Group Term Life Insurance Application

Complete this form and return to:
Insurance Specialists, Inc.
PO Box 588, Beaufort, SC 29901
(888) 474-1959

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

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 _____ Height _____ Weight _____ Social Security No. _____ Gender _____ Marital Status _____

☐ **I attest that I am a member of the North Carolina State Firefighters' Association.**

2 INSURANCE REQUESTED (Refer to the product summary for eligibility and coverage description)

I hereby apply for the following coverage(s): ☐ New ☐ Additional

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

Term Life Insurance

☐ Member Life: Enter a multiple of $5,000 $ _____ with a minimum of $10,000 and a maximum of $500,000 (under age 60)

☐ Dependent Spouse Life: Enter a multiple of $5,000 $ _____ with a minimum of $10,000 and a maximum of $100,000 or 50% of member's benefit, whichever is less (under the age of 60)

☐ Dependent Child Life
Age 15 days through age 25: ☐ $5,000 ☐ $10,000

Dependent Information

If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:

Name of your Spouse (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Height | Weight | Social Security Number

_____ _____ _____ _____ _____ ☐ Male ☐ Female

☐ Same Address as Member

_____ _____ _____ _____ _____
Home Address / City / State / Zip / Phone Number

Name(s) of your Child(ren) (First, Middle, Last) | Date of Birth (MM/DD/YYYY) | Social Security Number | Phone Number

_____ _____ _____ _____ ☐ Male ☐ Female

_____ _____ _____ _____ ☐ Male ☐ Female

☐ Same Address as Member

_____ _____ _____ _____ _____
Home Address / City / State / Zip / Phone Number

☐ Check here if you need more lines. Provide the additional information on a separate piece of paper and return it with your application.

2 INSURANCE REQUESTED (Continued)

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

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

MM/YYYY Product:

3 INSURANCE REPLACEMENT INFORMATION

RESIDENTS OF NEW YORK – 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 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 decide whether the replacement is in your best interest.

RESIDENTS OF NEW YORK: I have read the Important Replacement Information above.

	Member	Spouse
Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?	☐ Yes ☐ No	☐ Yes ☐ No
RESIDENTS OF ALL OTHER STATES: Is the insurance applied for intended to replace, discontinue, or change an existing insurance policy or annuity?	☐ Yes ☐ No	☐ 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

4 STATEMENT OF HEALTH

Please initial 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 your spouse if applying for coverage.

	Member	Spouse
1. 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?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	☐ Yes ☐ No	☐ Yes ☐ No
3. 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?	☐ Yes ☐ No	☐ Yes ☐ No
4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you pregnant?	☐ Yes ☐ No	☐ Yes ☐ No
6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	☐ Yes ☐ No	☐ Yes ☐ No
b. Arthritis, back trouble, bone or joint disorder?	☐ Yes ☐ No	☐ Yes ☐ No
c. Fainting spells, convulsions or epilepsy?	☐ Yes ☐ No	☐ Yes ☐ No
d. Sugar, blood, albumin or pus in urine?	☐ Yes ☐ No	☐ Yes ☐ No
e. Diabetes, kidney trouble, ulcers or digestive disorder?	☐ Yes ☐ No	☐ Yes ☐ No

4 STATEMENT OF HEALTH (Continued)

	Member	Spouse
f. Disorder of breast or reproductive organs or functions?	☐ Yes ☐ No	☐ Yes ☐ No
g. Nervous or mental disorder, emotional conditions or psychiatric care?	☐ Yes ☐ No	☐ Yes ☐ No
h. Cancer, tumor or cyst?	☐ Yes ☐ No	☐ Yes ☐ No
i. Varicose veins, hemorrhoids or hernia?	☐ Yes ☐ No	☐ Yes ☐ No
j. Disorder of eyes, ears, nose or sinuses?	☐ Yes ☐ No	☐ Yes ☐ No
k. Thyroid, liver or respiratory disorder?	☐ Yes ☐ No	☐ Yes ☐ No
l. Alcoholism or drug habit?	☐ Yes ☐ No	☐ Yes ☐ No
m. Disorder of the blood?	☐ Yes ☐ No	☐ Yes ☐ No
n. Standard AIDS Question (see attached page for further options):		
i. Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	☐ Yes ☐ No	☐ Yes ☐ No
ii. Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	☐ Yes ☐ No	☐ Yes ☐ No
iii. Any other impairment?	☐ Yes ☐ No	☐ Yes ☐ No
7. **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?	☐ Yes ☐ No	☐ Yes ☐ No
8. 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, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing?	☐ Yes ☐ No	☐ Yes ☐ No
9. Driver's License No.: Member: _____ State in Which Issued: _____ Spouse: _____ State in Which Issued: _____ Have you or your spouse had a driver's license suspended or revoked or had any moving violations within the last five years?	☐ Yes ☐ No	☐ Yes ☐ No
10. **Except for the residents of Minnesota and Connecticut,** have you been convicted of a crime or served time in prison because of a conviction or have an arrest pending?	☐ Yes ☐ No	☐ Yes ☐ No
For residents of Minnesota and Connecticut only, have you been convicted of a crime or served time in prison because of a conviction or been convicted for any reason during the past 15 years?	☐ Yes ☐ No	☐ Yes ☐ No

If you have answered any 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:

Personal Physician Information (Member)

Personal Physician's Name _____

Street Address _____ Telephone _____

City _____ State _____ Zip Code _____

Date of last visit (MM/DD/YYYY) _____ Reason for visit _____

Personal Physician Information (Spouse)

Physician's Name _____

Street Address _____ Telephone _____

City _____ State _____ Zip Code _____

Date of last visit (MM/DD/YYYY) _____ Reason for visit _____

5 BILLING

Payment Information

Send no money now — you will be billed if approved for coverage.

Bill Me:

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

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

☐ **Monthly**

If you select Monthly billing, you will be sent an ACH Authorization Form to complete.

6 BENEFICIARY DESIGNATION

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance policy, and if I am already covered under the policy, I hereby revoke any prior beneficiary designation. The beneficiary for dependent coverage shall be the insured member as provided in the Group Policy. (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.

Beneficiary Name (Last, First, Middle Initial) _____ Relationship _____ Social Security # _____ Assign % _____

Street Address _____ City _____ State _____ ZIP _____

Date of Birth _____ 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.

7 AUTHORIZATION

I understand that New York Life Insurance Company 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.

I hereby authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, LLC ("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 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.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent, representative, or I may request a copy of this AUTHORIZATION. This AUTHORIZATION shall be valid 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, the member requests the insurance indicated; and the member's and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted above and 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 below, 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.

X _____ **Member's Signature** (Please Sign and Date in Ink)

_____ Print Name

_____ Date Signed (MM/DD/YYYY)

(Necessary only if spouse coverage is requested)

X _____ **Spouse's Signature** (Please Sign and Date in Ink)

_____ Print Name

_____ Date Signed (MM/DD/YYYY)

8 FRAUD NOTICES

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:** For your protection California law requires the following to appear on this form: 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 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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9 IMPORTANT NOTICE (How New York Life Obtains Information and Underwrites Your Request For 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, LLC ("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 an 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, on this 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.

(continued on next page.)

9 IMPORTANT NOTICE (Continued)

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, LLC, 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone 866-692-6901. For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone 416-597-0590. 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.

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