



Request for Group Insurance from
New York Life Insurance Co.
51 Madison Avenue • New York, NY 10010



APPLICATION FOR LIFE INSURANCE
WISCONSIN NATIONAL GUARD ASSOCIATION

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

LAST NAME		FIRST		INITIAL	SOCIAL SECURITY NUMBER	
HOME ADDRESS: STREET			CITY		STATE/PROVINCE	ZIP CODE
HOME E-MAIL ADDRESS			WORK E-MAIL ADDRESS			
HOME PHONE NUMBER () ()		WORK PHONE NUMBER () ()		FAX NUMBER (IF APPLICABLE) () ()		
DATE OF BIRTH (day/month/year) / /		HEIGHT FT. IN.		WEIGHT LBS.		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
MARITAL STATUS: <input type="checkbox"/> MARRIED, MAIDEN NAME _____ <input type="checkbox"/> DIVORCED <input type="checkbox"/> SINGLE <input type="checkbox"/> WIDOWED						
Membership status with the Wisconsin National Guard: <input type="checkbox"/> Active <input type="checkbox"/> Separated <input type="checkbox"/> Surviving Spouse						
DATE OF ENLISTMENT (day/mo/year) / /		RANK		<input type="checkbox"/> ARMY <input type="checkbox"/> AIR - MILWAUKEE <input type="checkbox"/> AIR - MADISON		

DEPENDENT INFORMATION

** Attach a separate sheet to provide additional dependent information.**

If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 21, (or 23 if a full time student.)

SPOUSE'S FULL NAME (last, first, middle Initial)			DATE OF BIRTH (day/month/year) / /		<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	HEIGHT FT. IN.		WEIGHT LBS.
CHILD (Name)	DATE OF BIRTH (DD/MM/YY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	CHILD (Name)	DATE OF BIRTH (DD/MM/YY)	SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
1.	/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	3.	/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			
2.	/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	4.	/ /	<input type="checkbox"/> MALE <input type="checkbox"/> FEMALE			

NOTE: If both parents are members, child(ren) can only be covered by one parent — Attach a separate sheet to provide additional dependent information.

INSURANCE REQUESTED

(Refer to the brochure or your certificate for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Enrollment Change - Increase

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.

GUARDMEMBER		SPOUSE* (Spouse Only)			DEPENDENT (Spouse* & Child(ren))	
<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$ 5,000	<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$2,000	<input type="checkbox"/> \$10,000
<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$35,000	<input type="checkbox"/> \$10,000	<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$15,000
<input type="checkbox"/> \$20,000	<input type="checkbox"/> \$40,000	<input type="checkbox"/> \$15,000	<input type="checkbox"/> \$30,000	<input type="checkbox"/> \$45,000		
<input type="checkbox"/> \$25,000	<input type="checkbox"/> \$45,000	*Spouse total coverage amount cannot exceed Member's coverage amount				

In no event may the total coverage applied for exceed the maximum plan benefit of \$45,000. If a husband and wife are both members of the Wisconsin National Guard, both may apply for member coverage. **If both apply for member coverage, neither may apply for spouse (stand alone) coverage.**

INSURANCE REPLACEMENT: Is the insurance applied for intended to replace, discontinue or change an existing policy? Yes No

SECTION B – BENEFICIARY DESIGNATION

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

Beneficiary Name (Last, First, Middle Initial)		Beneficiary's Relationship to Member		Social Security Number	
Beneficiary's Street Address			City	State	Zip Code
G-14109-1					

SECTION C – STATEMENT OF HEALTH

To the best of your knowledge and belief: *(Please initial any changes you make on this form.)* **YES** **NO**

A.	Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>
B.	During the past five years has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, unexplained weight loss, or other illness disease or injury?	<input type="checkbox"/>	<input type="checkbox"/>
C.	During the past five years has any person proposed for coverage been counseled, treated or hospitalized for the use of alcohol or drugs?	<input type="checkbox"/>	<input type="checkbox"/>

If you have answered "Yes" to any of the questions above, please give details below *(attach a separate sheet if necessary)*

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

I request the group insurance shown on page 1 of 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 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 (or additional insurance) will become effective on the first day of the month on or following the date the initial premium payment is received by the Plan Administrator provided coverage is approved by New York Life and if I and any approved dependents are alive on that date.

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.

I authorize disclosure of the types of information detailed in the AUTHORIZATION below, for New York Life's use in considering this request for coverage. I have read the IMPORTANT NOTICE, which describes how New York Life underwrites this request for coverage

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, or insurance company to release information to New York Life, its subsidiaries or the Plan Administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. Other insurance companies may also furnish to New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, any criminal activity or association, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). I understand that the information provided may include information that may predate the time frame stated on the medical questions section on this application or any supplement to it. I also understand and agree that this information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release information covered by this AUTHORIZATION to the Plan Administrator, other insurance companies and to others whom I authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS).

This AUTHORIZATION may be used for a period of 24 months from the date signed below unless sooner revoked. I may revoke this AUTHORIZATION at any time by notifying the Plan Administrator in writing at the address given on this form. My 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. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. I acknowledge that I, or my authorized agent, may request a copy of this signed AUTHORIZATION.

By signing and dating this application, I request the insurance indicated, I understand the effective date criteria, I consent to authorize the disclosure of information to the providers noted, have read the Important Notices and to the best of my knowledge and belief that the answers to the questions are true and complete.

Member/Surviving Spouse Signature _____ (PLEASE SIGN IN INK) _____ DATE (DD/MM/YYYY)

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Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)?

If you have made corrections or strikeouts, these must be initialed by the member.

TO REQUEST GROUP TERM LIFE INSURANCE:

Complete this form in ink and mail to: WINGA INSURANCE PLAN • 2400 WRIGHT ST ROOM 205 • MADISON WI 53704-2572

Or you may contact us at 608-242-3100 or insinfo@winga.org