

Request for Group Insurance from



**NEW YORK LIFE  
INSURANCE COMPANY**

51 Madison Avenue New York, NY 10010

Group Term Life Insurance Plan  
for Members of the  
National Guard Association of Wisconsin  
G-14109-1

Member's Name \_\_\_\_\_ Social Security # \_\_\_\_\_

Mailing Address \_\_\_\_\_ Date of Enlistment \_\_\_\_/\_\_\_\_/\_\_\_\_  
Street Day Month Year

\_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
City State Zip Day Month Year

- Army
- Air
  - Madison
  - Milwaukee

**Beneficiary Designation: (Insert name, relationship and address)**

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan.

\_\_\_\_\_  
Beneficiary Name Relationship to Member Social Security #

\_\_\_\_\_  
Street Address City State Zip Code

**I HEREBY APPLY FOR \$10,000 OF GROUP TERM LIFE INSURANCE AT NO COST TO ME FOR ONE YEAR.**

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

**Please read the following statements carefully. If the statements are true, sign and date below in ink:**

**MEMBER DECLARATION:**

I declare that I have joined the National Guard of Wisconsin within the past 90 days and that I am currently an active guard member. I request the above indicated amount of insurance and understand that coverage will be effective on the first day of the month following receipt of this request for Group Term Life Insurance by the Plan Administrator provided the premium is paid when due by the Group Policyholder.

I also understand that any dividends apportioned by New York Life to the Plan will be paid to the Group Policyholder for the benefit of the policies and programs of the National Guard Association of Wisconsin.

By signing and dating this application, I request the insurance indicated; and attest to having read the Fraud Notice indicated below and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Day Month Year

**FRAUD NOTICE** –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.

G-14109-1

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Note: The maximum amount of coverage available with this request is \$10,000 per member. To apply for higher amounts of coverage for you and/or your dependents, contact WINGA at 608-242-3100 or by email at [insinfo@winga.org](mailto:insinfo@winga.org).

**Mail the completed form to: WINGA Insurance, 2400 Wright Street, Room 205, Madison WI 53704-2572**