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NEW YORK LIFE

HAGAN INSURANCE GROUP

GROUP FIRM TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION

EMPLOYEE APPLICATION

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

INSTRUCTIONS: Gray-shaded portion to be completed by the Employer. The balance is to be completed by the Employee. Print clearly in dark ink, sign the form, and return it to your employer's benefits person. Be sure to initial all changes.

1 Employer Information

Please print in ink or type. Do not use correction fluid or gel pens. Initial and date any changes made.

Name of Employer

Group Plan Number

Effective Date of Coverage/Change M M / D D / Y Y Y Y

Group Firm Number

This form is being completed due to: (Check all that apply)

Date of Hire M M / D D / Y Y Y Y

☐ Initial Enrollment ☐ New Enrollee ☐ Late Entrant (Evidence of Insurability Required)

☐ Address Change ☐ Other

2 Employee Information

Employee Name

Gender ☐ Male ☐ Female

Mailing Address

City, State, Zip

Primary Phone – –

Work Phone – –

DOB M M / D D / Y Y Y Y

Social Security # – –

Employee I.D. #

Marital Status ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Job Title

Annual Salary

Hours Worked Per Week

☐ Active Full-Time
☐ Active Part-Time

3 Coverage Selection

Basic Life /AD&D Insurance (Filled out by Employer)

☐ Employee Elect Coverage
☐ Employee Decline Coverage

Amount of Coverage $

4 Beneficiary Selection

I hereby make the following beneficiary designation with respect to all the insurance on my life under the Group Term Life and AD&D Insurance Plan. The total % of coverage for all beneficiaries must equal 100%.

EMPLOYEES PRIMARY BENEFICIARY	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY #		DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE	% OF BENEFITS
EMPLOYEES SECONDARY BENEFICIARY	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY #		DATE OF BIRTH
ADDRESS	CITY	STATE	ZIP CODE	% OF BENEFITS

5 Fraud Notice

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 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.
FOR 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 and 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 NY (applicable to AD&D only): any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.
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.

6 Authorization and signature:

To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of the coverage of the nonpayment of benefits. I am an active employee of the Employer show above. I understand that the terms of the coverage of which I am enrolled are set forth in the Group Policy issued to my Employer. Also subject to revocation by me b6 written notice to my Employer at any time, I authorize the required deduction (if any) from my wages for the insurance I have selected.

Employee's Signature (PLEASE SIGN AND DATE IN INK)

X _____

Date M M / D D / Y Y Y Y

Employee's Email Address _____

Employer's Signature or Name of Benefits Person

X _____

Date M M / D D / Y Y Y Y

All Employee Applications must be returned to your employers benefits person.

Questions? Call 1-877-801-3727