NADA Employee Life Insurance Program and Accidental Death & Dismemberment Simplified Issue Insurance Request Form

Please print in ink or type all answers – initial and date any changes you make

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

Complete this form and return to NADA Insurance Administrators ♦ PO Box 998 ♦ Covington, LA 70434
Questions? Call Toll Free (800) 462-3278 ♦ NADART Code _____

EMPLOYEE'S FULL NAME				**GROUP POLICY**: G-29618-0	CERTIFICATE #	
ADDRESS				SOCIAL SECURITY NO.		
CITY	STATE	ZIP CODE	DATE OF BIRTH MM / DD / YYYY	❒ MALE ❒ FEMALE	HEIGHT ft. in.	WEIGHT lbs.
HOME PHONE # ( )	WORK PHONE # ( )			FAX # ( )		
E-MAIL ADDRESS				CELL PHONE # ( )		

MARITAL STATUS: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Civil Union* ☐ Domestic Partnership* (submit a Declaration of Domestic Partnership form – not applicable in OR) *Eligibility determined by State Law Maiden Name_____

Do you intend to reside outside the U.S. or Canada in the next 12 months?
Employee: ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No If yes, Country _____ How Long?_____

MEMBERSHIP AFFILIATION (National Automobile Dealers Association (NADA) Membership is required to participate in this plan)

DEALERSHIP NAME & ADDRESS

Are you actively working full time (at least 20 hours per week) or 1000 hours per year at a factory-approved new car or truck franchise? ☐ Yes ☐ No

IF DEPENDENT COVERAGE IS REQUESTED, LIST ELIGIBLE DEPENDENTS lawful Spouse and unmarried, dependent children under 20 (under 25 if a Full-time Student) If *necessary attach a separate signed and dated sheet to provide additional dependent information*

SPOUSE'S FULL NAME: (Last, First, MI)	SOCIAL SECURITY NO.	DATE OF BIRTH MM / DD / YYYY	❒ MALE ❒ FEMALE	HEIGHT ft. in.	WEIGHT lbs.

Child (Name)	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE	Child (Name)	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE
1.			3.		
Child (Name)	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE	Child (Name)	Date of Birth MM / DD / YYYY	❒ MALE ❒ FEMALE
2.			4.		

INSURANCE REQUESTED: (Refer to the Plan Details for eligibility, amounts available and coverage descriptions)

I hereby apply for the following coverage(s) checked below: (Please view the brochure for eligibility options and coverage descriptions)
NOTE: If you are increasing or altering present coverage in any way, do not just indicate the additional amount of coverage. Instead, indicate the TOTAL AMOUNT of coverage you are requesting

☐ **NADA Employee Group Life Insurance** ❒ New Application ❒ Additional Coverage

Total **Employee** Amount Desired: Up to $250,000 in $25,000 increments..... $_____

Total **Spouse** Amount Desired: Up to $120,000 in $10,000 increments (not to exceed 50% Employee's amount)..... $_____

Child(ren) (check box if applying)..... ☐ $10,000 each

☐ **NADA Employee Group Accidental Death & Dismemberment Insurance** ❒ New Application ❒ Additional Coverage

Total **Employee** Amount Desired: ☐ $300,000 ☐ $150,000 ☐ $75,000 ☐ $25,000 ☐ $10,000
☐ $250,000 ☐ $100,000 ☐ $50,000 ☐ $15,000

Total **Spouse** Amount Desired: ☐ $150,000 ☐ $100,000 ☐ $50,000 ☐ $15,000
☐ $125,000 ☐ $75,000 ☐ $25,000 ☐ $10,000
(Spouse Coverage Amount may not exceed Employee amount)

Child(ren) (check box if applying)..... ☐ $10,000 each

LIFE INSURANCE QUESTIONS Must Be Completed

Do you have other life insurance in force? ..... **Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
If "Yes" total amount in all companies: Employee: $_____ Spouse: $_____

Do you have insurance applications pending? If "Yes" indicate amount/Company **Employee** ☐ Yes ☐ No **Spouse** ☐ Yes ☐ No
Employee:$_____Co._____ Spouse:$_____Co._____

REPLACEMENT INFORMATION Must Be Completed if applying for Life Insurance

Residents of ALL States (except New York): Is the Insurance applied for intended to replace, discontinue or change an existing insurance or annuity? ..... **Employee:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

Residents of New York: I have read the Important Replacement Information below. Is the insurance applied for intended to replace, in whole or in part, any existing insurance or annuity? **Employee:** ☐ Yes ☐ No **Spouse:** ☐ Yes ☐ No

IMPORTANT REPLACEMENT INFORMATION – RESIDENTS OF NEW YORK

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 a 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 you decide whether the replacement is in your best interest.

PAYMENT OPTION SELECTION: Do Not Include Payment with your Application – you will be billed when approved for coverage

☐ **Option 1: Direct Bill** in advance: (select one) ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

☐ **Option 2: Electronic Fund Transfer (EFT) Authorization –** I request and authorize NADA Insurance Administrators, Gilsbar Inc, to make (select one) ☐ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual (in advance) withdrawals against the account specified on the attached (select one) ☐ 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. The electronic debit will occur on the 1st or the 10th of each month that payment is due. If the transfer falls on a weekend or bank holiday, my account will be charged the next business day. I understand the amount of the automatic debit may vary due to changes in the amount of insurance or a premium contribution change and that I will be notified in advance any such changes due to a premium contribution change.

(Enclose a VOIDED check or deposit slip, as applicable.)

ACCOUNT OWNER'S NAME	BANK NAME	BANK ROUTING NUMBER (SAVINGS ONLY)
ACCOUNT NUMBER (SAVINGS ONLY)	SIGNATURE OF ACCOUNT OWNER (IF JOINT, BOTH REQUIRED) ***X***	

BENEFICIARY DESIGNATION Attach separate signed and dated sheet to provide additional beneficiary information

I hereby make the following beneficiary designation with respect to all the insurance on my life under the NADA Employee Group Life/AD&D Insurance Plan(s) being applied for under this application, 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 Employee as provided in the Group Policy

NOTE: 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 (not to exceed 100% Total). If naming a trust, please indicate the full name and date of the trust.

BENEFICIARY NAME	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY #	DATE OF BIRTH / /
BENEFICIARY STREET ADDRESS, CITY, STATE, ZIP CODE			% OR PROCEEDS %
BENEFICIARY NAME	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY #	DATE OF BIRTH / /
BENEFICIARY STREET ADDRESS, CITY, STATE, ZIP CODE			% OR PROCEEDS %
BENEFICIARY NAME	RELATIONSHIP TO EMPLOYEE	SOCIAL SECURITY #	DATE OF BIRTH / /
BENEFICIARY STREET ADDRESS, CITY, STATE, ZIP CODE			% OR PROCEEDS %

☐ Check if more Beneficiaries are attached

STATEMENT OF HEALTH: To the best of your knowledge and belief, answer the following questions as they apply to you and all dependents to be insured. (Please initial any changes you make on this form.)	**Employee**	**Spouse**
A. Is any person proposed for insurance now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?.....	☐ Yes ☐ No	☐ Yes ☐ No
B. During the past five years has any person proposed for insurance ever been medically diagnosed by a physician as having or been treated for: heart trouble, elevated blood pressure, gynecological or genitourinary disorders, ulcers, cancer, diabetes, mental or nervous disorder or psychotherapeutic treatment, epilepsy, respiratory disorder, kidney or liver disorder, (including hepatitis), enlarged lymph nodes or immunodeficiency disorder, thyroid disorder, blood disorder, albumin, blood or sugar in urine, back trouble/disorder, arthritis, or unexplained weight loss?.....	☐ Yes ☐ No	☐ Yes ☐ No
C. During the past five years has any person proposed for insurance been counseled, treated or hospitalized for the use of alcohol or drugs?.....	☐ Yes ☐ No	☐ Yes ☐ No
D. During the past five years has any person proposed for insurance suffered from incontinence or required assistance in bathing, toileting, dressing, eating, cooking or transferring?.....	☐ Yes ☐ No	☐ Yes ☐ No
E. Has any person proposed for insurance 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, neuromuscular or mental illness?	☐ Yes ☐ No	☐ Yes ☐ No

If you have answered "Yes," to any Question, give details below. (Attach a separate sheet if necessary, then sign and date it).

Name of Proposed Insured	Details

I request the above group insurance. 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, and on any supplemental forms.

AUTHORIZATION: I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company or MIB, Inc. ("MIB"), or other organization, institution or person, 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, 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. 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 as stated in the IMPORTANT NOTICE.

By signing and dating this application, the Employee **requests** the insurance indicated; and the Employee and any person proposed for insurance **consent** 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; and **attest** to having read the IMPORTANT NOTICE and Fraud Notices indicated on the attached; including how my/our information is exchanged with MIB, and that to the best of my/our knowledge and belief, the answers provided to the questions are true and complete.

Employee's Signature ***X*** _____ Date_____

Spouse's Signature ***X*** _____ Date_____
Only necessary if applying for coverage)

Fraud Notices - *Please read before signing the application form*

FRAUD NOTICE – ***For Residents of all states <u>except</u> 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.

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 MD: Any person who knowingly or willfully presents a false and 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 NY (applicable to AD&D only)**:** any person who knowingly and with intent to defraud any insurance company or any 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 is a crime, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

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-29618-0

GMA-EZ-4 ELIP 0715

Return the completed application to:

NADA Insurance Administrators ♦ PO Box 998 ♦ Covington LA 70434

Questions? Call Toll Free (800) 462-3278

IMPORTANT NOTICE

How New York Life Obtains Information and Underwrites Your Request for NADA Employee Group Term Life Insurance (ELIP)

In this notice, references to "you" and "your" include any person proposed for insurance. Information regarding insurability will be treated as confidential. In considering whether the person(s) in your request for insurance qualify 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. ("MIB"). MIB is a not-for-profit organization of insurance companies, which operates an information exchange on behalf of its members. If you apply for life or health insurance coverage, or a claim for benefits is submitted to a MIB member company, medical or non-medical information may be given to MIB, and such information may then be furnished by MIB, upon request, to a member company.

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 New York Life 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.

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, of the application. This information may be used during the underwriting and claims processes, where permitted by law.

New York Life may release this information to the Plan Administrator, other insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted and to others whom you authorize in writing. However, this will not be done in connection with test results concerning Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). We may also make a brief report of your protected health information to MIB, but we will not disclose our underwriting decision.

New York Life will not disclose such information to anyone except those you authorize or where required or permitted by law. 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

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). 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.*

New York Life Insurance Company 8.12ed