NEW YORK LIFE GROUP BENEFIT SOLUTIONS

NEW YORK LIFE GROUP INSURANCE COMPANY OF NY
51 Madison Ave.
New York, NY 10010
(herein called the Insurance Company)

Return form to:
NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306
Customer Service: 1.800.231.1193
Or fax toll-free 1.877.435.7181

Group Insurance Enrollment Application

CLEAR FORM

- *All information 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. FLY980026 (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.

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: $300,000

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 #** _____

PERSONAL ACCIDENT INSURANCE - POLICY NO. YOK-008416 (NYLGICNY)

I select the following insurance amount:

Employee Benefit Amount $ _____ (units of $10,000, up to $500,000)

Spouse/Domestic Partner ☐ 100% of my benefit -or- ☐ 50% of my benefit Maximum Amount: $250,000

☐ Children at 10% of my benefit Maximum Amount: $25,000

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 a signature.

Sign Here _____ _____

Employee Signature *(Month/Day/Year)*

****You should complete the Beneficiary Designation and read and sign the Agreements Section that follows in this form.****

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 #** _____

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

SECTION B: IMPORTANT - COMPLETE ALL OF THE MEDICAL QUESTIONS BELOW WHEN APPLYING FOR LIFE INSURANCE ABOVE THE GUARANTEED COVERAGE AMOUNT. IF YOU APPLY MORE THAN 31 DAYS AFTER YOU ARE ELIGIBLE, COMPLETE QUESTIONS A-K

In the past five years have you been diagnosed with, or treated for, any condition listed below?	Employee		Spouse/Domestic Partner	
	Yes	No	Yes	No
A. Cysts, moles, warts, polyps, cancer or tumor?	☐	☐	☐	☐
B. High blood pressure, heart attack, pain or pressure in chest, shortness of breath, irregular heartbeats, heart murmur, varicose veins or any other disease/disorder of the heart or circulatory system?	☐	☐	☐	☐
C. Enlarged glands, goiter, diabetes, thyroid disorders, or any other disease/disorder of the stomach, intestines, liver, gallbladder, kidneys, or any other disease/disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia,or disease of the throat, lungs or any other disease/disorder of the respiratory tract?	☐	☐	☐	☐
D. Any alcohol and/or drug addiction and/or substance abuse; Mental, emotional or any other nervous disorders?	☐	☐	☐	☐
E. Is there a current use of prescribed medications by the proposed Insured?	☐	☐	☐	☐
F. Ever been diagnosed with or been treated for AIDS-Related Complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) or tested positive for antibodies to the AIDS (Human Immunodeficiency) Virus?	☐	☐	☐	☐
G. Any illness, injury, birth or congenital defect, disease/disorder not mentioned in Questions A-F?	☐	☐	☐	☐
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness or any other disease/disorder of the nervous system?	☐	☐	☐	☐
I. Gout, arthritis, rheumatism, neck or back strain/sprain/injury, any deformity or loss of limb, or any other disease/disorder of the back, spine, muscles, bones or joints?	☐	☐	☐	☐
J. Any surgical operation performed or been advised to have any performed?	☐	☐	☐	☐
K. Ever been in a hospital or sanitarium for rest treatment, observation or diagnosis; undergone any special examinations or laboratory tests, such as x-rays, electrocardiograms, biopsies, blood or urine tests; or had any medical advice, examination, consultation or treatment not mentioned in questions A through J?	☐	☐	☐	☐

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

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

AGREEMENTS

To the best of my knowledge and belief all written information 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 family members' coverage will not go into effect unless the family member is not confined in a hospital, hospice, rehabilitation or convalescence center, or custodial care facility or confined at home under the direction of a physician. 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 information.
(3) I may need to take medical tests and report the results to the Insurance Company.
(4) 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.
(5) I must report any change in my health that happens before the insurance is effective.

Authorization. I hereby authorize any physician, medical professional, hospital or other medical facility, pharmacy, employee assistance plan, insurance company, benefit managers, health maintenance organization or similar entity, or any other person or organization that maintains records relating to my medical history, mental or physical condition, diagnosis or treatment, including motor vehicle driving record, to my employer's Plan Administrator and to their authorized representatives including New York Life Group Insurance Company of NY.

This permission 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 information 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 information 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. (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 and with intent to defraud any insurance company or other person: (1) files an application for insurance or 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.

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.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Beneficiary Designation Form
Cornell University-Active Employees
Voluntary Term Life (VTL) Insurance
Personal Accident Insurance (PAI)

NYL GBS Customer Service Center
Administered by Infosys McCamish Systems, LLC
P.O. Box 14577
Des Moines, IA 50306
1.800.231.1193
Fax: 1.877.435.7181
Collect 1.470.947.3435 from Alaska or Outside the U.S.A.

Employee Name: _____ **Employee Social Security Number:** _____

Current Address: _____ **City:** _____

State: _____ **Zip:** _____ **Home Phone:** _____ **Work Phone:** _____

Primary and Contingent Beneficiaries - Unless you designate a percentage, proceeds are paid to primary surviving beneficiaries in equal shares. Proceeds are paid to contingent beneficiaries only when there are no surviving primary beneficiaries. If you designate contingent beneficiaries and do not designate percentages, proceeds are paid to the surviving contingent beneficiaries in equal shares. Unless otherwise provided, the share of a beneficiary who dies before the insured will be divided proportionately among the surviving beneficiaries in the respective category (primary or contingent).

If you need additional space to indicate your beneficiary designations, attach a separate piece of paper using the below format including the appropriate policy number, the date, and your signature.

Voluntary Term Life Insurance, New York Life Group Insurance Company of NY **Policy Number** FLY980026

Employee Beneficiary

Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Spouse/Domestic Partner Beneficiary

Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Personal Accident Insurance, New York Life Group Insurance Company of NY **Policy Number** YOK-008416

Employee Beneficiary

Primary Beneficiary(ies):	Relationship	Social Security Number	Date of Birth	% (total must equal 100%)
				%
				%
				%
Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Spouse/Domestic Partner Beneficiary				
Primary Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%
Contingent Beneficiary(ies):	**Relationship**	**Social Security Number**	**Date of Birth**	**% (total must equal 100%)**
				%
				%
				%

Note: This form is not complete without your signature. Please sign the form where indicated.

Community Property Laws - If you are married, reside in a community property state (Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Texas, Washington, or Wisconsin), and name someone other than your spouse as beneficiary, payments of benefits may be delayed or disputed unless your spouse provides their signature in the space provided below.

☞ Spouse's Signature: _____ Date: _____

☞ Owner's Signature: _____ Date: _____

Guidelines for Designation of Beneficiaries

General - Please be sure to include the beneficiary's full name, social security number and relationship to you. Providing this information can help expedite the claim process by making it easier to locate and verify beneficiaries.

Minors - While you may designate minors as beneficiaries, please note that claim payments may be delayed due to special issues raised by these designations. In the event of a claim and the beneficiary is a minor child, the insurance proceeds will not be released to the minor child. The insurance proceeds may be paid to a duly appointed guardian of the child's estate. You may want to obtain the assistance of an attorney in drafting your beneficiary designation(s).

Trust as Beneficiary - You may designate a trust as beneficiary, using the following form: "To [name of trustee], trustee of the [name of trust], under a trust agreement dated [date of trust]."

If you wish to designate a testamentary trust as beneficiary (i.e., one created by will), you should recognize the possibility that your will which was intended to create this trust may not be admitted to probate because it is lost, contested, or superseded by a later will. Claim payment delays can result if the beneficiary designation does not provide for this situation.

Domestic Partner - If you wish to designate your domestic partner as your beneficiary, you must complete a beneficiary form. Otherwise, your death benefit will be paid according to the provisions of the policy.

Life Status Changes - We recommend that you review your beneficiary designation(s) when significant life status events occur, such as marriage, divorce, or birth of a child.

See an Attorney! The above guidelines are general and are not intended to be relied on as legal advice. Unless your designation is a simple one, we recommend that you obtain the assistance of an attorney in drafting your beneficiary designation(s). A qualified attorney can help assure that your beneficiary designation correctly reflects your intentions, is clear and unambiguous, and meets legal requirements.

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