NEW YORK LIFE GROUP BENEFIT SOLUTIONS

For more information and customer service, call or write
NYL GBS Customer Service Center:
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306
Phone: 1.800.231.1193, 8:00 a.m. to 5:00 p.m., CT
Fax: 1.877.435.7181

CLEAR FORM

Application for Insurance

Life Insurance Company of North America (LINA)

(herein called the Insurance Company(ies))

- *All info must be completed by the applicant.*
- *Applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*
- *The Insurance Company must approve your request for insurance before it becomes effective.*

Important: *Please enter all dates in mm/dd/yyyy format.*

Please print (preferably in black ink).

EMPLOYER USE
EMPLOYER Insperity Holdings, Inc. **WORKSITE** _____ **BILLING LOCATION** 0000

Employee Name (First) _____ (Last) _____ (Middle Initial) ____ Social Security Number _____ Birthdate _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Email Address _____

Date of Hire _____ Covered Annual Earnings* _____ **Covered Annual Earnings as paid by Insperity*

Important: You must complete the medical questions in this application if you apply:(1) for life insurance exceeding the Guaranteed Coverage Amount, or (2) as a newly hired employee more than 30 days after you are eligible to elect benefits (for life and Disability Insurance only). Such insurance will not take effect unless and until the insurance company has approved this medical questionnaire as satisfactory.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

Spouse/Domestic Partner Information Name (First) _____ (Last) _____ (Middle Initial) ____

Social Security Number _____ Birthdate _____

☐ I am currently married and my date of marriage is _____ *or* ☐ I currently have an eligible Domestic Partner*

*See Affidavit of Domestic Partnership requirement

VOLUNTARY TERM LIFE INSURANCE - POLICY NO. FLI980027 (LINA)

See the brochure for Guaranteed Coverage, and amounts of insurance you may purchase. Amounts of insurance may be limited by state law.

Employee

☐ I select the following insurance amount *(check one):*

☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x Covered Annual Earnings *

**Covered Annual Earnings as paid by Insperity*

Spouse/Domestic Partner

☐ I select the following insurance amount for my Spouse/Domestic Partner*(check one):*

☐ $ 10,000 ☐ $ 20,000 ☐ $ 30,000 ☐ $ 40,000

☐ $ 50,000 ☐ $ 100,000 ☐ $ 150,000 ☐ $ 200,000

Dependent Children: I wish to enroll for my dependent children and elect the following insurance amount: ☐ $ 5,000 ☐ $ 10,000

VOLUNTARY TERM LIFE INSURANCE BENEFICIARY DESIGNATION

To **specify a beneficiary**, once you are enrolled, access the NYL GBS Benefits Guide website by logging into your Insperity Employee portal and select “Benefits”, then “Voluntary Benefits”. Access 'My Account' link in the upper right-hand corner of the web page. Select the coverage option you wish to view. Select the “Beneficiary Information” link.

Applicant's Name _____ **Social Security Number** _____

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) INSURANCE - POLICY NO. OK823223 (LINA)

I select the following insurance Coverage: ☐ Myself only ☐ Myself and my family

If spouse only-60% of my benefit amount, if spouse and child(ren)-50%/10% of my benefit amount. if child(ren) only-15% of my benefit amount

I select the following amount of AD&D coverage: ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ 6x Covered Annual Earnings *

**Covered Annual Earnings as paid by Insperity*

VOLUNTARY ACCIDENTAL DEATH & DISMEMBERMENT (AD&D) BENEFICIARY DESIGNATION

To ***specify a beneficiary***, once you are enrolled, access the NYL GBS Benefits Guide website by logging into your Insperity Employee portal and select “Benefits”, then “Voluntary Benefits”. Access 'My Account' link in the upper right-hand corner of the web page. Select the coverage option you wish to view. Select the "Beneficiary Information" link.

VOLUNTARY DISABILITY INSURANCE - POLICY NO. SLK030024 (LINA)

NOTE: Eligibility for Voluntary Disability Insurance is determined by the Insperity benefits package available to you and may be affected by your participation in other benefit programs.Please confirm that Voluntary Disability is available to you by checking with your Insperity orientation representative or by calling Insperity toll-free at 866-715-3552 weekdays between 7 a.m. and 7 p.m. Central time.

☐ Yes, I am eligible and select Disability Coverage ☐ No, I do not select Disability Coverage

Pre-Existing Conditions Limitation (applicable to Long-Term Disability Insurance only): A pre-existing condition is any injury or illness for which you have consulted a Physician, received medical treatment, taken prescribed drugs or medicines, or incurred expenses during the 3 months prior to the effective date of your insurance. If you become totally disabled due to a pre-existing condition, you will not receive benefits unless your disability begins more than 12 months after the effective date of your coverage.

ACCEPTANCE / DECLINATION

I accept the insurance coverage(s) chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the needed amounts from my earnings. If I have not chosen coverage, I understand that if I wish to participate at a later date, I may be required to furnish evidence of insurability/good health at my own expense and that coverage is subject to the insurance company's approval.

In order to confirm your election, you must provide signature

Sign Here _____ *Employee Signature* Date _____ *(Month/Day/Year)*

IMPORTANT

Please complete each section that follows if it is needed. Each section states when it is needed.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Applicant's Name _____ **Social Security Number** _____

SECTION A: This section is needed when applying for Life and/or Disability Insurance.

Complete the Employee info in this section if you (i.e., the Employee) are:

- *applying for Life Insurance for yourself that is greater than the guaranteed amount, or*
- *applying for Life and/or Disability Insurance for yourself more than 30 days after you were eligible for the insurance.*

Complete the Spouse/Domestic Partner info in this section if:

- *applying for Life insurance for your Spouse/Domestic Partner that is greater than the guaranteed coverage amount, or*
- *applying for Life insurance for them more than 30 days after the Spouse/Domestic Partner is eligible for the Life insurance.*

Height and Weight Information

Employee	Spouse/Domestic Partner
Height : _____ ft _____ in Weight : _____ lbs	Height : _____ ft _____ in Weight : _____ lbs

SECTION B: This section is needed when applying for Life Insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

	Employee		Spouse/ Domestic Partner	
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:	Yes	No	Yes	No
A. A heart attack or stroke?	☐	☐	☐	☐
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	☐	☐	☐	☐
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐	☐	☐
D. HIV infection or AIDS?	☐	☐	☐	☐
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	☐	☐	☐	☐
F. Alcohol or drug abuse or dependency?	☐	☐	☐	☐
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) conviction?	☐	☐	☐	☐

SECTION C: This section is needed when applying for Disability Insurance.

Please indicate your answers for each question in this section by checking the Yes or No box for the question.

	Employee	
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:	Yes	No
A. A heart attack or stroke?	☐	☐
B. Cancer (other than Nonmelanoma Skin Cancer), Hodgkin's disease, or Leukemia?	☐	☐
C. Emphysema or Chronic Obstructive Pulmonary Disease (COPD)?	☐	☐
D. HIV infection or AIDS?	☐	☐
E. Diabetes, Hepatitis C or Cirrhosis of the liver?	☐	☐
F. Alcohol or drug abuse or dependency?	☐	☐
G. Anxiety disorder, Bipolar Disorder or Depression?	☐	☐
H. Chronic Fatigue, Fibromyalgia or Multiple Sclerosis?	☐	☐
I. Any bone, joint, or muscle condition persisting for, or having been treated for, 6 months or longer?	☐	☐
2. Within the last 5 years has the proposed insured had a Driving While Intoxicated (DWI) or Driving Under the Influence (DUI) conviction?	☐	☐

Applicant's Name _____ **Social Security Number** _____

AGREEMENTS

To the best of my knowledge and belief all written, telephonic and electronic info I gave is true and complete. I understand that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective are described in the policy and certificate. The approval of this request by the Insurance Company is one of those conditions. I understand and agree that:

(1) This request will be a part of the policy that provides the insurance.
(2) I may need to provide more medical info.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) I must report any change in my health that happens before the insurance is effective.
(5) Requested insurance will not be effective for a person if the person does not meet the underwriting requirements on the date insurance is to be effective.

Authorization. I permit any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, of me to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization is valid for 24 months from the date below. I accept that a copy of this Authorization is as valid as the original.

I understand that I and/or my authorized agent have the right to receive a copy of this authorization upon request.

I understand that the info will be used to assess my request for insurance.

I may revoke this authorization at any time in writing. Any such revocation will not: (1) change any action taken in reliance on the Authorization; and (2) change the Insurance Company's right to use the Authorization for contest of a claim or policy in accordance with applicable law.

I understand that info provided pursuant to this authorization may be disclosed by the recipient and is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (The Insurance Companies are subject to the Gramm-Leach-Bliley act and state privacy laws. They do not disclose protected information except as permitted by those laws.)

Caution: Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Sign Here _____ *Employee Signature* _____ *(Month/Day/Year)* _____ *Spouse/Domestic Partner's Signature (If applying for insurance for your Spouse/ Domestic Partner)* _____ *(Month/Day/Year)*

Notice: Personal information may be collected from persons other than those proposed for coverage. Information may be disclosed to third parties without your authorization as permitted by law. You have the right to access and correct all personal information collected. Additional information about the insurance company's privacy practices is available upon request.

CLICK TO PRINT