APPLICATION FOR SSLI TERM LIFE INSURANCE
WISCONSIN NATIONAL GUARD ASSOCIATION
2400 Wright Street Rm 205 · Madison, WI 53704

Request for Group Insurance from
New York Life Insurance Company
51 Madison Avenue · New York, NY 10010

SECTION A—MEMBER INFORMATION

PLEASE PRINT IN INK OR TYPE ALL ANSWERS

LAST NAME	FIRST	MIDDLE	SOCIAL SECURITY NUMBER

STREET ADDRESS	CITY	STATE	ZIP CODE

E-MAIL ADDRESS	CELL PHONE NUMBER	WORK PHONE NUMBER
	( )	( )

DATE OF BIRTH (MM/DD/YYYY)	HEIGHT	WEIGHT	SEX
/ /	FT. IN.	LBS.	☐ MALE ☐ FEMALE

MARITAL STATUS: ☐ MARRIED, MAIDEN NAME: ☐ DIVORCED ☐ SINGLE ☐ WIDOWED

MEMBERSHIP STATUS WITH THE WISCONSIN NATIONAL GUARD: ☐ ACTIVE ☐ SEPARATED ☐ SURVIVING SPOUSE

DATE OF ENLISTMENT (MM/DD/YYYY)		
/ /	☐ ARMY	☐ AIR– MILWAUKEE ☐ AIR– MADISON

SPOUSE/DEPENDENT INFORMATION (Attach a separate sheet to provide additional dependent information)

If a dependent coverage is requested, list eligible dependents (i.e. lawful spouse and unmarried, dependent children under age 21, or 26 if a full time student).

SPOUSE'S FULL NAME (Last, First, Middle)			DATE OF BIRTH (MM/DD/YYYY) / /	☐ MALE ☐ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET ADDRESS: ☐ Address/Phone Number same as Member	CITY	STATE	ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	
CHILD 1 FULL NAME (Last, First, Middle)			DATE OF BIRTH (MM/DD/YYYY) / /	☐ MALE ☐ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET ADDRESS: ☐ Address/Phone Number same as Member	CITY	STATE	ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	
CHILD 2 FULL NAME (Last, First, Middle)			DATE OF BIRTH (MM/DD/YYYY) / /	☐ MALE ☐ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET ADDRESS: ☐ Address/Phone Number same as Member	CITY	STATE	ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	
CHILD 3 FULL NAME (Last, First, Middle)			DATE OF BIRTH (MM/DD/YYYY) / /	☐ MALE ☐ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET ADDRESS: ☐ Address/Phone Number same as Member	CITY	STATE	ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	
CHILD 4 FULL NAME (Last, First, Middle)			DATE OF BIRTH (MM/DD/YYYY) / /	☐ MALE ☐ FEMALE	HEIGHT FT. IN.	WEIGHT LBS.
STREET ADDRESS: ☐ Address/Phone Number same as Member	CITY	STATE	ZIP CODE	PHONE NUMBER ( )	SOCIAL SECURITY NUMBER	

NOTE: If both parents are members, child(ren) can only be covered by one parent.

INSURANCE REQUESTED (Refer to the brochure or your certificate for eligibility, options and coverage description)

I HEREBY APPLY FOR THE FOLLOWING COVERAGE(S): ☐ New Enrollment ☐ Change– Increase ☐ $1,000 (NO COST to you– premium is paid by WINGA)

NOTE: If you are increasing or altering present coverage in any way, do not indicate just the additional amount of coverage, instead indicate the TOTAL AMOUNT of coverage you are requesting.

GUARDMEMBER		SPOUSE* (Spouse Only)			DEPENDENT (Spouse* & Child(ren)	
☐ $10,000	☐ $30,000	☐ $5,000	☐ $20,000	☐ $35,000	☐ $5,000	☐ $15,000
☐ $15,000	☐ $35,000	☐ $10,000	☐ $25,000	☐ $40,000	☐ $10,000	☐ $20,000
☐ $20,000	☐ $40,000	☐ $15,000	☐ $30,000	☐ $45,000		
☐ $25,000	☐ $45,000					

**Spouse and/or Dependent total coverage amount cannot exceed Member's coverage amount.*

In no event may the total coverage applied for exceed the maximum plan benefit of $45,000. If a husband and wife are both members of the Wisconsin National Guard, both may apply for member coverage. **If both apply for member coverage, neither may apply for spouse (stand alone) coverage.**

INSURANCE REPLACEMENT: Is the insurance applied for intended to replace, discontinue or change an existing policy? ☐ Yes ☐ No

SECTION B— BENEFICIARY DESIGNATION

I hereby make the following beneficiary designation with respect to all the insurance on my life under this Group Term Life Insurance Plan, and if I am already covered under the plan, I hereby revoke any prior beneficiary designation. The beneficiary for dependent and spouse coverage shall be the insured member as provided in the Group Policy.

Full Name (Last, First, Middle)	Relationship to Member	Date of Birth

Phone Number	Social Security Number

Street Address	City	State	Zip Code

BE SURE TO COMPLETE AND SIGN REVERSE SIDE

ONLY ACTIVE GUARD MEMBERS ARE REQUIRED TO SUBMIT A DD FORM 2558 WITH THIS APPLICATION

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SECTION C— STATEMENT OF HEALTH

To the best of your knowledge and belief: Answer the following questions as they apply to you and your spouse (if spouse coverage is requested).

Please initial any changes you make on this form.

		YES	NO
A.	Are you or your spouse now taking any prescribed medication or receiving or contemplating any medical attention or surgical treatment?	☐	☐
B.	During the past five years have you or your spouse 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?	☐	☐
C.	During the past five years have you or your spouse been counseled, treated or hospitalized for the use of alcohol or drugs?	☐	☐

If you have answered "Yes" to any of the questions above, please give details below (*attach a separate sheet if necessary*).

Name(s) of Proposed Insured	Illness or Condition-Date of Onset-Duration-Treatment-Operations-Degree of Recovery and Date	Name and address of Physicians or other Medical Care Practitioners and Hospitals where confined or treated

I understand that New York Life Insurance Company 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.

FRAUD NOTICE: 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.

AUTHORIZATION: I authorize any licensed physician, medical practitioner, hospital, clinic or other medical or medically related facility, laboratory, insurance company, 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 Insurance Company, 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.

READ & SIGN: 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 on the attached and Fraud Notice indicated above and that to the best of my knowledge and belief, the answers provided to the questions are true and complete.

Member/Surviving Spouse Signature _____ / /

(PLEASE SIGN IN INK) DATE (MM/DD/YYYY)

TO REQUEST GROUP TERM LIFE INSURANCE,

Complete this form in ink and mail to:

WINGA INSURANCE PLAN (SSLI)
WRIGHT ST ROOM 205
MADISON WI 53704-2572

For more information visit: www.winga.org/insurance.html

Phone: (608) 242-3100 Fax: (608) 242-3106 Email: insinfo@winga.org

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