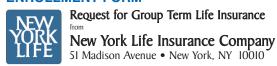
ENROLLMENT FORM



State Sponsored Life Insurance Guardian Group Term Life Insurance Plan FOR THE

National Guard Association of Rhode Island



1. MEMBER II	NFORMATION:		Please Print	in Ink or Ty	pe (Be Sure to	Complete t	he Reverse Sid	e)		
Rank:	AGR: Yes]	NG Unit			Unit	Location			
Last Name		First		Initial	Date of Birth Height: ft.	// // // // // // // // // // // // //	Social Security Weight:	Number lbs. Sex:	 	
Mailing Address City Email Address		State	Zip		Home: P			l .	ne Number	
Spouse Informati	on:									
Last Name		First		Initial	Date of Birth Height: ft.		Social Security Weight:			
Mailing Address	Same as Member									
City		State	Zip		Home:P	hone Number		Pho	ne Number	
Child Information	n:							_		
Last Name		First		Initial	Date of Birth	1M / DD / YY	Social Security	Number		
Address Same as	Member	City	State		Date of Birth	1M / DD / YY	Social Security	Number		
Last Name		First		Initial	_					
Address Same as	Member	City	State	e Zip						
nsurance Replacement	t: Is the insurance app	olied for inten	ded to replace, di	scontinue or c	hange any other exis	sting policy?	Member Yes	☐No Spou	se Yes No	
I hereby make t	ARY DESIGNAT the following bene ficiary for depend	eficiary des						Level Term l	Life Insurance	
Beneficiary Name				Relationship to Member		Social Sec. # Date of Birth			th %	
Street Address				City		Sta	State Zip Phone #			
Beneficiary Name			Relationship to Member		Soc	cial Sec. #	Date of Birt	h %		
Street Address	Same Address and Phone	as Member		City		Sta	te Zip	Phoi	ne #	
3. MEMBERS	HIP AFFILIATION	ON:								
am a Member of th	ne Rhode Island Na	ational Guar	d, and a Membe	r or Associa	te Member of The	National G	uard Association	of Rhode Islar	nd. □Yes □N	
4. INSURANC	E REQUESTE	D:	Refer to Bro	chure for e	ligibility, options	and covera	ge description.			
☐ I hereby	apply for the follo	owing cover	rage(s) as indic	ated below:	□ New Covera	ge 🗆 Incr	ease in Coverag	ge		
		Guard M	<u>lember</u>		Spouse		Children			
	Coverage	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*	Coverage Amount	Current Monthly Premium*		
	□ \$ 1,000 ((no cost)**	□ \$15,000	(\$5.33)	□ \$ 5,000	(\$2.00)	□ \$ 5,000	(\$1.50)		
	□ \$ 5,000 (□ \$10,000 (` '	□ \$20,000	(\$7.00)	\$10,000 \$15,000 \$20,000	(\$5.33)	□ \$10,000 □ \$15,000	` /		
	L regate Plan maximum 1 Benefits may be pay:				coverage terminates	with a convers				

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*Premiums are not guaranteed. See Plan Brochure for complete rate details. **No Cost Premium is paid by your National Guard Association.

5. STATEMENT OF HEALTH: Co	omplete only if you are applyi	ng more than 120 days	s since you enli	sted or if spouse cover	age amount desired excee	eds \$5,000.						
(Please initial any changes you n they apply to you and your spous		e best of your knov	wledge and	belief, answer the	following questions a	สร						
a. Is any person to be insured now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment? YES NO.												
b. During the past 5 years has a treated for: heart trouble, eleva or nervous disorder or psychot titis), enlarged lymph nodes curine, back trouble/disorder, a	ated blood pressure, gynd therapeutic treatment, ep or immunodeficiency disc	ecological or genito pilepsy, respiratory o order, thyroid dison	ourinary diso disorder, kio	orders, ulcers, cance dney or liver disord	er, diabetes, mental ler (including hepa-	YES NO						
c. During the past 5 years has any	person to be insured bea	en counseled, treated	ed or hospital	lized for the use of	alcohol or drugs?							
IF YOU HAVE ANSWERE	ED "YES" TO ANY OF		NS ABOV		•	. YES NO						
Name(s) of Proposed Insured		e of Onset-Duration-Treat		Name and address	of Physicians or other Med	lical Care						
Training(e) or Frephenous meaners	Operations-Degre	ree of Recovery and Date		Practitioners and Hospitals where confined or treated								
FRAUD NOTICE — Any person knowingly presents false information confinement in prison. I understand that New York Life	ation in an applicatio	n for insurance	is guilty o	of a crime and n	nay be subject to	fines and						
examination by a physician. I as to it, while considering this reque and statements set forth above.	k New York Life to re	ely on all such s	statements	s made on this f	form, and any sup	plements						
AUTHORIZATION: I authorize a related facility, laboratory, insura edge of me or my health to releast benefit managers, and other sour or the plan administrator about to cant history, findings, diagnosis a	nce company or oth se information, inclu- irces of information the he physical and mei	er organization, ding prescriptior to New York Life ntal health of an	, institution on drug rec e Insuranc ny persons	n or person, that cords, maintained ce Company, its s proposed for i	t has any records ed by physicians, p reinsurers, its su	or knowl- pharmacy bsidiaries						
A photocopy of this AUTHORIZA rized agent or representative, or for a period of 24 months from the	r I may request a co	ppy of this AUTH	HORIZATI	ION. This AUTH	HORIZATION may	y be used						
READ & SIGN: By signing and cand any person proposed for in noted above and in the IMPORT Fraud Notice indicated above, a are true and complete.	surance consent to ANT NOTICE, and a	authorize the dattest to having	disclosure read the	of information	to and from the posterior	providers iched and						
Member's Signature x			Da	ate								
(Please sign	and date in ink)											
TO REQUEST MIT TERM LIFE INS	SUBANCE	ΜΙΙΙΤΙΔ ΔΡΜΙΝ	NISTR ATI\	/F SERVICES II	NC							
Complete this form in ink and mail	to:	MILITIA ADMINISTRATIVE SERVICES, INC. 48 Main Street Sturbridge, MA 01566										
		APPLY TODAY										
			000 555	222								
G-14109-7	FOR MORE INFO	DRMATION 1-8	-800-633-	-8333								
<u> </u>												

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