

Group Disability Income Insurance Plan Guaranteed Acceptance* Application for NEW Federal Employees offered through CSEBA

IT'S EASY TO APPLY. SEND NO MONEY NOW, you will be billed at a later date. As a new Federal Employee within 45 days of your employment date, you cannot be denied this coverage. But don't delay.

1. Complete the sections below for your desired coverage with a specialty-negotiated rate of \$18.75 per quarter/per \$10,000 of covered salary.
2. Sign and date the application where indicated.
3. Return to: NBFSA • P.O. Box 24279 • Winston Salem, NC 27114-4279



Request for Group Insurance from:
New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

Administered by
NBFSA • P.O. Box 24279
Winston Salem, NC 27114-4279



STARR
WRIGHT
USA

Federal Employee Program Administrator/Licensed Producer

Questions? Call NBFSA at (844) 746-1452
Monday through Friday, 9:00 a.m. to 7:00 p.m. Eastern

| | | | | |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-------------|-----------------------------------------------------------------------------------|---------------------------|-----------|
| Member's Name (First, Middle Initial, Last): | | <input type="checkbox"/> Male <input type="checkbox"/> Female | Phone Number: | |
| Home Street Address: | | City: | State: | Zip Code: |
| Date of Birth: | Occupation: | | Date of Hire | |
| Government Agency Name: | | Retirement Option: <input type="checkbox"/> CSRS <input type="checkbox"/> FERS | E-mail Address: | |
| DISABILITY INCOME INSURANCE REQUESTED: <i>(Refer to the brochure / website for eligibility, options and coverage description.)</i> | | | | |
| COVERAGE INFORMATION: <input type="checkbox"/> Total Coverage Requested \$ _____ per month <i>(Waiting Period: 60 days.)</i> | | | | |
| Your Current Annual Salary \$ _____ and Effective Date: ____/____/____ | | | | |
| <i>Your Insured Annual Salary amount may not exceed your Actual Annual Salary (including AUO/AVP if applicable). Coverage Amount Available: 65% of your Average Monthly Insured Income to a maximum of \$8,992 per month.</i> | | | | |
| Beneficiary Name: | | | Beneficiary Relationship: | |
| Beneficiary Phone Number: | | Beneficiary Address: | | |

READ AND SIGN:

By signing and dating this application, the member **requests** the insurance indicated; **attests** to having read the Fraud Notices indicated on the reverse, and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

I represent that I am under age 60, work at least 17.5 hours a week, am enrolling within 45 days after my date of hire and that the statements above are true and complete to the best of my knowledge and belief. By applying for coverage, I understand that the benefit amount cannot exceed 65% of my Average Monthly Income (minus any Other Income Benefits). I understand that this plan will not cover Pre-existing Conditions (conditions for which I received medical advice or treatment within 12 months of this coverage) until 12 treatment free months have passed (ending on or after my effective date) or until the coverage has been in effect for 1 year.

Member's Signature: (Please sign and date in ink)

X _____ Date _____
Required Required

Please refer to the website for more details including costs, exclusions, limitations and terms of coverage.

*This policy is guaranteed acceptance, but it does contain a Pre-existing Condition limitation.

FRAUD NOTICES

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.

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 or 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: For accident and health insurance 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.