10-YEAR LEVEL GROUP TERM LIFE INSURANCE APPLICATION FORM

Coverage Amounts of $100,000 or more

FOR MEMBERS OF THE CIVIL SERVICE EMPLOYEES BENEFIT ASSOCIATION

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

Complete this form and return to:
CSEBA Plan Administrator, Wright & Co.
706 Philadelphia Pike, Suite 1
Wilmington, DE 19809
Toll Free 1-800-424-9801

MEMBER INFORMATION [PRINT IN INK OR TYPE ALL ANSWERS] **Group Policy: G-29151-0 Certificate No.________**

Last Name First Initial Social Security Number

Billing Address: Street City State/Province Zip Code

Home Address: Street City State/Province Zip Code

______________ (____)__________ (____)__________ (____)__________
e-Mail Address Day Time Phone Number Evening Phone Number Day Fax Number

Date of Birth ____/____/______ (MM / DD / YYYY) Height _____ft_____in. Weight ________lbs. Sex: ❒ Male ❒ Female

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 an (❒active / ❒retired) employee of: Agency Name ________________________ Annual Income $________________

GS/SES Level__________ Occupation____________________ How did you hear about Wright?________________________

Are you or your spouse presently insured by any CSEBA Group Insurance plan? ❒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?_______

DEPENDENT INFORMATION: If dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 19, or 25 if a full time student.) *Attach separate sheet to provide additional dependent information.*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH	❒ MALE ❒ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.

Child (Name)	Date of Birth		Child (Name)	Date of Birth	
Child (Name) 1.	Date of Birth / /	❒ MALE ❒ FEMALE	Child (Name) 3.	Date of Birth / /	❒ MALE ❒ FEMALE
Child (Name) 2.	Date of Birth / /	❒ MALE ❒ FEMALE	Child (Name) 4.	Date of Birth / /	❒ MALE ❒ 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 your certificate, or www.wrightusa.com for eligibility, options, and coverage description)
I HEREBY APPLY FOR THE FOLLOWING GROUP LIFE COVERAGE(S): ❒ New Coverage ❒ Additional Coverage
NOTE: If you are increasing or altering present coverage in any way, indicate the Total Amount of Coverage, not just the increased amount
- *Spouse Amount of coverage cannot exceed Member Amount of coverage* COVERAGE AMOUNT:

(Check to Apply)
❒ **Member** (from $100,000 to $1,000,000 in $25,000 increments)………………………… $________________
❒ **Spouse** Coverage(from $100,000 to $1,000,000 in $25,000 increments)……………………… $________________
❒ **Child(ren)** $5,000 per child ($500 from 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)

<u>INSURANCE REPLACEMENT – RESIDENTS OF NEW YORK</u>: I have read the Important Replacement Information on page 4 of this application. 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

<u>FOR CURRENT 10-YEAR LEVEL GROUP TERM LIFE INSUREDS:</u>
❒ I intend to cancel my in-force 10-Year Level Group Term Life Insurance upon approval of this application, and replace it with the total amount of coverage applied for on this application.
❒ I intend to keep in-force my 10-Year Level Group Term Life Insurance upon approval of this application and add separately the coverage applied for on this application.
NOTE: The Aggregate amount of coverage available under all NYL policies is $1,000,000 per insured.

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BENEFICIARY DESIGNATION: 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: Relationship to Member Social Security #

Beneficiary's Address: Street City State/Province Zip Code

STATEMENT OF HEALTH To the best of my knowledge and belief:

	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?	❒	❒
2. Are you or any other person to be insured now ill, or receiving medical attention or surgical treatment?	❒	❒
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?	❒	❒
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?	❒	❒
5. Is any person to be insured now pregnant?	❒	❒
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:		
a. Heart or circulatory trouble, high blood pressure, pain or pressure in chest?	❒	❒
b. Arthritis, back trouble, bone or joint disorder?	❒	❒
c. Fainting spells, convulsions or epilepsy?	❒	❒
d. Sugar, blood, albumin or pus in urine?	❒	❒
e. Diabetes, kidney trouble, ulcers or digestive disorder?	❒	❒
f. Disorder of breast or reproductive organs or functions?	❒	❒
g. Nervous or mental disorder, emotional conditions or psychiatric care?	❒	❒
h. Cancer, tumor or cyst?	❒	❒
i. Varicose veins, hemorrhoids or hernia?	❒	❒
j. Disorder of eyes, ears, nose or sinuses?	❒	❒
k. Thyroid, liver or respiratory disorder?	❒	❒
l. Alcoholism or drug habit?	❒	❒
m. Disorder of the blood?	❒	❒

	Yes	No
n. Other Health or physical impairment including:		
(i) Being medically diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	❒	❒
(ii) Chronic cough, persistent diarrhea, enlarged lymph glands, chronic fatigue in the past five years?	❒	❒
(iii) Any other impairment?	❒	❒
7. 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?	❒	❒
8. 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?	❒	❒

9. 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?	❒	❒
10. 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?	❒	❒
For residents of Minnesota and Connecticut only, 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?	❒	❒

11. If you have answered yes to any of the above questions, please explain (attach a separate sheet if necessary, then sign and date it).

Name of Proposed Insured	Details

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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. Sign and Date Page 3 of this application.

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 following pages, 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

PAYMENT OPTION SELECTION: *Choose only one*

❒ **OPTION 1: ELECTRONIC FUNDS TRANSFER (EFT):** ❒ Monthly ❒ Quarterly ❒ Annually

I request and authorize CSEBA Insurance Administrators to make withdrawals against the account specified on the attached ❒voided check ❒ statement savings account deposit slip, or any account subsequently named by me, and such bank to process these withdrawals as if I had signed them, for the purpose of collecting premium Contributions due under this plan. (Enclose a VOIDED check or deposit slip, as applicable.)

X____ ______________________

Signature(s) as required on checks issued against this account Date

❒ **OPTION 2: QUARTERLY DIRECT BILL** (Renewals are billed each January, April, July and October)

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.

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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.

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(*PLEASE DETACH THIS NOTICE AND RETAIN IT FOR FUTURE REFERENCE)*

IMPORTANT NOTICE:

How New York Life Obtains Information and Underwrites Your Request Group Life Insurance

Information regarding insurability will be treated as confidential. In considering your request for insurance, we will rely on the medical information you provide, and on the information you authorize us to obtain from your physician, other medical practitioners and facilities, other insurance companies to which you have applied for insurance and MIB, Inc. (formerly known as Medical Information Bureau). MIB and other insurance companies may also furnish New York Life, its subsidiaries or the Plan Administrator with non-medical information (such as driving records, past convictions, hazardous sport or aviation activity, use of alcohol or drugs, and other applications for insurance). The information provided may include information that may predate the time frame stated on the medical questions section, if any, on this application. This information may be used during the underwriting and claims processes, where permitted by law.

Your AUTHORIZATION may be used for a period of 24 months from the date you signed the application for insurance, unless sooner revoked. The AUTHORIZATION may be revoked at any time by notifying the Administrator in writing at the address provided. Your revocation will not be effective to the extent 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. The information New York Life obtains through your AUTHORIZATION may become subject to further disclosure. 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.

New York Life may release this information to the Plan Administrator, MIB, other insurance companies to whom you may apply for insurance, or to whom a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with information concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. We may make a brief report to MIB; however, we will not disclose our underwriting decision. Information in our files may be seen by New York Life and Plan Administrator employees, but only on a "need to know" basis in considering your request. Upon receipt of all requested information, we will make a determination as to whether your request for insurance can be approved.

MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. When you apply for insurance or submit a claim for benefits to a MIB member company, medical or non-medical information may be given to the Bureau, which may then be furnished to member companies.

If we cannot provide the coverage you requested, we will tell you why. If you feel our information is inaccurate, you will be given a chance to correct or complete the information in our files. Upon written request to New York Life or MIB, you will be provided with non-medical information. Generally, medical information will be given either directly to the proposed insured or to a medical professional designated by the proposed insured. Your request is handled in accordance with the Federal Fair Credit Reporting Act procedures. If you question the accuracy of the information provided by MIB, you may contact MIB and seek a correction. MIB's information office is: MIB, Inc., 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734, telephone (866) 692-6901 (TTY 866-346-3642). For Canadian residents, the address is: MIB Information Office, 330 University Avenue, Suite 501, Toronto, Ontario, Canada M5G 1R7, telephone (416) 597-0590. Information for consumers about MIB may be obtained on its website at www.mib.com.

For NM Residents: ***PROTECTED PERSONS*** [1] *have a right of access to certain* ***CONFIDENTIAL ABUSE INFORMATION*** [2] *we maintain in our files and they may choose to receive such information directly. You have the right to register as a* ***PROTECTED PERSON*** *by sending a signed request to the Administrator at the address listed on the application. Please include your full name, date of birth and address.*

[1] ***PROTECTED PERSON*** *means a victim of domestic abuse: who has notified us that he/she is or has been a victim of domestic abuse; and who is an insured person or prospective insured person.*

[2] ***CONFIDENTIAL ABUSE INFORMATION*** *means information about: acts of domestic abuse or abuse status; the work or home address or telephone number of a victim of domestic abuse; or the status of an applicant or insured as family member, employer or associate of a victim of domestic abuse or a person with whom an applicant or insured is known to have a direct, close, personal, family or abuse-related relationship.*