Scan the QR code to get more details on this exclusive coverage available to NGAUS members.

Complete this form and Return to:
NGAUS Insurance Trust
P.O. Box 47060
Phoenix, AZ 85068-47060

Residents of PR:
Please send your applications to:
Global Insurance Agency, Inc.
P.O. Box 9023918
San Juan PR 00902-3918

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

GROUP TERM LIFE AND DISABILITY APPLICATION
NGAUS INSURANCE PLAN

PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. Please complete the information requested. ❑ Title 32 ❑ Title 5

Applicant's name *(First, Middle Initial, Last)*		Sex ❒ M ❒ F	Date of birth month / day / year	Age	Social security number	
Address	City		State	ZIP	Height ' "	Weight lbs.
Technicians daytime phone number	Location of pay office		Pay office phone number		Pay office code	
Employing office	Date of employment month / day / year		Job duty		Annual salary $	

2. If dependent coverage is requested, list eligible dependents **lawful Spouse/Domestic Partner (DP) and unmarried, dependent children. Attach a separate signed and dated sheet to provide additional dependents.**

FULL NAME:	Spouse/DP SS#:	DATE OF BIRTH	SEX	HEIGHT	WEIGHT
Spouse/DP			☐ Male ☐ Female	FT. IN.	LBS.
Child 1			☐ Male ☐ Female	FT. IN.	LBS.
Child 2			☐ Male ☐ Female	FT. IN.	LBS.

OTHER INSURANCE: Do you have other life insurance in force? Member: ☐ YES ☐ NO Spouse: ☐ YES ☐ NO

If "Yes," total amount in all companies: Member $_____ Spouse $_____

Do you have other life insurance applications pending? Member: ☐ YES ☐ NO Spouse: ☐ YES ☐ NO

If "Yes," indicate amount and company: Member $_____ Company_____

Spouse $_____ Company_____

3. Insurance requested: I hereby apply for the following coverage(s) checked below.

❑ New Enrollment
❑ Change/add coverage

☑ Check the box for the coverage you want to apply for.
Rates are based on bi-weekly deductions. Refer to the brochure for eligibility, options and coverage description.

❑ A. Term Life Insurance

	Amount Coverage				
Technician	❑ $25,000	❑ $50,000	❑ $150,000	❑ $250,000	Other Amount: $_____
Spouse	❑ $25,000	❑ $50,000	❑ $150,000	❑ $250,000	Other Amount: $_____
Child(ren) per child	❑ $5,000	❑ $10,000			

❑ B. Basic Disability Income (Technician) and Supplemental Disability Income (Technician) Insurance

SALARY $28,000 - $31,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $700 Basic	$ 3.00	$ 8.10	$21.65
❑ $700 Basic + $700 Supplemental	$ 5.00	$12.60	$31.55

SALARY $32,000 - $39,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $800 Basic	$ 3.20	$ 9.20	$24.80
❑ $800 Basic + $800 Supplemental	$ 5.60	$14.60	$38.60

SALARY $40,000 - $49,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $1,000 Basic	$ 4.40	$11.70	$31.20
❑ $1,000 Basic + $1,000 Supplemental	$ 7.40	$18.70	$48.70

SALARY $50,000 - $59,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $1,100 Basic	$ 4.95	$13.20	$34.65
❑ $1,100 Basic + $1,400 Supplemental	$ 9.85	$23.70	$59.85

SALARY $60,000 - $74,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $1,250 Basic	$ 5.63	$15.00	$39.38
❑ $1,250 Basic + $1,750 Supplemental	$11.76	$28.13	$70.88

SALARY $75,000 - $89,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $1,500 Basic	$ 6.75	$18.00	$47.25
❑ $1,500 Basic + $2,250 Supplemental	$14.63	$34.88	$87.75

SALARY $90,000 - $104,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $1,800 Basic	$ 9.20	$24.55	$ 64.43
❑ $1,800 Basic + $2,700 Supplemental	$21.01	$49.86	$125.18

SALARY $105,000 - $119,999	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $2,100 Basic	$10.73	$28.64	$ 75.16
❑ $2,100 Basic + $3,150 Supplemental	$24.50	$58.16	$146.04

SALARY $120,000 AND OVER	Your Age		
MONTHLY BENEFITS	Under 40	40-49	50-64
❑ $2,400 Basic	$12.26	$32.74	$ 85.90
❑ $2,400 Basic + $3,600 Supplemental	$27.99	$66.47	$166.90

Note: Term Life Insurance and Disability Income (Technician) do not require completion of the health questions if the Applicant applies for $25,000 or $50,000 within 31 days of the date of employment. (All Spouse coverage requires evidence of insurability.)

4. Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum or electronic cigarettes)?

Member: ❑ YES ❑ NO
Spouse: ❑ YES ❑ NO

FOR OFFICE USE ONLY - Deduction amount for above coverages

A. _____ B. _____ C. _____ D. _____ E. _____ _____

Total Deduction amount	Effective date month / day / year	Transmittal number HRO	Consec. no.

I understand that, upon issuance of such insurance, I will become a Member of the NGAUS Insurance Trust. I understand that my employer, as a service performed for me, will make regular payroll deductions for the premiums. I direct that all experience credits declared as a result of my participation in the NGAUS Insurance Trust, after payment of Trust expenses, shall be paid to the National Guard Association of the United States or The National Guard Education Foundation, as determined by the NGAUS Insurance Trust. No obligation shall be incurred because of information furnished unless and until coverage is approved by New York Life Insurance Company and the first premium is paid in full. You must be actively at work for the National Guard at the time you apply. Payroll deduction for your selected coverage must begin by the 2nd pay period after the open enrollment period ends. For all details of this Insurance Program, see the Technician booklet at your HRO.

5. Name of beneficiary for each life plan applied for. (Name and Relationship)

Life Insurance Beneficiary Designation (If necessary, attach a separate signed and dated sheet.)

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life and/or AD&D Insurance Plan, and if I am already covered under the plan(s), I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policies). (If you wish to name a different beneficiary for spouse coverage, contact the administrator.) 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Group Term Life (Technician)

Beneficiary Name _____
Last First Middle Initial

Relationship to the applicant _____ SSN _____

Beneficiary Address _____
Street City State/Province Zip Code

Supplemental Term (Technician)

Beneficiary Name _____
Last First Middle Initial

Relationship to the applicant _____ SSN _____

Beneficiary Address _____
Street City State/Province Zip Code

Term Life (Spouse)

Beneficiary Name _____
Last First Middle Initial

Relationship to the applicant _____ SSN _____

Beneficiary Address _____
Street City State/Province Zip Code

Beneficiary of the Children's Coverage will be the insured parent.

6. Health Questions

STATEMENT OF HEALTH (Please initial and date 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 all dependents to be insured:

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 20 or more hours per week at your usual place of business?	❒	❒	❒	❒
2. Are you or any other person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance?	❒	❒	❒	❒
3. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❒	❒	❒	❒
4. During the past five years, has any person to be insured 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?	❒	❒	❒	❒
5. Are you or any other person to be insured under any kind of medication or, so far as you know, in impaired physical or mental health?	❒	❒	❒	❒
6. Is any person to be insured now pregnant?	❒	❒	❒	❒

7. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having been treated for:	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
a) Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	❒	❒	❒	❒
b) Arthritis, back trouble, bone or joint disorder?	❒	❒	❒	❒
c) Fainting spells, convulsions or epilepsy?	❒	❒	❒	❒
d) Sugar, blood, albumin or pus in urine?	❒	❒	❒	❒
e) Diabetes, kidney trouble, ulcers or digestive disorder?	❒	❒	❒	❒
f) Disorder of breasts or reproductive organs or functions?	❒	❒	❒	❒
g) Nervous or mental disorder, emotional conditions or psychiatric care?	❒	❒	❒	❒
h) Cancer, tumor or cyst?	❒	❒	❒	❒
i) Varicose veins, hemorrhoids or hernia?	❒	❒	❒	❒
j) Disorder of eyes, ears, nose or sinuses?	❒	❒	❒	❒
k) Thyroid, liver or respiratory disorder?	❒	❒	❒	❒
l) Alcoholism or drug habit?	❒	❒	❒	❒
m) Disorder of the blood?	❒	❒	❒	❒

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
n) Other health or physical impairment including:				
i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❒	❒	❒	❒
ii) Any other disorder of the immune system?	❒	❒	❒	❒
iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	❒	❒	❒	❒
iv) Any other impairment?	❒	❒	❒	❒
8. Except for residents of Maryland, has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuro-muscular or mental illness?	❒	❒	❒	❒
9. Within the past two years, have you or your spouse participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snow-mobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	❒	❒	❒	❒

	MEMBER YES	MEMBER NO	SPOUSE YES	SPOUSE NO
10. Driver's license number: Member License No.				
_____ State Issued				
_____ Spouse License No.				
_____ State Issued				
_____				
Have you or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years?	❒	❒	❒	❒
11. ***Except for residents of Connecticut and Minnesota,*** in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	❒	❒	❒	❒
For residents of Connecticut and Minnesota only, in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason?	❒	❒	❒	❒

12. If you have answered Question 1 "No" or any other Questions "Yes" give complete details below. (Attach a separate sheet if necessary then sign and date it)

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:

AUTHORIZATION AND SIGNATURE

Authorization: I authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB LLC ("MIB"), or electronic health record companies; health care information technology companies; or any health or medical organizations 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 for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. 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.

I also authorize New York Life Insurance Company to obtain from consumer reporting agencies driving records (if any) about myself or any other person proposed for insurance for the purpose of evaluating this application for insurance.

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. The authorization may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that 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.

By signing and dating this application, I **request** the insurance applied for myself and/or my dependents; I **affirm** that the information provided in my application is true and complete to the best of my knowledge and belief and that I, and any other person proposed for insurance, has read the Fraud Notice (if any) and the IMPORTANT NOTICE , [including how my/our information is exchanged with MIB]; and I, and any other person proposed for insurance, **consents** to authorize the disclosure of information, to and from the providers noted in the IMPORTANT NOTICE, [including making a brief report of my/our protected health information to MIB.]

Member's Signature _____ Date _____

Spouse's/Domestic
Partner's Signature _____ Date _____

(Necessary only if Spouse/Domestic Partner coverage is requested)

This Policy permits the Policyholder to change, reduce, restrict or terminate the insured's rights or benefits under the Policy without the insured's consent. Such change, reduction, restriction or termination may occur at a time when the insured's health status has changed and may affect his or her ability to procure individual coverage.

FRAUD NOTICE – *For Residents of all states except those listed below:* 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 may be a crime and may subject such person to criminal and civil penalties. **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.
RESIDENTS OF AL/AR/LA/RI: 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.
RESIDENTS OF CA: Any person who knowingly presents false or fraudulent information to obtain or amend insurance coverage or to make a claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.
RESIDENTS OF D.C.: WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits, if false information materially related to a claim was provided by the applicant.
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 KS: 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 may be guilty of insurance fraud as determined by a court of law.
RESIDENTS OF ME: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or a denial of insurance benefits.
RESIDENTS OF MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.
RESIDENTS OF NJ: WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.
RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
RESIDENTS OF PUERTO RICO: Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.
RESIDENTS OF TN/WA: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.
RESIDENTS OF VA: Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing false or deceptive statements may have violated state law.

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