GEVBT Hospital Indemnity Insurance Application

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

Please Print. Use Dark Ink. Do Not Erase. Initial All Changes.

Complete application in full, sign and date where indicated and mail to the GEVBT SHIP Plan Administrator. Questions? Call **1-800-221-3083**.

Administrator: Mass Benefits Consultants, Inc. • P.O. Box 828 • Annandale, VA 22003-0828

Enrollment Form: SHIP

MEMBER'S NAME		SOCIAL SECURITY NO.	GROUP POLICY G-29162-0
STREET - Name & Number			CERTIFICATE NO.
CITY	STATE (OR PROVINCE)	ZIP CODE	DATE OF BIRTH ☐ Male ☐ Female
FEDERAL AGENCY NAME	OFFICE PHONE	HOME PHONE	MARITAL STATUS

If Dependent Coverage is Required, List Eligible Dependents

i.e.; lawful spouse and unmarried dependent children to age 22. (If more than 3 children., please list on separate sheet.)

SPOUSE'S NAME	DATE OF BIRTH	SEX ☐ Male ☐ Female
CHILD'S NAME	DATE OF BIRTH	SEX ☐ Male ☐ Female
CHILD'S NAME	DATE OF BIRTH	SEX ☐ Male ☐ Female
CHILD'S NAME	DATE OF BIRTH	SEX ☐ Male ☐ Female

Check Appropriate Categories:

Please indicate if request is for:

❑ **New Coverage**

❑ **Change in Coverage**

Indicate who is to be covered:

❑ Member Only

❑ Member plus 1 dependent

❑ Member plus 2 or more dependents

Select the Daily Hospital Indemnity plan you desire:

❑ **Blue** ❑ **White** ❑ **Red**

Coverage terminates for employee and dependents when employee reaches attained age 70.

Payment Mode:

❑ **Annual** ❑ **Semi-Annual**

❑ **Quarterly** ❑ **Monthly** ❑ **Bi-weekly**

See Additional Information for Payment Details

I request the group insurance as indicated on this application. To the best of my knowledge, I am eligible for this insurance and the statements I have made are true and complete. I understand that my insurance will not pay benefits for conditions where an individual consulted a doctor or received any medical services or supplies, or took any medication, during the 12 months prior to their effective date of coverage until after: 12 consecutive months lapsing while insured and during which no treatment, care or advice was received for that condition; or, if earlier 24* consecutive months of coverage under the plan. I further understand that any dividends apportioned to the group policy will be paid to the policyholder.
**12 months in Montana*

FRAUD NOTICE: 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 AR, CO, DC, HI, KY, LA, ME, NJ, NM, OH, & PA: 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 an materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and subjects such person to criminal and civil penalties. **For 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. **For residents of DC, the following also applies:** An insurer may deny insurance benefits if false information materially related to a claim is provided by the applicant.

Member Signature X _____