

HOW TO APPLY

1. Determine the eligibility of yourself, and/or your children.
2. Choose the amount of coverage that fits your need. (Don't forget to specify Optional AD&D and Children's Coverage, if desired.)
3. Complete all pages of our easy Application Form. (Be sure to answer all health questions.)
4. Sign and date the Application.
5. Sign and date the Certification form.
6. Mail all forms with a check for the first 2 months' premiums to:

Uniformed Services Benefit Association
P.O. Box 25956
Overland Park, KS 66225-0956

Questions? 1-800-368-7021

PREMIUM PAYMENT SERVICES

- Use the USBA EZ PAY plan—just complete the attached form and return it to us with a voided check from the account you'll use for future payments. USBA does the rest.
- Premium payments after the first 2 months can be made through military allotment or federal payroll deduction. Let us know which method you prefer and we'll send you the necessary form.
- If you prefer, we can bill you direct. You can choose an annual, semiannual, or quarterly payment.



Starting Your USBA EZ PAY Method

1. Complete and send us the USBA EZ PAY Authorization form below.
2. Send a sample check marked "Void".
3. We will notify you of the amount and date of the first withdrawal from your checking account.
4. Your account will be debited on or near the first of each month.

USBA EZ PAY AUTHORIZATION FOR AUTOMATED PAYMENT SERVICES. SELECT ONE:

- Premium Payments and/or Deposits
 Direct Deposits (Credits)
 Premium Payments (Debits)

Authorization for Automatic Payments

I authorize Uniformed Services Benefit Association, hereinafter called the Company, to make monthly withdrawals in the amount of the premium payment due from my account or, if selected above, to initiate credit deposits to my account at the depository financial institution named below, hereafter called Depository. I (we) acknowledge that the origination of ACH transactions to my (our) account must comply with provisions of U.S. law.

Member & Spouse Information

Member's Name _____

Social Security Number or USBA Member I.D. Number _____

Spouse's Name (if Joint Account) _____

Social Security Number or USBA Member I.D. Number _____

Financial Institution Information

Name of Account Holder _____

Name of Financial Institution _____

Street Address of Financial Institution _____

City _____

State _____

ZIP _____

Transit/ABA Number _____

(First 9 digit # between the two colons on the bottom of your check)

Account # _____

Checking

Savings

Terms of Agreement: I have an account at the depository named and for all withdrawals have funds sufficient to pay such entries upon presentation. The automatic debiting of my bank account is voluntary and will be debited on a monthly basis as long as a statement balance exists. No payment to the company shall be deemed to have been made until the Company receives actual credit.

The Company reserves the right to refuse or terminate automated payment services.

This authorization is to remain in full force and effect until the Company has received written/verbal notification from me (or either of us) of its termination in such time and manner as to afford the Company and Depository a reasonable opportunity to act on it.

Signature of Account Holder _____

Date _____

Application for USBA Group Generation 3SM Life Insurance

BR4-0203A



Uniformed Services Benefit Association®

UNIFORMED SERVICES BENEFIT ASSOCIATION
P.O. Box 25956 • Overland Park, KS 66225-0956



Request for Group Life Insurance from
NEW YORK LIFE INSURANCE COMPANY
51 Madison Avenue • New York, N.Y. 10010

Name And Address

If name or address is incorrect, please print corrections below:
Fully complete your application using black ink, and initial any changes you make.

USBA09GEN3

1. Is your spouse currently insured with USBA? Yes No
If "yes," give name and SSN: _____

2. Are any of your children currently insured through USBA? Yes No
If "yes," list name(s) & ID# for insured member: _____

ALTERNATE ADDRESS — (This can be the address of a parent, other relative, or a friend where we can send mail for forwarding to you.)

Relative's /Friend's Name _____

Street _____

City _____

State & Zip _____

Your email address: _____

Need help with your Application? Call 1-800-368-7021.

I am requesting this USBA coverage as (check one):
 A USBA Member **or** A USBA Associate Member
 (See the brochure for Eligibility details.)

Part 1 Applicant Information

Male Female

1. Name (Please Print)			2. Social Security Number	
First	Initial	Last		
3. Birth Date (Mo/Day/Yr)	4. Home Ph.	Work Ph.		
		_____/_____/_____		
5. In the last 24 months, have you used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum? <input type="checkbox"/> Yes <input type="checkbox"/> No		6. Are you on active military flight status as a pilot or a crew member? <input type="checkbox"/> Yes <input type="checkbox"/> No		
7. U.S. Citizen? <input type="checkbox"/> Yes <input type="checkbox"/> No	8. Marital Status	9. Date of Marriage	10. Maiden Name	
11. Home Address				
Street		City	State	Zip

Part 2 Children's Coverage

If applying for Children's Coverage, provide the following for each child to be insured (attach additional sheet if necessary):

Full Legal Name	Sex	Birth Date (Mo/Day/Yr)	Relationship To Member	Social Security Number
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			
	<input type="checkbox"/> Male <input type="checkbox"/> Female			

Part 3 Beneficiary Designation*

PRIMARY *NOTE: Beneficiary for coverage on Children is the Insured Member.

Name (First, M.I., Last)	Relationship	Social Security #	
Street Address	City	State	Zip

SECONDARY Your children are automatically named secondary beneficiary equally or survivor. This includes future as well as present children, and adopted children. To include stepchildren, attach a signed statement listing names and relationships of stepchildren to be included. If you wish to name someone else, please complete this section:

Name (First, M.I., Last)	Relationship	Social Security #	
Street Address	City	State	Zip

Part 4 Insurance Requested (Refer to brochure for eligibility, options and coverage description.)

Please initial any corrections in this section

MONTHLY PREMIUM

- a. **Generation 3 Level Lifetime Coverage**, Amount of Coverage: _____ = \$ _____
- b. **Optional \$40,000 Accidental Death & Dismemberment** (\$2.00 per month) = \$ _____
- c. **Children's Coverage**, number of units: _____ X \$ 1.50 monthly premium per unit = \$ _____
(1 unit available for each \$25,000 of Generation 3 coverage, to a maximum of 4 units)
- TOTAL MONTHLY PREMIUM** = \$ _____

d. Is the life insurance applied for intended to replace, discontinue or change an existing policy? Yes No

Part 5 Payment Method

Amount enclosed \$ _____ (Enclose 2 months' premium with your application.)

FUTURE PREMIUM PAYMENTS BY:

- Military allotment Federal Payroll Deduction
- USBA EZ PAY (Enclose voided check and signed USBA EZ PAY Authorization.) Direct Billing (3, 6, or 12-months)

Coverage will become effective as soon as Application is approved and first premium is paid.

Part 6 Please complete this part if you are on Active Military Duty.

1. Date of pre-enlistment or pre-commission exam: Month _____ Year _____
2. Have you been assigned overseas in the last two years? Yes No
- If yes, date deployed: Month _____ Year _____

Part 7 Please complete this part if you are Retired from the Military.

1. Date of Retirement: ____/____/____ Receive disability pay? Yes No If yes, what percentage? ____ %
2. Are you employed for 30 hours per week or more? If yes, please attach copy of report defining medical reason for disability.
- Yes No If no, what is your normal activity? _____

Part 8 Statement of Health Answer all questions as they apply to you. (Please initial any changes.)

a. Height Weight

- | | Yes | No |
|---|--------------------------|--------------------------|
| b. Are you now disabled or eligible for any disability benefits, workers' compensation benefits or waiver of premium for life or health insurance? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Are you now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. During the past 10 years have you: | | |
| 1) Had heart trouble or elevated blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> |
| 2) Had gynecological or genitourinary disorders? | <input type="checkbox"/> | <input type="checkbox"/> |
| 3) Had ulcers, cancer or diabetes? | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Had mental or nervous disorder or psychotherapeutic treatment? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5) Had tuberculosis, liver disorder (including hepatitis), asthma or emphysema? | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Had enlarged lymph nodes or disorder of the immune system? | <input type="checkbox"/> | <input type="checkbox"/> |
| <small>(Disorder of the immune system includes the hyperimmune conditions, disorders of gammaglobulin synthesis (hypo-gammaglobulinemia) of white blood cell production and maturation, the immune-deficiency disorders, both congenital and acquired. Also included in disorders of immunity are lupus erythematosus, Grave's disease, rheumatoid arthritis, primary biliary cirrhosis, and others.)</small> | | |
| 7) Had albumin, blood or sugar in urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Had back trouble/disorder or unexplained weight loss in the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) Been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
| <small>(AIDS Related Complex is a condition with signs and symptoms which may include generalized Lymphadenopathy (swollen lymph nodes), loss of appetite, weight loss, fever, oral thrush, skin rashes, unexplained infections, dementia, depression or other psychoneurotic disorders with no known cause.)</small> | | |
| 10) Had other illness including: | | |
| (i) Chronic cough, persistent diarrhea, chronic fatigue or undiagnosed symptoms in the past 5 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| (ii) Any abnormal medical or diagnostic test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| (iii) Any other disease or injury? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. During the past 10 years have you been counselled, treated or hospitalized for the use of alcohol or drugs? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. During the past 5 years have you consulted any physician, chiropractor or medical care practitioner <u>other than</u> for a routine physical examination or checkup, or been confined or treated in any hospital, rest home or similar institution? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. If a consultation with a physician was for a routine or annual examination or checkup, were there any symptoms or adverse findings? | <input type="checkbox"/> | <input type="checkbox"/> |

h. Date of last doctor visit: ___/___/___
 Name & address where medical records are now located:

IF YOU ANSWERED YES TO ITEMS b.- g. PLEASE GIVE NAMES, DATES AND FULL DETAILS HERE.

(If you need more space, use a separate sheet, signed and dated. Please avoid the use of such terms as "etc.", "various" or "miscellaneous".)

Item	Person to whom it applies	Date	Names and addresses of physicians or medical facility where records are located	Include all information as to nature of illness or injury, symptoms, number of attacks, duration, treatment and results

Part 9 Certification

I request the group insurance as indicated on this form. I understand that insurance will become effective on the date approved by New York Life if the initial contribution is paid and I am performing my normal activities; dependent children if approved must not be hospital confined.

I also understand that: if I am not performing my normal activities on the day coverage would otherwise become effective, I will not become insured until the date I am performing such activities provided I am still eligible; any dependent child who is hospitalized on the date coverage would normally be effective will not become insured until the day following the child's discharge from the hospital; and no dependent coverage will be effective unless my coverage is also in effect. I understand that any dividend apportioned to the group policy will be paid to the Uniformed Services Benefit Association.

To the best of my knowledge and belief, I am eligible for insurance and the statements I have made are true and complete. I understand that New York Life may: (a) require more information and a medical exam; and (b) invalidate coverage if it finds that I am not eligible or have not answered any of the above questions truthfully and completely. For residents of VA: I certify that I have read (or had read to me) this completed application and understand that any false statement or misrepresentation may result in a loss of coverage under the group policy. In order to determine insurability, I ask New York Life to rely on all statements made on this form, and any supplements to it, and I authorize disclosure of the types of information detailed in the AUTHORIZATION below. I have read the IMPORTANT NOTICE Section in the brochure which describes how New York Life underwrites this application.

Applicant's Signature X _____ **Date** _____

(Please sign in black ink using full name.)

To the best of my knowledge and belief the statements made regarding my health are true and complete.

G-10649-0
Form GPA-L38—NC

Agent's Signature _____ **Agent's No.** _____
(For Agent Use Only)

USBA 06/06 ed.

AUTHORIZATION: I authorize the release of information to New York Life Insurance Company, its subsidiaries or the Group Policyholder, about the physical and mental health of any persons proposed for insurance including significant history, findings, diagnosis and treatment by any physician, medical practitioner, hospital, medical or medically related facility or insurance company. New York Life and its subsid-

aries may release to the Group Policyholder, other insurance companies and to others I authorize in writing, information covered by this AUTHORIZATION. This AUTHORIZATION may be used for a period of 30 months from the date signed above. A photocopy of this request shall be as valid as the original. I know that I or my authorized representative may request a copy of this AUTHORIZATION.

FRAUD NOTICE: 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 AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH, & PA: 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 is a crime, and subjects such person to criminal and civil penalties. **For 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. **For residents of DC, the following also applies:** An insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

Please Note: Some, not all, applicants may need a physical exam, blood or urine test, depending upon their age and benefit level requested. If this information is needed, we can obtain it quickly—at your convenience and without any cost to you—through our professional paramedic service. A paramedic will contact you to make an appointment.

➔ **TO REQUEST INSURANCE:** Please make allotment and check or money order payable to USBA. Send this application and your check or money order to: **Uniformed Services Benefit Association • P.O. Box 25956 • Overland Park, KS 66225-0956**

Premium payment for insurance does not mean there is any coverage in force before the effective date as specified by New York Life.

USBA MEMBERSHIP/SPONSOR FORM. Complete only if NOT a current Member of USBA

NAME AND ADDRESS: PLEASE PRINT IN BLACK INK

First _____ Initial _____ Last _____

Street Address _____

City _____ State (or Province) _____ Zip Code _____

PHONE NUMBERS:

() _____
Home

() _____
Work

Date of Birth _____ Sex Male Female

Month Day Year

SOCIAL SECURITY #: _____

Email Address: _____

State in which application was written: _____ (For agent use)

<p>Duty Status: (Check one)</p> <p><input type="checkbox"/> Full Time Active Duty</p> <p><input type="checkbox"/> Retired</p> <p><input type="checkbox"/> Federal Employee</p> <p>Pay Grade _____</p> <p><input type="checkbox"/> Honorably Discharged Veteran</p> <p>Date of separation _____</p>	<p>ELIGIBILITY</p> <p><input type="checkbox"/> Reserves—Full time</p> <p><input type="checkbox"/> Reserves—Part time</p> <p><input type="checkbox"/> Nat'l Guard—Full time</p> <p><input type="checkbox"/> Nat'l Guard—Part time</p> <p><input type="checkbox"/> I.R.R.</p>	<p>Branch of Service: (Check one)</p> <p><input type="checkbox"/> Army <input type="checkbox"/> MC</p> <p><input type="checkbox"/> Navy <input type="checkbox"/> CG</p> <p><input type="checkbox"/> AF <input type="checkbox"/> PHS</p> <p><input type="checkbox"/> NOAA</p>
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Rank _____

(If retired, complete as of retirement date.)

Estimated date of separation or retirement _____

If Member of Reserve or ROTC Unit, complete below:

Reserve Assignment or ROTC University _____

(If none, attach copy of Reserve Orders)

I hereby apply for membership in The Uniformed Services Benefit Association. I am eligible for such membership and the statements I have made are true and complete.

Member's Signature X _____ **Date** _____

(Please sign in black ink)



New York Life Insurance Company
 51 Madison Avenue
 New York, NY 10010

Presented by: Uniformed Services Benefit Association
 PO Box 25956
 Overland Park, KS 66225-0956



Generation 3 Notice

To all USBA Members applying for the USBA sponsored Generation 3 Life Insurance Plan. Some life insurance plans require that buyers be provided with an illustration, or forecast of expected future premiums and values. Your signature on this Certification document indicates that you understand your illustration will be sent to you with your Certificate of Insurance.

Please **read** and **sign** the Certification below and **return it to USBA** with your Application for Coverage.

CERTIFICATION LIFE INSURANCE ILLUSTRATIONS

I am applying for coverage under USBA's Generation 3 Life Insurance Plan. I understand this coverage is underwritten by New York Life. I also understand, if my coverage is approved, I will be provided with a formal Illustration for this coverage in accordance with the Insurance Department Regulation of my state (if required) and that this Illustration will be sent to me with my Certificate of Insurance.

APPLICANT'S NAME:

APPLICANT'S SIGNATURE:

 Print: Last, First and Middle Initial

X _____ DATE: _____

AGENT'S NAME:
 (If applicable)

AGENT'S SIGNATURE:

 Print: Last, First and Middle Initial

X _____ DATE: _____

Please return this form with your Application to:
 USBA, PO Box 25956, Overland Park, KS 66225-0956