FASTFORM

Group Term Life Insurance
Guaranteed Acceptance

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

Sponsored by Insurance Specialists Inc. Insurance Trust

1 MEMBER INFORMATION

Please Print In Ink Or Type.

Name ____
First Middle Last

Home Address ____

City ____________________ State ____________ Zip ____________

Email Address ____________________ Home Phone ____________ Cell Phone ____________

Date of Birth ____________ Social Security No. ____________ Gender ________ Marital Status ________

☐ **I attest that I am a member of the Association of Texas Professional Educators.®**

I hereby apply for the following coverage(s):

Term Life Insurance

☐ $50,000 - Under the Age of 50
☐ $25,000 - Ages 50-54
☐ $15,000 - Ages 55-59

Nicotine Use: Have you used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine chewing gum, and electronic cigarettes)?.. ☐ Yes ☐ No

If "yes," please state when you last used tobacco or nicotine products and specify the product used.

____
MM/YYYY Product:

2 INSURANCE REPLACEMENT INFORMATION

Is the insurance applied for intended to replace, discontinue, or change an existing insurance policy or annuity? ☐ **Yes** ☐ **No**

Do you have other life insurance in force? If "Yes," please indicate the total amount, with all companies. (If none, check "None.") ☐ **None**

Do you have other insurance applications pending? If "yes," indicate amount and company below.

Name of Company	Type of Coverage	Amount	Year Issued	Do you plan to replace this coverage? Yes/No

Be sure to complete all pages and sign the last page

3 BENEFICIARY DESIGNATION: Insert name, relationship, and Social Security Number

I make the following beneficiary designation with respect to all the insurance on my life under this group term life insurance plan. (If you want to name more than one beneficiary, or a trust, please contact the Plan Administrator.) (1) In naming more than one beneficiary, please 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. (Attach a separate sheet if necessary, then sign and date it.)

Beneficiary Name (Last, First, Middle Initial) | Relationship to Proposed Insured | Assign %

Date of Birth (MM/DD/YYYY) | Social Security Number | Phone

☐ Check here if you're adding more beneficiaries. Provide the additional information on a separate piece of paper and return it with your application.

4 BILLING

Payment Information

Bill Me:

☐ **Annually** ☐ **Semiannually** ☐ **Quarterly**

If billing choice is not made, you will automatically be billed Semiannually.

☐ **Monthly (EFT Authorization is required for monthly billing)**

EFT Authorization

I request and authorize Insurance Specialists, Inc. to make monthly withdrawals against the account specified below, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium contributions due under this Group Level Term Life Insurance Plan.

X

SIGNATURE(S) AS REQUIRED ON CHECKS ISSUED/WITHDRAWALS MADE AGAINST THIS ACCOUNT | DATE

Routing No. ____________ Account No. ____________

5 FRAUD NOTICES (PLEASE READ BEFORE SIGNING THE APPLICATION FOR INSURANCE.)

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 AL/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.

6 AUTHORIZATION AND SIGNATURE

By signing and dating this application, I request the insurance indicated. The effective date will be the first day of the calendar quarter following receipt of my application. I attest to having read the fraud notices indicated above. To the best of my knowledge and belief, the answers to the questions above are true and complete.

X

Member's Signature (Please Sign and Date in Ink) | Print Name | Date Signed (MM/DD/YYYY)

After completion, make a copy for your records and return the original to:
Insurance Specialists, Inc. PO Box 2327 Beaufort SC 29901.
Or e-mail to sales@isi1959.com