EVIDENCE OF INSURABILITY FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

New York Life Group Insurance Company of NY
(herein called the Insurance Company)
For info and customer service call 1-866-607-2360

PO Box 20310
Lehigh Valley, PA 18003

- *The applicant must sign and date this form.*
- *This form cannot be considered unless received within 30 days of the date it is dated.*

Important: Please enter all dates in mm/dd/yyyy format.

Return form to: New York Life address above, Fax 1-800-440-0856, Email: bethlehemmail@newyorklife.com

Employer Use: (Mandatory Data Needed) In order to process this form, the employer must complete this information.

Employer: Barr & Barr, Inc. Policy: SGN600603

Class: _____ Location: _____ Date of Hire: _____ Annual Salary: _____ Verified By: _____

Reason for Request: (i.e. New Hire, Late Entrant, Initial/Ongoing Enrollment, etc.) _____

VOLUNTARY COVERAGE	EMPLOYEE AMOUNT	SPOUSE* AMOUNT
1. Enter Requested Coverage Amount (Total)		
2. Enter Current Coverage including guarantee issue *(enter zero if no current coverage)*		
3. Subtract Line #2 from Line # 1, this is the amount subject to Underwriting		

EMPLOYEE SECTION

Employee Name (first, middle, last) _____ Social Security # _____

Address _____ City _____ State _____ Zip _____

Phone _____ ID # _____ Birthdate _____ Gender: ☐ M ☐ F

COMPLETE IF ELECTING SPOUSE* COVERAGE

☐ I am currently married and my date of marriage is: _____ *–or–* ☐ I currently have an eligible Domestic Partner

Spouse* Name: (first, middle, last) _____ Social Security # _____

Phone _____ Birthdate _____ Gender: ☐ M ☐ F

IMPORTANT
Please complete each section that follows.
Read the Agreements and Authorization. Sign and date the form in the space provided.

Complete the employee and spouse information in this section if you (i.e., the Employee) or your spouse* are applying for Life Insurance that is greater than the guaranteed amount or are applying for Life Insurance more than 31 days after you were eligible for the insurance.

Height and Weight Information

Employee	Height ___ft.___in. Weight _____lbs.	*Spouse**	Height ___ft.___in. Weight _____lbs.

PHYSICIAN SECTION

Employee Physician Name _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

Spouse*: Physician Name _____ Phone Number _____

Street Address _____ City _____ State _____ Zip _____

Name _____ Social Security #_____

Section A: Please indicate your answers for each question in this section by checking the Yes or No box for the question.				
	Employee		Spouse*	
In the past five years, has the proposed insured been diagnosed with, or treated for, any condition listed below?	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 or disorder of the heart or circulatory system?	❑	❑	❑	❑
C. Enlarged glands, goiter, diabetes, thyroid disorder, any disease or disorder of the stomach, intestines, liver gallbladder, kidneys, or any disease or disorder of the gastrointestinal or urinary tract, asthma, emphysema, tuberculosis, pneumonia, or disease of the throat, lungs, or other disease or 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 or disorder not mentioned in questions A through F?	❑	❑	❑	❑
H. Stroke, paralysis, epilepsy, fainting, headaches, seizures, dizziness, or 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 or 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?	❑	❑	❑	❑

If you answered "Yes" to any questions above, please provide details in the table below.

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**	*Medical Condition*	*Date Occurred*	*Duration/Treatment Received*	*Current Status*

Name _____ Social Security #_____

AGREEMENTS AND AUTHORIZATION

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 family members' coverage will not go into effect unless the family member is not confined in a hospital or institution, or receiving certain medical treatment. These conditions 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) My spouse may need to take medical tests. The results of those tests must be reported to the Insurance Company.
(5) I must report any change in my health that happens before the insurance is effective.
(6) I must report any change in the health of a spouse for whom coverage is requested that happens before the insurance is effective.
(7) 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 Named Parties with any records or knowledge of personal info, medical history, mental or physical condition, diagnosis or treatment of me to give such info to the Insurance Company, its authorized agents or its reinsurers. "Named Parties" are: licensed practitioners, hospitals, clinics, Veterans Administration or medically related facilities, insurance companies, employers, or other organizations, institutions or persons. This permission 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 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).

**For purposes of this form, wherever the term Spouse appears, it shall also include Domestic Partner registered under any state which legally recognizes Domestic Partnerships or Civil Unions.*

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's Signature* _____ *Month/Day/Year* _____ *Spouse's Signature** _____ *Month/Day/Year*
(If applying for insurance for your spouse)

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.

(NY-I)