GROUP LIFE E-Z APPLICATION FORM

Upon Completion Mail To:
Compass Rose Benefits Group
1768 Business Center Dr. • Suite 3500
Reston, VA 20190

Request for Group Insurance Form:
New York Life Insurance Company
New York, NY 10010
Policy Form GMR-ER-P-FACE

PLEASE PRINT IN BLUE OR BLACK INK OR TYPE ALL ANSWERS

1. EMPLOYEE INFORMATION:

Last Name _____ First _____ MI _____ Social Security Number _____

Home Address _____ City _____ State _____ Zip Code _____ E-mail Address _____

Home Phone Number _____ Cell Phone Number _____

___ /___ /___ Date of Birth ___ft. ___in. Height _____lbs. Weight Sex: ☐ M ☐ F

This section MUST be completed

____ / ____ / ____ Date of Employment _____ Employer/Agency

Marital Status: ☐ Single ☐ Married: Date of Marriage ____ / ____ / ____

2. DEPENDENT INFORMATION:

List eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 22). Basic coverage for spouse and child ($10,000 per individual) provided at no cost to employee. Please notify Compass Rose Benefits Group of any changes to your dependent information while you are covered under this policy.

Full Name (First, MI, Last)	Date of Birth (mo/day/yr)	M/F	Height	Weight	Full Name (First, MI, Last)	Date of Birth (mo/day/yr)	M/F
Spouse					Child 2		
Child 1			N/A	N/A	Child 3		

3. INSURANCE REQUESTED:

(Refer to the brochure for eligibility, options, and coverage description)
I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): ☐ New ☐ Additional

FOR NEW EMPLOYEES WITHIN 60 DAYS OF HIRE: You are eligible for up to $250,000 in Guaranteed Issue Coverage (Ages 65-69 up to $162,500 and 70+ up to $125,000) and up to $50,000 in Guaranteed Issue Spouse Supplemental Coverage. You do not have to complete Section 5 if you are applying within these limits.

NOTE: If you are increasing your coverage in any way, do not indicate on line (a) or (b) below the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting (Existing plus Additional Coverage).

a) Total Employee Amount Desired $ _____ ($50,000 to $500,000)
b) Total Supplemental Spouse Amount Desired **(not to exceed 50% of employee coverage)** $ _____ ($10,000 to $100,000)

4. BENEFICIARY DESIGNATION:

I make the following beneficiary designation with respect to all the insurance on my life under this Group Life Insurance Plan, and if I am already covered under the Plan, I hereby revoke any prior beneficiary designation. The beneficiary for spouse and dependent coverage shall be the insured employee as provided in the Group Policy: 1) If naming more than one beneficiary, note if each is to be primary or contingent, and the percentage of death proceeds to be distributed to each. Total must equal 100% for both primary and contingent. 2) If naming a trust, please indicate the full name and date of the trust and contact information.

Beneficiary Name: _____ _____ ☐ Primary ___% ☐ Contingent ___%
Last First MI Relationship Social Security #

_____ _____ _____ _____
Street Address City State Zip Code

Beneficiary Name: _____ _____ ☐ Primary ___% ☐ Contingent ___%
Last First MI Relationship Social Security #

_____ _____ _____ _____
Street Address City State Zip Code

For additional beneficiaries attach a separate sheet of paper, sign and date = 100% = 100%

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5. STATEMENT OF HEALTH: Section to be completed by:

a) Employee enrolling more than 60 days after the employment date
b) Employee within 60 days of the employment date requesting over $250,000 of coverage (65-69 requesting > $162,500 or 70+ requesting > $125,000)
c) Employee requesting Spouse Supplemental Life Coverage 60 days after the employment date or the marriage date
d) Employee within 60 days of employment or marriage date who is requesting over $50,000 in Spouse Supplemental Coverage

To the best of your knowledge and belief, answer the following questions as they apply to you and your spouse if opting for Supplemental Coverage. Please check your answers.

	Member	*Spouse*
(1) Are you or your spouse now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐ YES ☐ NO	☐ YES ☐ NO
(2) During the past five years have you or your spouse 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, or unexplained weight loss?	☐ YES ☐ NO	☐ YES ☐ NO
(3) During the past five years have you or your spouse been counseled, treated, or hospitalized for the use of alcohol or drugs?	☐ YES ☐ NO	☐ YES ☐ NO

If you answered "Yes" to any questions, please provide complete details below. Attach a separate sheet if necessary, sign and date.

(#)	Name of Proposed Insured	Details (Name of drug, condition, diagnosis and treatment, etc.)

6. DIRECT DEBIT WITHDRAWAL OF INSURANCE PREMIUM: In order to collect premium payment for your Term Life Insurance, please provide the following banking information. Premium will be collected on a monthly basis based on your coverage and age according to the rate chart. In the event your Term Life Application is not accepted, this Authorization will become null and void. Deductions will be made on the 1st of the month, or the following business day, and will appear as 'Term Life Insurance' on your bank statement.

Visit our website at **www.compassrosebenefits.com/samplecheck** for a sample check if you need help determining your bank routing and account numbers.

Savings Account ☐ Checking Account ☐

Name of Account Holder _____ Bank Routing Number _____ Bank Account Number _____

Numbers must be 9 digits & start with 0, 1, 2, or 3 Include all leading zeros & omit any spaces/characters

I authorize Compass Rose Benefits Group to bill my bank account for this plan for the premium amount based on my current age and the coverage selected; it will remain in force until I notify them in writing to cancel.

Automatic Bank Draft Signature: _____

7. FRAUD NOTICE:

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.

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

I ask New York Life to rely on all such statements made on this Form, and any supplements to it, while considering this request. If I have completed Section 5 I also understand that coverage afforded will be in consideration of the answers set forth above. If a decision regarding my insurability cannot be made solely on the basis of the answers on this Request Form, New York Life has the right to request additional information and, if necessary, I will also be given information regarding how my coverage is underwritten and my right to correct information in my file. Any information will be furnished through Compass Rose Benefits Group who will insure the confidentiality of the person proposed for insurance. A photocopy of this Request Form shall be as valid as the original.

Member's Signature X _____ Date _____

Spouse's Signature X _____ Date _____

Required if applying for Supplemental Spouse Coverage

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Optional: To better serve our members, we'd like to know: *How did you hear about Compass Rose Benefits Group?*

_____ Thank you!

Questions?
Call (866) 368-7227