



INSURANCE ENROLLMENT FORM

Empty rounded rectangular box

New York Life Group Insurance Company of NY (NYLGICNY) (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 Cornell University

Employee Name (First) (Last) (Middle Initial) Social Security #
Address City State Zip
Work Phone Home Phone Email Address
Birthdate

Important: You must complete the medical questions in this application, if you apply for life insurance: (1) exceeding the Guaranteed Coverage amount, or (2) after the completion of any open enrollment period (as agreed upon by your employer and the insurance company), or (3) as a newly hired employee more than 60 days after you are eligible to elect benefits.

COMPLETE IF ELECTING SPOUSE/DOMESTIC PARTNER COVERAGE

Spouse/Domestic Partner information
Name (First) (Last) (Middle Initial)
Social Security # Birthdate

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

\*See your Employer for more information about eligibility requirements for Domestic Partners, including whether an Affidavit must be on file with your Employer if you are not in a state-registered Domestic Partnership or in a Civil Union.

VOLUNTARY TERM LIFE INSURANCE - POLICY NO. (NYLGICNY)

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

Employee:

I would like my insurance amount to match the following (check one):
1x 2x 3x 4x 5x 6x 7x 8x 9x 10x Annual Salary.
Guaranteed Amount: The lesser of 5 times Annual Salary or \$1,000,000.
Maximum Amount: The lesser of 10 times Annual Salary or \$2,000,000.
I elect to contribute \$ each month to my Cash Accumulation Fund. (ex: \$5, \$10, \$25. etc.)

Spouse/Domestic Partner:

I select the following insurance amount for my Spouse/Domestic Partner:
\$ (in units of \$10,000)
Guaranteed Amount: \$50,000 Maximum Amount: \$250,000
I elect to contribute \$ each month to my Spouse's/Domestic Partner's Cash Accumulation Fund. (ex: \$5, \$10, \$25. etc.)

Dependent Children: I currently have eligible dependent children, and:

I elect following insurance amount: \$2,000 \$4,000 \$6,000 \$8,000 \$10,000 \$12,000 \$14,000 \$16,000 \$18,000 \$20,000



Applicant's Name \_\_\_\_\_

Social Security # \_\_\_\_\_

**SECTION A: This section is needed when applying for Life 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 Insurance for yourself more than 60 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 60 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

**Physician Section**

**Employee Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Spouse/Domestic Partner Physician**

Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**SECTION B: COMPLETE SECTION B AND C IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT, OR IF APPLYING MORE THAN 60 DAYS AFTER YOU ARE ELIGIBLE.**

Please indicate your answers for each question in this section by checking the Yes or No box for the question. The questions in Section C must also be answered.

Within the last 5 years has the proposed insured been: a) diagnosed with any of the conditions shown in this Section, b) told by a medical professional he/she has or may have any of the conditions shown in items A through J below, c) or been treated by a medical professional for any of the conditions shown in items A through J below?	Employee		Spouse/Domestic Partner	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Insulin Dependent, Diabetes, glandular condition, Hepatitis, Cirrhosis of the liver, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
C. Asthma, Chronic Bronchitis, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any other condition affecting the lungs or respiratory tract?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's Disease, Paralysis, Epilepsy, fainting, Seizures, headaches, or other condition affecting the nervous system?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
G. Anemia or any other condition affecting the blood; Lupus, Arthritis, deformity or loss of limb?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
H. Anxiety disorder, Depression, Bipolar Disorder, or any other mental disorder or condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
I. Cancer (other than Nonmelanoma Skin Cancer), Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
J. Alcohol or drug abuse or dependency?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**SECTION C: COMPLETE SECTION B AND C IF APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT, OR IF APPLYING MORE THAN 60 DAYS AFTER YOU ARE ELIGIBLE.**

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

Within the last 5 years has the proposed insured been:	Employee		Spouse/Domestic Partner	
	Yes	No	Yes	No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
B. Smoked cigarettes:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Use the space below to explain "Yes" answers. If more space is needed, use a new page. Sign and date it. Attach it to this form.

Name of Employee/ Spouse/Domestic Partner	Condition	Date Occurred	Duration/Treatment Received	Current Status

**Caution:** With regard to accident and health insurance, any person who, knowingly and with intent to defraud any insurance company or other person: (1) files an application for insurance or a statement of claim containing any materially false information; or (2) conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act. This is a crime subject to a civil penalty not to exceed \$5,000 and the stated value of the claim for each such violation.

Applicant's Name \_\_\_\_\_

Social Security # \_\_\_\_\_

**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 my insurance 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, the Medical Information Bureau (MIB) 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 30 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.)



Sign Here

\_\_\_\_\_  
*Employee Signature*

\_\_\_\_\_  
*(Month/Day/Year)*

\_\_\_\_\_  
*Spouse/Domestic Partner's Signature*  
*(If applying for insurance for your Spouse/  
Domestic Partner)*

\_\_\_\_\_  
*(Month/Day/Year)*

\_\_\_\_\_