INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: NYL GBS Benefit Summary Proof

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: ____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

❑ I am currently married and my date of marriage is: _____ or ❑ I currently have an eligible Domestic Partner

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employer-Paid (Basic) Term Life Insurance Policy # NYL 111111		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	$50,000	Guaranteed Coverage*: $50,000

Employee-Paid (Voluntary) Term Life Insurance Policy # NYL 111111		
Applicant	Available Coverage	Choose your desired coverage amount below or enter a different amount in the "Other" field.
Employee	Units of $10,000 up to $300,000. Guaranteed Coverage: The lesser of 3 times your salary, or $50,000.	❑ $10,000 ❑ $50,000* ❑ $300,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $5,000 up to $150,000. Guaranteed Coverage: $25,000	❑ $5,000 ❑ $25,000* ❑ $150,000** ❑ Other _____ *Amount must be a multiple of $5,000. The amount cannot exceed 100% of the employee's coverage.* ❑ Decline Coverage
Child	Units of $1,000 up to $10,000.	❑ $1,000 ❑ $10,000** ❑ Other _____ *Amount must be a multiple of $1,000.* ❑ Decline Coverage

Employer-Paid (Basic) Accidental Death & Dismemberment Insurance Policy # NYL 222222	
Applicant	**The coverage below is provided by your employer at no cost to you.**
Employee	$50,000

Please turn to other side to complete enrollment process.
Be sure to make a copy for your records.

Employee & Family
The Term Life insurance costs above include an equal amount of Voluntary Accidental Death & Dismemberment (AD&D) Insurance under Policy #NYL 222222.

Employer-Paid (Basic) Short-term Disability Insurance Policy # NYL 333333		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	60% of your weekly covered earnings, to a maximum of $1,500 per week.	
Employee-Paid (Core Buy-Up) Short-term Disability Insurance Policy # NYL 333333 *Your employer provides the Basic coverage above at no cost to you. You have the option to elect the following plan in addition to what your employer provides.*		
Applicant	Accepting or decline coverage below, and choose your desired amount, in units.	
Employee	You can elect coverage in units of $100 to a maximum of $3,000 per week.	❑ Accept Coverage # of Units _____ ❑ Decline Coverage

Employer-Paid (Basic) Long-term Disability Insurance Policy # NYL 444444		
Applicant	**The coverage below is provided by your employer at no cost to you.**	
Employee	60% of your monthly covered earnings, to a maximum of $5,000 per month.	
Employee-Paid (Core Buy-Up) Long-term Disability Insurance Policy # NYL 444444 *Your employer provides the Basic coverage above at no cost to you. You have the option to elect the following plan in addition to what your employer provides.*		
Applicant	Review your available plan below before accepting or declining coverage.	
Employee	60% of your monthly covered earnings to maximum of $10,000 per month.	❑ Accept Coverage ❑ Decline Coverage

**The GI amount is only available between* 07/01/2021 *and* 07/31/2021 *or if enrolling within the first 31 days of eligibility. For any coverage that is not Guaranteed Issue, you must complete the Evidence of Insurability Form.*
***This is the maximum amount that you can choose under this plan.*
All coverage elected during this enrollment period will take effect on the latest of 08/01/2021, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by GA: Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to short-term disability insurance only): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here ☛ Signature _____ Date _____

Created on 06/2021.