เร	
a. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?							
 b. During the past 5 years has a treated for: heart trouble, eleva or nervous disorder or psychot titis), enlarged lymph nodes o urine, back trouble/disorder, an 	ited blood pressure, gynec herapeutic treatment, epi ir immunodeficiency disor	cological or gen lepsy, respirato rder, thyroid di	itourinary dis ry disorder, k	sorders, ulcers, cance kidney or liver disord	er, diabetes, mental er (including hepa-	YES NO	
c. During the past 5 years has any	person to be insured beer	n counseled, trea	ated or hospit	talized for the use of	alcohol or drugs?		
IF YOU HAVE ANSWERE		THE QUEST		ve, please give	DETAILS BELOW	YES NO	
Name(s) of Proposed Insured	Illness or Condition-Date of			Name and address	of Physicians or other Med	lical Care	
Name(s) of Froposed insured	Operations-Degree	of Recovery and D	ate	Practitioners and F	lospitals where confined or	treated	
application for insurance or state misleading, information concernin may subject such person to crimi I understand that New York Life I examination by a physician. I asl to it, while considering this reque and statements set forth above. AUTHORIZATION: I authorize a related facility, laboratory, insural edge of me or my health to release benefit managers, and other sou or the plan administrator about the cant history, findings, diagnosis at A photocopy of this AUTHORIZA rized agent or representative, or	ng any fact material the nal and civil penalties and civil penalties ansurance Company k New York Life to releast. I also understand any licensed physicial nee company or other information, includinces of information to the physical and menand treatment, but example and request for I may request a coperation of the physical and the sample and treatment.	ereto commits. has the right ly on all such that the cover organization in the cover organization in the cover of this AU of this AU	to require a statement rerage afformatitioner, institution drug realife Insurariany personation therapy is valid as the THORIZA	additional inform ts made on this f rded will be in co hospital, clinic or on or person, that ecords, maintaine nce Company, its ns proposed for it notes. the original. In al TION. This AUTH	ation and, if necestorm, and any supposed for the medical or thas any records to by physicians, preinsurers, its sunsurance, including licircumstances, reincological or the surance, including licircumstances, reincological or the surance, including licircumstances, reincological or the surance, including licircumstances, reincological or the surance of the surance of the surance or the surance of the surance	essary, an oplements e answers medically or knowloharmacy bsidiaries ng signifimy authoy be used	
for a period of 24 months from the READ & SIGN: By signing and deand any person proposed for instanced above and in the IMPORT Fraud Notice indicated above, as are true and complete.	lating this applicatio surance consent to a ANT NOTICE, and at	n, the memb authorize the test to havin	er request e disclosur ng read the	s the insurance ire of information IMPORTANT NO	indicated; and the to and from the p OTICE on the atta	e member providers iched and	
Mambar's Signature v			r	Data			
Member's Signature x	and date in ink)			Jale			
TO REQUEST MIT TERM LIFE INS	SURANCE.	MILITIA ADM	NINISTRAT	IVE SERVICES, II	NC.		
Complete this form in ink and mail	to:	18 Main Stre Sturbridge, <i>I</i>	eet				
	,	APPLY TODA	Y				
				2 0000			
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