



Scan the QR code to get more details on this exclusive coverage available to NGAUS members.



Complete this form and Return to:
 NGAUS Insurance Trust
 P.O. Box 47060
 Phoenix, AZ 85068-47060

Request for Group Insurance from:
 New York Life Insurance Company
 51 Madison Avenue,
 New York, NY 10010



GROUP DISABILITY APPLICATION NGAUS INSURANCE PLAN

*PLEASE PRINT IN INK OR TYPE ALL ANSWERS.
 DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.*

1. Please complete the information requested Title 32 Title 5

Applicant's name <i>(First, Middle Initial, Last)</i>		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of birth month / day / year	Age	Social security number
Address	City	State	ZIP		
Technicians daytime phone number ()	Location of pay office	Pay office phone number ()		Pay office code	
Employing office	Date of employment month / day / year	Job duty		Annual salary \$	

2. Insurance requested: I hereby apply for the following coverage(s) checked below. New Enrollment
 Check the box for the coverage you want to apply for. Change/add coverage
 Rates are based on bi-weekly deductions. Refer to the brochure for eligibility, options and coverage description.

A. Basic Disability Income (Technician)

Salary Under \$18,000 \$18,000 to \$27,999 \$28,000 to \$31,999 \$32,000 to \$39,999 \$40,000 to \$49,999
 \$50,000 to \$59,999 \$60,000 to \$74,999 \$75,000 to \$89,999 \$90,000 to \$104,999 \$105,000 to \$119,999
 \$120,000 and over

B. Supplemental Disability Income (Technician) (must have Basic Disability)

Salary Under \$20,000 \$20,000 to \$23,999 \$24,000 to \$25,999 \$26,000 to \$31,999 \$32,000 to \$39,999
 \$40,000 to \$49,999 \$50,000 to \$59,999 \$60,000 to \$74,999 \$75,000 to \$89,999 \$90,000 to \$104,999
 \$105,000 to \$119,999 \$120,000 and over

Note: Coverage A does not require completion of the health questions if the Applicant applies within 31 days of the date of employment.

FOR OFFICE USE ONLY - Deduction amount for above coverages

A. _____ B. _____ C. _____ D. _____ E. _____			
Total Deduction amount	Effective date month / day / year	Transmittal number HRO	Consec. no.

4. Health Questions - Complete if applying after 31 days of employment or applying for Supplemental Disability Income coverage. STATEMENT OF HEALTH (Please initial and date any changes you make on this form.)

To the best of your knowledge and belief, answer the following questions as they apply to you to be insured:

	Member YES	NO		Member YES	NO
1. Are you now, and have you been for the last 30 days, performing all the duties of your occupation on a full time basis for 20 or more hours per week at your usual place of business?	<input type="checkbox"/>	<input type="checkbox"/>	7. During the past five years, has any person to be insured ever been medically diagnosed by a physician as having been treated for:		
2. Are you 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"/>	a) Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	<input type="checkbox"/>	<input type="checkbox"/>
3. Are you insured now ill, or receiving medical attention or surgical treatment?	<input type="checkbox"/>	<input type="checkbox"/>	b) Arthritis, back trouble, bone or joint disorder?	<input type="checkbox"/>	<input type="checkbox"/>
4. 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"/>	c) Fainting spells, convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>
5. Except for resident of New Hampshire, are you insured under any kind of medication or so far as you know, in impaired physical mental health?	<input type="checkbox"/>	<input type="checkbox"/>	d) Sugar, blood, albumin or pus in urine?	<input type="checkbox"/>	<input type="checkbox"/>
6. Are you pregnant?	<input type="checkbox"/>	<input type="checkbox"/>	e) Diabetes, kidney trouble, ulcers or digestive disorder?	<input type="checkbox"/>	<input type="checkbox"/>
			f) Disorder of breasts or reproductive organs or functions?	<input type="checkbox"/>	<input type="checkbox"/>
			g) Nervous or mental disorder, emotional conditions or psychiatric care?	<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"/>

<p style="text-align: center;">Member YES NO</p> <p>n) Other health or physical impairment including:</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) Any other disorder of the immune system? <input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>iii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p style="text-align: center;">Member YES NO</p> <p>10. Driver's license number: Member License No.</p> <p>_____</p> <p>State Issued</p> <p>_____</p> <p>Has your driver's license been suspended <input type="checkbox"/> YES <input type="checkbox"/> NO or revoked or had any moving violations within the last five years?</p>
<p>8. Except for residents of Maryland and North Dakota, has any person to be insured had a parent, brother or sister who, prior to age 60 has been medically diagnosed by a physician as having, or been treated for, cancer, paralysis, hypertension, diabetes, heart disease, neuro-muscular or mental illness? <input type="checkbox"/> YES <input type="checkbox"/> NO</p>	<p>11. Except for residents of Connecticut and Minnesota, in the last seven years, have you 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</p> <p>For residents of Connecticut and Minnesota only, in the last seven years, have you 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>
<p>9. Within the <i>past 9 months</i>, have you participated in, or do you, within the next 9 months, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snow-mobiling, 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>12. Height _____ Weight _____ lbs.</p>
<p>9. Within the <i>past 9 months</i>, have you participated in, or do you, within the next 9 months, plan to participate in: aircraft flying other than as a passenger, scuba diving, ultralight flying, ballooning, parachuting, mountaineering, rodeo riding, snow-mobiling, 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>13. Have you used tobacco or any nicotine substitute in any form (including nicotine patches, nicotine, chewing gum or electronic cigarettes)? Member: <input type="checkbox"/> YES <input type="checkbox"/> NO</p>

<p>14. If you have answered Question 1 "No" or any other Questions "Yes" give complete details below. (Attach a separate sheet if necessary then sign and date it)</p>		
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:

AUTHORIZATION AND SIGNATURE

Authorization: I authorize any licensed physician, medical practitioner, hospital, pharmacy, clinic or other medical or medically related facility, laboratory, insurance company, MIB, LLC. ("MIB"), or electronic health record companies; health care information technology companies; or any health or medical organizations that has any records or knowledge of me or my health 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 reinsurers, its subsidiaries or the plan administrator about the physical and mental health of any persons proposed for insurance, including significant history, findings, diagnosis and treatment, but excluding psychotherapy notes for the purpose of evaluating my application for insurance. Health information obtained will not be re-disclosed without my authorization unless permitted by law, in which case it may not be protected under federal privacy rules. For example, New York Life may be required to provide it to insurance, regulatory, or other government agencies. In this case, the information may no longer be protected by the rules governing your authorization.

I also authorize New York Life Insurance Company to obtain from consumer reporting agencies driving records (if any) about myself or any other person proposed for insurance for the purpose of evaluating this application for insurance.

A photocopy of this AUTHORIZATION and request form shall be as valid as the original. In all circumstances, my authorized agent or representative, 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. The authorization may be revoked at any time by sending written notice to New York Life Insurance Company. My revocation will not be effective to the extent that New York Life or any other person already has disclosed or collected information or taken other action in reliance on it, or to the extent that New York Life has a legal right to contest a claim under an insurance certificate or the certificate itself.

By signing and dating this application, I **request** the insurance applied for myself and/or my dependents; I **affirm** that the information provided in my application is true and complete to the best of my knowledge and belief and that I, and any other person proposed for insurance, has read the Fraud Notice (if any) and the IMPORTANT NOTICE, including how my/our information is exchanged with MIB; and I, and any other person proposed for insurance, **consents** to authorize the disclosure of information, to and from the providers noted in the IMPORTANT NOTICE, including making a brief report of my/our protected health information to MIB.

Member's Signature _____ Date _____

FRAUD NOTICE – For Residents of all states except those listed below: 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 AL/AR/LA/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.

RESIDENTS OF CA: 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. The falsity of any statement in the application for any policy shall not bar the right to recovery under the policy unless such false statement was made with actual intent to deceive or unless it materially affected either the acceptance of the risk or the hazard assumed by the insurer.

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 MD: Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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.