

PAYMENT METHODS

HOW TO APPLY

1. Determine the eligibility of yourself, your spouse, 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. If you wish to be considered for Preferred Rates, complete the Supplement to Application.
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. When processing is completed, 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 (Automatic Clearing House) transactions to my (our) account must comply with provisions of U.S. law.

Member 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 Financial Institution _____

Name of Account Holder _____

Transit/ABA Number
(First 9 digit # between the two colons on the bottom of your check) _____

Street Address of Financial Institution _____

City _____

State _____

ZIP _____

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 _____



SUPPLEMENT TO APPLICATION FOR USBA SPONSORED GROUP LEAN~15 LEVEL TERM INSURANCE PROGRAM

For **PREFERRED RATE** consideration answer all of the following questions, complete below and return to USBA. **Smokers are not eligible for Preferred Rates.** A smoker is defined as a person who has used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum within the last 24 months.

I am applying for the USBA Lean~15 Level Term Life Plan

1. Present Occupation and Duties: _____

2. Have you had a parent, brother, or sister who experienced angina, stroke or heart trouble prior to age 60?
 Yes No

If "yes", give relationship, age at onset, details of history: _____

3. Within the past two years have you participated in, or do you within the next two years plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, organized motorcycle racing, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or any other type of organized motorized racing?
 Yes No

4. Driver's license number: _____ State in which issued: _____

Has your driver's license been suspended or revoked or had any moving violations within the last five years?
 Yes No

If "yes", give date(s) and reason(s): _____

5. In the last seven years have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?
 Yes No

If "yes," give details: _____

6. If you are not eligible for the preferred rate do you wish to have:

a. Coverage issued at the standard rate with the highest amount of insurance possible based on the monthly premium you submitted? Yes No

OR

b. The same amount of coverage you requested, issued at the standard rate? Yes No

I hereby declare that to the best of my knowledge, the statements made above are true and complete. I authorize New York Life Insurance Company, its subsidiaries, or the plan administrator to obtain my Motor Vehicle Record for the sole purpose of underwriting this application for insurance coverage. This authorization shall be valid until 24 months after the effective date of any insurance coverage for which this authorization was required and can be revoked at anytime by writing the Administrator at the address shown on the application. A photocopy of this authorization shall be as valid as the original. I understand that I or my authorized representative may request a copy of this authorization.

Applicant's Name _____ **Social Security No.** _____
First MI Last

Status (Check One): Member Associate Member

Applicant's Signature _____ **Date** _____



USBA
PO Box 25956
Overland Park, KS 66225-0956

Underwritten by:



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



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. Please print in black ink or type all answers and initial any changes you make.

I am requesting this USBA coverage as (check one):
 A USBA Member or A USBA Associate Member
If applying as an Associate Member fill out the name and ID# of your Sponsor below.
Name: _____ ID#: _____
(See the brochure for Eligibility details.)

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

Part 1 Applicant Information

Male Female

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

Part 2 Insurance Requested

Please initial any corrections in this section.

(Refer to Plan Brochure for eligibility, options and coverage descriptions.)

I hereby apply for the following coverage(s):

- | | | | |
|---|------------------------------|------------|-----------------|
| a. <input type="checkbox"/> USBA Lean~15 Level Term Life Plan | Amount of Coverage: \$ _____ | = \$ _____ | MONTHLY PREMIUM |
| b. <input type="checkbox"/> USBA Group Whole Life Plan | Amount of Coverage: \$ _____ | = \$ _____ | |
| c. <input type="checkbox"/> USBA Standard Level Term Life Plan | Amount of Coverage: \$ _____ | = \$ _____ | |

Check here if you are requesting preferred rate consideration.

(If applying for \$100,000 of coverage or higher under Lean-15 Level Term, be sure to complete the Supplement to Application and mail it with this application.)

d. **Optional \$40,000 Accidental Death & Dismemberment** (\$2.00 per month) = \$ _____

e. **Children's Coverage**, number of units: _____ X **\$1.50** monthly premium per unit = \$ _____
 (You may request 1 unit for each \$25,000 of selected USBA Group Life Insurance Plans, to a maximum of 4 units.)

TOTAL MONTHLY PREMIUM (a THROUGH e) \$ _____

IMPORTANT REPLACEMENT INFORMATION

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or a different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against or withdrawn from, reduced in value by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced, to help you decide whether the replacement is in your best interest.

INSURANCE QUESTION

I have read the Important Replacement Information above.

Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? Yes No

Part 3 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 of Child	Birth Date (Mo/Day/Yr)	Relationship To Applicant	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 4 Beneficiary Designation*

PRIMARY

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

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

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 To the best of your knowledge and belief, answer all questions as they apply to you. (Please initial any changes.)

a. Height Weight

	Yes	No
b. Are you now disabled or receiving any disability or workers' compensation benefits or waiver of premium for life or health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
c. Are you now ill or receiving medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
d. During the past 5 years , have you ever consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized, or had an operation, or had any illness, disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>
e. Are you taking any kind of medication or, so far as you know, in impaired physical or mental health?	<input type="checkbox"/>	<input type="checkbox"/>
f. Are you now pregnant?	<input type="checkbox"/>	<input type="checkbox"/>
g. During the past 5 years have you ever been medically diagnosed by a physician as having or been treated for:		
1) Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>
2) Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
3) Fainting spells, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
4) Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>
5) Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
6) Disorder of breast or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>
7) Nervous or mental disorder, emotional conditions or psychiatric care?	<input type="checkbox"/>	<input type="checkbox"/>
8) Cancer, tumor or cyst?	<input type="checkbox"/>	<input type="checkbox"/>
9) Varicose veins, hemorrhoids or hernia?	<input type="checkbox"/>	<input type="checkbox"/>
10) Disorder of eyes, ears, nose or sinuses?	<input type="checkbox"/>	<input type="checkbox"/>
11) Thyroid, liver or respiratory disorder?	<input type="checkbox"/>	<input type="checkbox"/>
12) Alcoholism or drug habit?	<input type="checkbox"/>	<input type="checkbox"/>
13) Disorder of the blood?	<input type="checkbox"/>	<input type="checkbox"/>
14) Other health or physical impairment including:	<input type="checkbox"/>	<input type="checkbox"/>
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS related Complex (ARC)?	<input type="checkbox"/>	<input type="checkbox"/>
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue, in the past five years?	<input type="checkbox"/>	<input type="checkbox"/>
(iii) Any other impairment?	<input type="checkbox"/>	<input type="checkbox"/>

Note to Lean-15 Level Term Applicants: If applying for Preferred Rate Consideration, please complete the enclosed Supplement to Application.

IF YOU ANSWERED ANY QUESTIONS "YES," GIVE COMPLETE DETAILS BELOW.

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

Question Letter/No.	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:

Part 9 Certification

I understand that New York Life 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.

For AD&D only, any person who knowingly and with intent to defraud any insurance company or any 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 shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, or insurance company 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 subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or 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 I may request a copy of this AUTHORIZATION. The AUTHORIZATION may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, I request the insurance indicated, and I authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, and attest to having read the IMPORTANT NOTICE and Fraud Notice indicated on the enclosed, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Applicant's Signature X _____ **Date** _____
(Please sign in black ink using full name.)

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

G-5393-0, -2; 10648; 11008

GMA - PRS1

USBA NY 09/09 ed.

 **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

EMAIL ADDRESS: _____

Date of Birth _____ Sex Male Female
Month Day Year

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

ELIGIBILITY

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

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request for USBA Group Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance. Other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance.) The information provided may include information that may predate the time frame stated on the medical questions section, if any, on your application. This information may be used during the underwriting and claims processes, where permitted by law.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying the Administrator in writing at the address provided. Your revocation will not be effective to the extent New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. For example, New York Life may be required to provide it to insurance, regulatory or other government agencies. In this case, the information may no longer be protected by the rules governing your AUTHORIZATION.

New York Life may release this information to the plan administrator, other insurance companies to whom you may apply for insurance, or to whom a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Fair Credit Reporting Act procedures.

For NM Residents: PROTECTED PERSONS¹ have a right of access to certain CONFIDENTIAL ABUSE INFORMATION² we maintain in our files and they may choose to receive such information directly. You have the right to register as a PROTECTED PERSON by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.

¹ ***PROTECTED PERSON*** means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.

² ***CONFIDENTIAL ABUSE INFORMATION*** means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.

New York Life Insurance Company

2/09 ed.