



# Application for *LifeRing* Group Term Life Insurance

**For Office Use Only**  
Group Policy G-10657-0  
Certificate No.

**Exclusively for Credit Union Members.... Up to \$500,000 in Benefits Available Now**

**Important Information on 'How To Apply'.....**

- ❖ Credit Union Members can apply for their eligible spouse and dependent children
- ❖ A spouse who is also a Member must apply for Member coverage and only one parent can cover any eligible dependent children.

**If you have questions or need more forms.....**

Call your plan Administrator toll free at 1-800-223-8646 weekdays between 8:00 a.m. and 5:00 p.m. Central Time  
You can also find LifeRing on the internet at [www.lifering.net](http://www.lifering.net).  
Mail your completed application in the postage paid envelope provided for your convenience. **DO NOT SEND MONEY.**



## Application for 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

**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

Last Name \_\_\_\_\_ First \_\_\_\_\_ Initial \_\_\_\_\_ Social Security Number \_\_\_\_\_

Home Address: Street \_\_\_\_\_ City \_\_\_\_\_ State/Province \_\_\_\_\_ Zip Code \_\_\_\_\_

Home E-mail Address \_\_\_\_\_ Work E-mail Address \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
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  Divorced  Domestic Partner\*(Submit a completed Declaration of Domestic Partnership Form – Not Applicable in Oregon)  
Maiden Name \_\_\_\_\_  Single  Civil Union\* \*Eligibility is determined by State Law

I am now a Member of: \_\_\_\_\_ Credit Union Account # \_\_\_\_\_  
(Insert Name of your Credit Union) (check one)  Share Savings  Share Draft Checking

Are you presently insured under any of the LifeRing Group 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<br><input type="checkbox"/> FEMALE | HEIGHT<br>FT. IN.  | WEIGHT<br>LBS. |
|---------------------------------------|---------------|--|---------------|--|--|----------------|
| Child (Name)                          | Date of Birth | SEX  | Child (Name)  | Date of Birth  | SEX  |                |
| 1.                                    | / /           | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE | 3.            | / /  | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE |                |
| 2.                                    | / /           | <input type="checkbox"/> MALE<br><input type="checkbox"/> FEMALE | 4.            | / /  | <input type="checkbox"/> MALE<br><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 [www.lifering.net](http://www.lifering.net), 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 LIFE INSURANCE:** Note: The maximum coverage amount available under all New York Life plans is \$1,000,000

**Member Amount\*** (from \$25,000 to \$500,000 in \$25,000 increments) \$ \_\_\_\_\_ \*Includes up to \$50,000 Accidental Death Benefit

**Spouse Amount** (from \$25,000 to \$500,000 in \$25,000 increments) \$ \_\_\_\_\_ (can not exceed member amount)

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

G-10657-0

Continued on next page....

**SMOKING QUESTION:** Have you or your spouse used tobacco or nicotine in any form, including nicotine patches and nicotine chewing gum, within the last 12 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

**RESIDENTS OF NEW YORK - 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 or 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 in your best interest.**

**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 # | % |

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

|   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 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"/> | <input type="checkbox"/> | b. Arthritis, back trouble, bone or joint disorder?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?   | <input type="checkbox"/> | <input type="checkbox"/> | c. Fainting spells, convulsions or epilepsy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> | <input type="checkbox"/> | d. Sugar, blood, albumin or pus in urine?   | <input type="checkbox"/> | <input type="checkbox"/> |
| 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"/> | <input type="checkbox"/> | e. Diabetes, kidney trouble, ulcers or digestive disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Is any person to be insured now pregnant?  | <input type="checkbox"/> | <input type="checkbox"/> | f. Disorder of breast or reproductive organs or functions?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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:   |                          |                          | g. Nervous or mental disorder, emotional conditions or psychiatric care?  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?  | <input type="checkbox"/> | <input type="checkbox"/> | h. Cancer, tumor or cyst?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | i. Varicose veins, hemorrhoids or hernia?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | j. Disorder of eyes, ears, nose or sinuses?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | k. Thyroid, liver or respiratory disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | l. Alcoholism or drug habit?  | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | m. Disorder of the blood?   | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | n. Other Health or physical impairment including:   |                          |                          |
|   |                          |                          | (i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | (ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?           | <input type="checkbox"/> | <input type="checkbox"/> |
|   |                          |                          | (iii) Any other impairment?   | <input type="checkbox"/> | <input type="checkbox"/> |

7. If you have answered "Yes" to any of the questions above, please give complete details below.

| 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: |
|-----------------------------|---|---|
|                             |   |   |
|                             |   |   |
|                             |   |   |

(Attach a separate sheet if necessary, then sign and date it).

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, 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

G-10657-0

GMA-PR1

Page 3 of 3

WEBPTD 10

**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.

**Return the completed application to the LifeRing Plan Administrator:**

*PO Box 152501  
 Irving, TX 75015-9955*

**Questions?** Call Toll Free (800) 223-8646 or visit [www.lifering.org](http://www.lifering.org)

**Residents of Puerto Rico should mail applications to:**

*Global Insurance Agency  
 P.O. Box 9023918  
 San Juan, Puerto Rico 00902-3918*

## ***Fraud Notices***

*Please read before signing the enrollment form*

**FRAUD NOTICE – For Residents of all states except those listed below and New York:** 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 AR/LA/MD/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.

**FOR 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 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 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 PUERTO RICO:** Any person who, knowingly and with the intent to defraud, presents false information in an insurance request form, or who presents, helps or has presented a fraudulent claim for the payment of a loss or other benefit, or presents more than one claim for the same damage or loss, will incur a felony, and upon conviction will be penalized for each violation with a fine no less than five thousand (5,000) dollars nor more than ten thousand (10,000) dollars, or imprisonment for a fixed term of three (3) years, or both penalties. If aggravated circumstances prevail, the fixed established imprisonment may be increased to a maximum of five (5) years; if attenuating circumstances prevail, it may be reduced to a minimum of two (2) years.

**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.

G-10657-0

GMA-PR1

WEBPTD10