INSURANCE ENROLLMENT FORM

Please use this form to apply for coverage. Simply fill in any missing information below. Don't forget to include your Social Security Number, Birthdate, sign your name and enter today's date.

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Offered by Life Insurance Company of North America

Employer: City of Scottsdale

ALL ABOUT YOU – THE EMPLOYEE

Your Name _____ **Social Security #** _____ **Birthdate** _____

Address _____ City _____ State _____ Zip _____

Work Phone _____ Home Phone _____ Employee ID # _____ Gender: _____

COMPLETE THIS SECTION ONLY IF YOU WANT COVERAGE FOR YOUR SPOUSE OR DOMESTIC PARTNER*

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

My Spouse/ Domestic Partner's Information Name _____ **Social Security #** _____

Birthdate _____ Gender _____

**To be eligible for Domestic Partner coverage, you must have a state-registered Domestic Partnership or Affidavit on file with your employer, and accepted by the Insurance company. If not, an Affidavit should be requested from your employer.*

YOUR COVERAGE ELECTIONS

View the enclosed Summary of Benefits for full costs and instructions for how to calculate premium.

Employee-Paid (Voluntary) Term Life Insurance Policy # VTL0004689

Applicant	Coverage Amount	Accept your desired coverage amount or decline coverage below.
Employee	Units of $10,000 up to the lesser of 5 times annual compensation or $300,000. Guaranteed Coverage: $150,000	❑ $10,000 ❑ $150,000* ❑ $300,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Spouse	Units of $10,000 up to $150,000. Guaranteed Coverage: $10,000	❑ $10,000* ❑ $150,000** ❑ Other _____ *Amount must be a multiple of $10,000.* ❑ Decline Coverage
Child	Units of $2,000 up to $10,000.	❑ $2,000 ❑ $10,000** ❑ Other _____ *Amount must be a multiple of $2,000.* ❑ Decline Coverage

Employee-Paid (Voluntary) Short-term Disability Insurance Policy # VDT0961362

Applicant	Review your available plan below before accepting or declining coverage.		
Employee	**Option 1**	50% of your weekly covered earnings, to a maximum of $1,500 per week.	❑ Accept Option 1 ❑ Accept Option 2 ❑ Decline Coverage
	Option 2	70% of your weekly covered earnings, to a maximum of $1,500 per week.	

**The GI amount is only available if enrolling within the first 31 days of eligibility. For any coverage that is not Guaranteed Issue, you must complete the Evidence of Insurability Form.*
***This is the maximum amount that you can choose under this plan.*

All coverage elected during this enrollment period will take effect on the latest of 07/01/2024, the date your election form is received by your employer, or if applicable the day your Evidence of Insurability Form is approved by the Insurance Company.

SIGN HERE TO ACCEPT YOUR DEDUCTION FROM YOUR PAYCHECK

I accept the insurance options chosen above. If premiums are to be paid by payroll, I authorize my employer to deduct the necessary amounts from my paycheck. If I did not choose coverage now, and I decide I want coverage at a later date, I may be required to provide evidence of insurability at my own expense. I understand that coverage is subject to New York Life Group Benefit Solutions' approval and that my insurance will not go into effect unless I am actively at work on the effective date. I also understand that coverage for each of my dependents will go into effect only if the person is not confined in a hospital or institution, or receiving certain medical treatment. I understand my information is protected by privacy laws and will be released only in accordance with these laws. Additional information about the rules and conditions around the requested insurance is described in the policy and certificate. Insurance coverage is underwritten by Life Insurance Company of North America.

Pre-Existing Condition Limitation (applies to disability insurance only): "Pre-existing Condition" means any Injury or Sickness for which the Employee incurred expenses, received medical treatment, care or services, including diagnostic measures, took prescribed drugs or medicines, or for which a reasonable person would have consulted a Physician within 3 months before his or her most recent effective date of insurance.

I understand if I become insured, I will not receive benefits for a Pre-existing Condition until I have been insured for 12 months for the Disability coverage.

Please Sign Here Signature _____ Date _____

Created on 08/2024.

EVIDENCE OF INSURABILITY FORM

NEW YORK LIFE GROUP BENEFIT SOLUTIONS

Life Insurance Company of North America (LINA)
(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: City of Scottsdale Policy: VTL0004689

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.				
1. Within the last 5 years has the proposed insured been diagnosed with any of the conditions, told by a medical professional he/she has or may have any of the conditions, or been treated by a medical professional for any of the conditions:	Employee		Spouse*	
	Yes	No	Yes	No
A. High blood pressure, heart attack, chest pain or Angina, a heart murmur, poor circulation or any other condition affecting the heart or circulatory system?	❑	❑	❑	❑
B. Diabetes, glandular condition, Hepatitis, or any condition affecting the esophagus, stomach, intestines, liver or pancreas?	❑	❑	❑	❑
C. Asthma, Chronic Bronchitis, Emphysema, or any other condition affecting the lungs or respiratory tract?	❑	❑	❑	❑
D. Any condition affecting the kidneys, urinary tract, prostate gland or reproductive system?	❑	❑	❑	❑
E. HIV infection, AIDS, or any other condition affecting the immune system or lymph nodes?	❑	❑	❑	❑
F. Stroke, Transient Ischemic Attack (TIA), Alzheimer's disease, paralysis, Epilepsy, fainting, seizures, headaches, or other condition affecting the nervous system?	❑	❑	❑	❑
G. Anemia or any other condition affecting the blood, Lupus, Arthritis, deformity or loss of limb?	❑	❑	❑	❑
H. Anxiety, Depression, Bipolar Disorder, or any other mental disorder or condition?	❑	❑	❑	❑
I. Cancer, Tumor, Leukemia, Hodgkin's Disease, Polyps or Mole?	❑	❑	❑	❑
J. Alcohol or drug abuse or dependency?	❑	❑	❑	❑

SECTION B: Please indicate your answers for each question in this section by checking the Yes or No box for the question.				
1. Within the last 5 years has the proposed insured:	Employee		Spouse*	
	Yes	No	Yes	No
A. Had a Driving While Intoxicated (DWI), Driving Under the Influence (DUI) or Operating Under the Influence (OUI) conviction?	❑	❑	❑	❑
B. Smoked cigarettes:	❑	❑	❑	❑
1. For how many years has the proposed insured smoked?				
2. Approximately how many cigarettes are, or were, smoked on average per day?				
3. If cigarette smoking has been discontinued, when (month and year) did the proposed insured quit smoking?				
C. Used any controlled or illegal drug or other substance?	❑	❑	❑	❑
D. Been seen for, or been advised to have sought treatment for, observation and/or consultation for surgery, medical examination, and/or tests, such as blood, urine, X-rays, electrocardiograms, scans, biopsies, or any medical tests/exams not listed here or above, other than normal routine physical exams?	❑	❑	❑	❑
E. Used any medication prescribed by a physician or other medical practitioner, or used any form of alternative and complementary medical treatment or remedy, including herbs or acupuncture?	❑	❑	❑	❑
F. Been seen, sought treatment for, consulted, advised they had and/or received any medical advice from a health care practitioner for any disease, disorder and/or medical impairment not listed above?	❑	❑	❑	❑

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 information 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 coverage for each of my dependents will not go into effect unless the person is not confined in a hospital or institution, or receiving certain medical treatment. The conditions for the requested insurance to be effective 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) I must report any change in my health that happens before the insurance is effective.
(5) 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 any hospital, clinic, health care practitioner, pharmacy, benefit manager, employer, insurance company, the Medical Information Bureau (MIB) or any other person or organization having info about the health, medical history, physical or mental condition, diagnosis or treatment, employment or income, or motor vehicle driving record, to disclose to the Insurance Company or its authorized agent, any such info, for the purpose of underwriting this application for insurance or administering any claim under any insurance which is approved. This authorization 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 is no longer subject to the protections of the Health Insurance Portability and Accountability Act (HIPAA). (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.

Sign Here

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

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.