Group Insurance Application Form

Return this form to the Plan Administrator:
3000 Insurance Group, 3000 NW 149th St., Oklahoma City, OK 73134

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

MEMBER INFORMATION

Please print in ink or type all answers – initial and date any changes you make

MEMBER'S FULL NAME			**GROUP POLICY**: G-29304-0 (ADI) G-29330-0 (DI) G-29211-0 (10YT) G-29210-0 (L) G-29330-1 (BOE)		CERTIFICATE #
ADDRESS			SOCIAL SECURITY NO.		
CITY	STATE	ZIP CODE	DATE OF BIRTH MM / DD / YYYY	❒ MALE ❒ FEMALE	HEIGHT FT. IN. / WEIGHT LBS.
HOME PHONE #	WORK PHONE #		FAX #		
E-MAIL ADDRESS			CELL PHONE #		

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed Maiden Name________________ Date of Marriage_______
☐ Civil Union* ☐ Domestic Partnership*(submit a Declaration of Domestic Partnership form. *Eligibility determined by State Law)

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Member: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No If yes, Country ____________________________ How Long?_______________

MEMBERSHIP AFFILIATION

Name of Organization you are an active member of:____

Are you presently insured by any other OPIT plan? ☐ Yes ☐ No If yes, indicate which plan(s) and provide details (person(s) insured and amount) ____

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS

lawful Spouse and unmarried, dependent children . *(If necessary attach a separate signed and dated sheet to provide additional dependent information)*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	❒ MALE ❒ FEMALE	HEIGHT ft. in.	WEIGHT lbs.

Child (Name)	Date of Birth		Child (Name)	Date of Birth	
1.	/ /	❒ MALE ❒ FEMALE	3.	/ /	❒ MALE ❒ FEMALE
2.	/ /	❒ MALE ❒ FEMALE	4.	/ /	❒ MALE ❒ FEMALE

I HEREBY APPLY FOR THE COVERAGE(S) CHECKED BELOW, BASED UPON ALL MY STATEMENTS MADE IN THIS APPLICATION: (Refer to www.3000IG.com or brochure for plan details)

NOTE: If you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting.

☐ **Disability Income Insurance** (G-29330-0) (check one) ❒ New Application ❒ Additional Coverage

a. Plan Type………………………………………………………………………………… ☐ **Plan 5-2** ☐ **Plan 65-65**

b. Principal Monthly Benefit – **Under Age 60**, up to $10,000 $ ____________

c. Waiting Period (WP)……………………..…………………… ☐ 30-day ☐ 60-day ☐ 90-day ☐ 180-day ☐ 365-day

c. Optional Rider (Check if desired): ❒ Residual Disability ❒ Future Purchase ❒ Hospital Indemnity ❒ Recovery

d. Do you have in force or are you applying for any other disability income insurance? ☐ Yes ☐ No
If Yes, indicate company, type and amounts below.

Company	Plan	Monthly Benefit	Benefit Period

Will the coverage applied for with us, If approved, replace any of the above? ☐ Yes ☐ No If yes, indicate which, and date it will be terminated____

☐ **10-Year Level Term Life Insurance** (G-29211-0) (check one) ❒ New Application ❒ Additional Coverage

Member/Spouse under age 65 - $50,000 to $1,000,000 (multiples of $50,000) – Note: Spouse coverage may not exceed member coverage.

Total **Member** Amount Desired……………………………………………………………………….. $ ___________

Total **Spouse** Amount Desired (spouse coverage amount may not exceed member amount)……………………………… $ ___________

Application continued – see following page

☐ **Term Life Insurance** (G-29210-0) (check one) ❒ New Application ❒ Additional Coverage

Member / Spouse under age 60 - $25,000 through $500,000 (multiples of $25,000) –

Total **Member** Amount Desired.. $ ____________

Total **Spouse** Amount Desired (spouse coverage amount may not exceed member amount).. $ ____________

☐ **Business Overhead Expense Insurance** (G-29330-1) ☐ New Coverage ☐ Additional Coverage

Monthly benefits $500 to $15,000 ($100 increments) if under age 55; $500 to $10,000 ($100 increments) ages 55-59

Monthly Benefit Amount: $ __________________

Type of Organization: ☐ Proprietorship ☐ Corporation ☐ Partnership

If Corporation or Partnership, my share of eligible expenses are:_____________% Average number of employees in past 6 months? ______________

☐ **Accident Disability Insurance** (G-29304-0) ❒ New Application ❒ Additional Coverage

Member under age 60 may select coverage amounts . Dependent Coverage is a percentage of Member's principal sum.

Select Desired Plan**:** ☐ Member Only Plan ☐ Family Plan **Member** Principal Sum Desired: $ ___________

OCCUPATIONAL STATUS Must be completed if applying for Disability Insurance

What is your occupation?___________________________ Main Duties____

FULL-TIME WORK means actively performing the regular deities of your normal occupation for pay or profit on the basis of at least 30 hours per week at the place such duties are normally performed. Are you now at FULL-TIME WORK? ☐ Yes ☐ No

Gross Annual Income from: Salary $ _______________ Bonus $ _______________ Commissions $ _______________

Self Employment $_______________ (Self Employment Start Date _______________) **Total** $_______________

LIFE INSURANCE QUESTIONS Must Be Completed if applying for Life 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 insurance applications pending? If "Yes," indicate amount and company:

Member: ☐ Yes ☐ No Amount $______________________ Company________________________________

Spouse: ☐ Yes ☐ No Amount $______________________ Company________________________________

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance

Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? .... **Member:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

BENEFICIARY DESIGNATION (necessary if applying for Life Insurance ONLY)

(*If necessary, attach separate signed and dated sheet to provide additional beneficiary information)*

I hereby make the following beneficiary designation with respect to a) all the insurance on my life under the Group Term Life Insurance Plan(s) being applied for under this application, and if I am already covered under the Plan(s), I hereby revoke any prior beneficiary designation; b) ONLY the new insurance requested in this application for Group 10-Year Level Term Life Insurance. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy.

NOTE: *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. If naming a trust, please indicate the full name and date of the trust.*

☐ Primary ☐ Secondary Percent of Proceeds ___________%		
BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

☐ Primary ☐ Secondary Percent of Proceeds ___________%		
BENEFICIARY NAME	BENEFICIARY RELATIONSHIP TO MEMBER	BENEFICIARY SOCIAL SECURITY #
BENEFICIARY STREET ADDRESS		BENEFICIARY DATE OF BIRTH / /
CITY	STATE	ZIP CODE

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MEDICAL HISTORY Please indicate the best contact number for a Service Provider to contact you and/or your spouse/Domestic partner on behalf of New York Life Insurance Company for Medical History. (Please provide a contact number for each applicant that has the ability to accept voice messages for missed calls.)			
Member	Contact #___________________________________ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile	**Spouse /Domestic Partner**	Contact #____________________________________ (xxx) xxx-xxxx ☐ Residence ☐ Business ☐ Mobile

I request the group insurance shown on this application. To the best of my knowledge and belief: (a) I am eligible for such insurance; and (b) the statements I have made are true and complete. 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, and on any supplemental forms, and that any material misstatements or failures to report information material to the risk may be used as the basis for rescission of my insurance subject to the incontestable period provision of the policy. **I understand** that (a) insurance will become effective the first of the month on or following the date approved by New York Life if I am alive on that date and the initial contribution is paid within 31 days after the date I am billed and (b) I and any approved dependents are actively performing the activities of a person in good health of like age and sex on the date coverage is effective (and I am actively working 30 or more hours per week). *(Residents of NC: Any reference to "performing normal activities" is replaced by the requirement that the health status of any proposed insured person remains the same as stated in your application)*.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company or MIB, Inc. ("MIB"), or other organization, institution or person, 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, 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. 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 as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member **requests** the insurance indicated; and the member and any person proposed for insurance **consent** 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; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated on the attached; including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature____ Date__________________________

Spouse's Signature ____ Date__________________________

(Necessary only if Spouse coverage is requested)

Fraud Notices

Please read before signing the application form

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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 AR/LA: 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 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.

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Application continued – see following page

IMPORTANT NOTICE

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

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify 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 and MIB, Inc. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, or a claim for benefits is submitted to a MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

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 New York Life 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.

MIB and 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, of the application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

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 or MIB, 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 Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866- 692-6901. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: *PROTECTED PERSONS [1] have a right of access to certain CONFIDENTIAL ABUSE INFORMATION [2] 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.