

**Application for 10-Year Level Premium Group Term Life Insurance for
Members of Participating Credit Unions in the ACU Group Insurance Trust**



LIFERING PLAN ADMINISTRATOR: PO Box 152501, Irving, TX 75015-9955 1-800-223-8646 (visit www.lifering.net)

REQUEST FOR GROUP INSURANCE FROM: New York Life Insurance Company, 51 Madison Avenue, New York, NY 10010

SECTION A – MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

For Office Use Only – Group No. G-10658-0
Certificate No. _____

Last Name _____ First _____ Initial _____

Home Address: Street _____ City _____ State/Province _____ Zip Code _____

Home E-mail Address _____ Work E-mail Address _____ Social Security Number _____

(_____) _____ (_____) _____ (_____) _____
Home Phone Number _____ Office Phone Number _____ Fax Number _____

Date of Birth ____/____/____ Height ____ft ____in. Weight ____lbs. Sex: Male Female

(MM / DD / YYYY)

Marital Status Married.....Maiden Name _____ Divorced Single Widowed

I am now a Member of: _____
(Insert Name of your Credit Union)

Credit Union Account # _____ Share Savings Share Draft Checking

Are you presently insured under the LifeRing Term Life Insurance Program? Yes No If Yes, provide details _____

Do you intend to reside outside the U.S. or Canada in the next 12 months? Member: Yes No Spouse: Yes No

Member: If yes, Country _____ How Long? _____ Spouse: If yes, Country _____ How Long? _____

BILLING INFORMATION: Your Credit Union Account will be billed when your coverage is approved AND provided you complete and sign SECTION D – AGREEMENT FOR PRE-AUTHORIZED CHARGES –

If **DEPENDENT** coverage is requested, list eligible dependents (i.e. lawful spouse under age 65 and unmarried, dependent children under 25.)

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	<input type="checkbox"/> MALE	HEIGHT	WEIGHT
			<input type="checkbox"/> FEMALE		
Child (Name)	Date of Birth	<input type="checkbox"/> MALE		Date of Birth	<input type="checkbox"/> MALE
1. / /	<input type="checkbox"/> FEMALE	3. / /		<input type="checkbox"/> FEMALE	
Child (Name)	Date of Birth	<input type="checkbox"/> MALE		Date of Birth	<input type="checkbox"/> MALE
2. / /	<input type="checkbox"/> FEMALE	4. / /		<input type="checkbox"/> FEMALE	

NOTE: If both parents are members, child(ren) can only be covered by one parent. Attach separate sheet to provide additional dependent information.

INSURANCE REQUESTED: (Refer to the brochure or your certificate for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): New Change

NOTE: If you are increasing or altering present coverage in any way, do not indicated just the additional amount of coverage, instead indicate the TOTAL AMOUNT of coverage you are requesting.

GROUP 10-YR LEVELTERM LIFE INSURANCE: **Note:** The maximum coverage amount available under all New York Life plans is \$1,000,000

Member Amount (from \$100,000 to \$1,000,000 in \$25,000 increments)..... \$ _____

Spouse Amount*(from \$100,000 to \$1,000,000 in \$25,000 increments).....\$ _____
**Spouse Amount cannot exceed member amount of coverage*

Child(ren) \$4,000 for each eligible child; (\$1,000 age 14 days to 6 months)

SMOKING QUESTION: Have you or your spouse used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 24 months? Member: Yes No Spouse: Yes No

If yes, when did you last use tobacco or nicotine products? Member: _____ (mo/year) Spouse: _____ (mo/year)

INSURANCE REPLACEMENT – RESIDENTS OF NEW YORK: I have read the Important Replacement Information below. Is the life insurance applied for intended to replace, in whole or in part, any existing insurance or annuity?

Member Yes No Spouse Yes No

RESIDENTS OF ALL OTHER STATES:

Is the insurance applied for intended to replace, discontinue or change an existing policy? Member Yes No Spouse Yes No

FOR CURRENT NEW YOUR LIFE GROUP INSURED:

I intend to cancel my in-force Group Term Life Insurance upon approval of this application, and replace it with this 10-Year Level Term Life Insurance that I am applying for on this Application

I intend to keep in-force my Group Term Life Insurance upon approval of this application and add separately the new Group 10-Year Level Term Life Insurance coverage that I am applying for on this application.

SECTION B – BENEFICIARY DESIGNATION

(Attach a separate sheet signed and dated to provide additional beneficiary information)

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 dependent coverage shall be the insured member as provided in the Group Policy. 1.) If naming more than one beneficiary, note if each is to be primary and/or secondary, and the percentage of death proceeds to be distributed to each. 2.) If naming a trust, please indicate the full name and date of the trust.

Beneficiary's Name: _____ Complete Address _____ Relationship _____ Social Security # _____ % _____

Beneficiary's Name: _____ Complete Address _____ Relationship _____ Social Security # _____ % _____

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Continued on Reverse Side.....

NEW YORK RESIDENTS - IMPORTANT REPLACEMENT INFORMATION:

It may not be in your best interest to replace existing life insurance policies or annuity contracts in connection with the purchase of a new life insurance policy, whether issued by the same or different insurance company. A replacement will occur if, as part of your purchase of a new life insurance policy, existing coverage has been, or is likely to be, lapsed, surrendered, forfeited, assigned, terminated, changed or modified into paid-up insurance or other forms of benefits, loaned against to withdrawn from, reduced in value, by use of cash values or other policy values, changed in the length of time or in the amount of insurance that would continue or continued with a stoppage or reduction in the amount of premium paid. Prior to completing a replacement transaction, you may want to contact the insurance company or agent who sold you the life insurance or annuity contract that will be replaced to help decide whether the replacement is on your best interest.

SECTION C - STATEMENT OF HEALTH To the best of your knowledge and belief: (Please initial any changes)

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| <p>1. Is any person to be insured disabled or receiving any disability or workers compensation benefits or on waiver of premium for life or health insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3. During the past five years, has any person to be insured consulted any physician or other medical care practitioner other than for a routine physical examination, or checkup, or been hospitalized or had an operation or had any illness, disease or injury? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>4. Are you or any other person to be insured taking any kind of medication or, so far as you know, in impaired physical or mental health? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>5. Is any person to be insured now pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>6. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having or been treated for:</p> <p>a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>b. Arthritis, back trouble, bone or joint disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>c. Fainting spells, convulsions or epilepsy? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>d. Sugar, blood, albumin or pus in urine? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>e. Diabetes, kidney trouble, ulcers or digestive disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>f. Disorder of breast or reproductive organs or functions? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>g. Nervous or mental disorder, emotional conditions or psychiatric care? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>h. Cancer, tumor or cyst? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>i. Varicose veins, hemorrhoids or hernia? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>j. Disorder of eyes, ears, nose or sinuses? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>k. Thyroid, liver or respiratory disorder? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>l. Alcoholism or drug habit? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>m. Disorder of the blood? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> | <p>n. Other Health or physical impairment including: <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>(iii) Any other impairment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>8. Except for residents of Maryland, has any person to be insured had a parent, brother or sister who, prior to age 60 had been medically diagnosed by a physician as having, or been treated for, cancer, a stroke, paralysis, hypertension, diabetes, heart disease, kidney disease, neuro-muscular or mental illness? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>9. Within the past two years, have you or your spouse participated in, or do either of you, within the next two years, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snowmobiling, hang gliding, parasailing, bungee jumping, or organized motorcycle racing, or any type of organized motorized racing? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>10. Driver's License No.: Member _____
Spouse _____
State in which issued: Member _____
Spouse _____
Have you or your spouse's driver's license been suspended or revoked or had any moving violations within the last five years? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>11. Except for the residents of Minnesota and Connecticut, in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or have an arrest pending? <input type="checkbox"/> Yes <input type="checkbox"/> No
<i>For residents of Minnesota and Connecticut only,</i> in the last seven years, have you and/or your spouse been convicted of a crime or served time in prison because of a conviction or been arrested and convicted for any reason? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> |
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12. If you have answered "Yes" to any of the questions above please give complete details below.
(Attach a separate sheet if necessary, then sign and date it).

Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date:	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated:

I understand that New York Life has the right to require additional information and, if necessary, an examination by a physician. I ask New York Life to rely on all such statements made on this form, and any supplements to it, while considering this request. I also understand that the coverage afforded will be in consideration of the answers and statements set forth above.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or the MIB (Medical Information Bureau) to release information, including prescription drug records, maintained by physicians, pharmacy benefit managers, and other sources of information to New York Life Insurance Company, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis or treatment, but excluding psychotherapy notes. A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or I may request a copy of this AUTHORIZATION. This Authorization may be used for a period of 24 months from the date signed, unless sooner revoked as stated in the IMPORTANT NOTICE.

By signing and dating this application, the member requests the insurance indicated, and the member and any person proposed for insurance consent to authorize the disclosure of information to and from the providers noted in the IMPORTANT NOTICE, and attest to having read the IMPORTANT NOTICE and Fraud Notices indicated on the enclosed, including how my information is exchanged with MIB (Medical Information Bureau), and that to the best of my/their knowledge and belief, the answers provided to the questions are true and complete.

Member Signature X _____ (PLEASE SIGN AND DATE IN INK) _____ DATE _____

Spouse's Signature X _____ (NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED) _____ DATE _____

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SECTION D – AGREEMENT FOR PRE-AUTHORIZED CHARGES – ** Send NO Money NOW **

As an account owner, I hereby authorize my Credit Union to deduct from my account such premium amounts as may be required and to pay such amounts on behalf of the insured to the Insurance Company. I understand that each quarter, the Credit Union will access my account. If this account has insufficient funds, I understand I will be billed direct for that quarter's premium. I understand that the Credit Union will exercise reasonable care in administering this request, but shall not be liable for failure or delay in providing these deductions.

I further understand that if the amount of the premiums due differs from that of the last previous charge, due to any change in age, amount of coverage, or otherwise, I will receive at least 7 days written notice prior to the billing date as to the amount of the new charge. I authorize the Credit Union to release information about my address from time to time as may be required by the Administrator to contact me on matters pertaining to my insurance coverage.

Print Name on Account _____ **Account Number** _____
Signature of Applicant X _____ **Signature of Account Holder X** _____

Have all questions been answered? Have you provided names and addresses of all doctors you have consulted (even routinely)? If you have made corrections or strikeouts, the member must initial them. Mail your completed form to the Plan Administrator listed on the front.