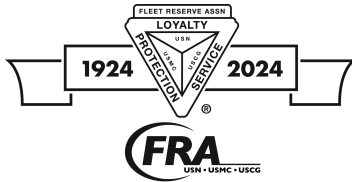


Office of the Administrator
P.O. Box 14536
Des Moines, IA 50306



Dear FRA Member,

The enclosed Enrollment Form confirms your eligibility status in connection to a valuable benefit offer extended exclusively to FRA Shipmates.

The FRA-endorsed Senior Term Life Insurance Plan is a senior group term life insurance benefit negotiated specifically for members ages 50-74.

Please let me explain:

At an age when veterans report that adding additional life coverage can be difficult, you can now easily add \$5,000* to \$25,000* in \$5,000 increments (\$5,000* or \$10,000* for ages 65-74) in life insurance to help protect your family's financial security.

You don't need a medical exam. You don't need your doctor to send in your medical records.

All it takes is a few answers on the enclosed Enrollment Form and we'll get the paperwork going on as much as \$25,000 (or up to \$10,000 for ages 65-74) in Senior Term Life Insurance coverage.

The FRA-endorsed Senior Term Life plan was carefully developed as a term life insurance benefit for members like you (and your spouse/domestic partner if you'd like).

No one else can activate this coverage.

It's a benefit offer reserved exclusively for FRA Shipmates – to thank you for your service to our country and your dedication to FRA.

(Over for more details) >>>

ADDITIONAL MONEY FOR YOUR LOVED ONES ...

When an FRA member switches jobs or retires, the employer-sponsored life coverage stops, or can drastically reduce as we get older.

Regardless of the reason, the end result can be the same:

Not enough money to help pay off a mortgage or big medical bills.

Not enough money to take care of final expenses or funeral costs.

But today you can enroll for life insurance ranging from \$5,000 to \$25,000 (in \$5,000 increments), depending on your age.

Sent straight to your family just when they may need it most.

Just take advantage of your membership opportunity to request Senior Term Life Insurance coverage right away.

GUARANTEED ACCEPTANCE MEANS YOU CANNOT BE TURNED DOWN

Your status as a guaranteed acceptance FRA member makes you eligible for simplified enrollment privileges when you request Senior Term Life coverage.

There are no physicals involved. No medical exam required. You don't even have to be actively at work.

As an FRA member age 50 or over, everything you need to decide to enroll in life insurance is included right here in this benefit documentation packet.

Just complete the enclosed Enrollment Form and sign where indicated.

SEND NO MONEY NOW

SURVIVING SPOUSE/DOMESTIC PARTNER CONTINUATION OF COVERAGE

And what about protection for your spouse/domestic partner if you die while your spouse/domestic partner is covered under the Policy.

Your spouse/domestic partner may continue his or her coverage as long as we receive the spouse's/domestic partner's request and required premium to continue the coverage within 31 days of the premium due date next following the member's death.

ECONOMICAL GROUP RATES

Take a 54-year-old member, for example.

70¢ a day sets up \$25,000 of coverage.

And you can even add your spouse/domestic partner. All it takes is 70¢ more a day to add a 54-year-old spouse/domestic partner for \$25,000 of Senior Term Life benefits.

100% SATISFACTION GUARANTEE

Of course, there's no obligation when you request your FRA-endorsed Senior Term Life coverage.

Just mail back your completed Enrollment Form to get the paperwork started on your Senior Term Life Insurance coverage.

We'll mail your official Certificate of Insurance as soon as your enrollment process is complete.

Look it over for 30 days. If Senior Term Life isn't what you had in mind, just let us know during that time. You'll get a 100% refund of any money you may have sent, minus any claims paid.

No hassles and no questions asked.

Guaranteed acceptance; "no-medical-exam" enrollment opportunity.

Sincerely,



Steven Miller, Senior Vice President
Association Member Benefits Advisors, LLC
FRA-endorsed Insurance Programs Administrator
License #1936106

P.S. Your guaranteed acceptance status now makes you eligible to request Senior Term Life coverage – with NO extra paperwork required.

*At age 80, coverage, if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.

Please refer to the fact sheet for more information including costs, exclusions, limitations, reduction of benefits and terms of coverage.

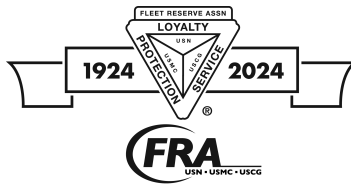
GRADED DEATH BENEFIT: During the first two years of coverage, the benefit payable for death due to sickness will be the premiums paid plus interest.

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Hartford Life and Accident Insurance Company, Hartford, CT 06155

Master Policy #AGL-1931

FRASRL



FRA-ENDORSED SENIOR TERM LIFE INSURANCE PLAN

A good value comes down to what you get for what you pay.

What you get:

- ✓ A choice of benefit amounts to suit your specific needs
- ✓ The opportunity to bring your current coverage up to date
- ✓ Important benefits that can be used to help pay final expenses, including funeral costs, mortgage payoff and outstanding debt
- ✓ Easy enrollment, with no medical exam required

What you pay:

Economical member-only rates negotiated on your behalf.

The Senior Term Life Insurance Plan is offered for the exclusive benefit of eligible FRA Shipmates. For this reason, we are able to make it available to members in good standing at economical group rates. The chart below shows the rate for the benefit amount you select, based on your and your spouse's age.

FRA-endorsed Senior Term Life Insurance Plan

MONTHLY GROUP RATES (Ages 50-64)

ATTAINED AGE - Member & Spouse/ Domestic Partner	\$25,000**	\$20,000**	\$15,000**	\$10,000**	\$5,000
50-54	\$21.44	\$17.15	\$12.86	\$8.58	\$4.29
55-59	\$32.50	\$26.00	\$19.50	\$13.00	\$6.50
60-64	\$50.79	\$40.63	\$30.48	\$20.32	\$10.16
*65-69	\$82.60	\$66.08	\$49.56	\$33.04	\$16.52
*70-74	\$131.13	\$104.90	\$78.68	\$52.45	\$26.23
*75-79	\$209.77	\$167.82	\$125.86	\$83.91	\$41.95
*80-84	n/a	n/a	n/a	n/a	\$69.28
*85-89	n/a	n/a	n/a	n/a	\$120.87

*Renewal premiums only. Members ages **50-64** can apply for up to \$25,000 (in \$5,000 increments).

**At age 80, coverage if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.

MONTHLY GROUP RATES (Ages 65-74)

ATTAINED AGE - Member & Spouse/ Domestic Partner	\$10,000**	\$5,000
65-69	\$33.04	\$16.52
70-74	\$52.45	\$26.23
*75-79	\$83.91	\$41.95
*80-84	n/a	\$69.28
*85-89	n/a	\$120.87

*Renewal premiums only. Members ages **65-74** can only apply for \$10,000 or \$5,000.

**At age 80, coverage if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.

You will be billed Quarterly; four times a year. If applicable, an additional \$2 billing fee will be included on your billing notice payable to the administrator. To save the fee, select Electronic Funds Transfer (EFT) as a safe and secure payment option. Rates and/or benefits may be changed on a class basis. Rates are based on the attained age of the Insured Person and increase as you enter each new age category. Coverage begins on the first day of the month following approval by the Insurer and payment of the first premium. Coverage continues with no decrease in coverage until you reach age 80. At age 80, coverage, if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.

Coverage cannot be canceled as long as you remain a member of FRA, pay your premiums on time and the Master Policy remains in force. Coverage for your Spouse/Domestic Partner will continue for as long as your coverage is in force and he/she remains eligible due to age and marital status. Full details are contained in the Certificate of Insurance, which will be issued to persons who become insured under the Plan. The Plan may not be available to residents of all states. This Plan terminates at age 90.

Limitations

If you or your dependent die while covered under the Policy, we will pay the deceased person's life insurance benefit after we receive Proof of Loss, in accordance with the Proof of Loss provision and: 1) if death is the result of an Injury and occurs during the first 2 years of coverage under the policy, we will pay the deceased person's Amount of Life Insurance; 2) if death is the result of sickness and occurs during the first 2 years of coverage under the Policy, the amount payable will be an amount equal to the premiums paid for coverage, with interest, using an annual interest rate of at least the company's corporate interest rate; or 3) if death is the result of an Injury or Sickness and occurs after 2 years of coverage under the Policy, we will pay the deceased person's amount of life insurance.

Eligibility

As an active FRA member, between the ages of 50 and 74, and a resident of the U.S., you and your Spouse/Domestic Partner are eligible for coverage. Your Spouse/Domestic Partner may not be legally separated or divorced from you.

When a Member and Spouse/Domestic Partner are both Eligible Members, coverage may not be duplicated by applying as dependents of each other.

This coverage is available only for residents of the United States excluding MT, NH and WA.

Effective Date

Your coverage will become effective upon receipt of the Enrollment Form and your first premium payment.

GRADED DEATH BENEFIT: During a person's first two years of coverage, benefits for loss of life due to Injury are covered. Loss of life due to sickness is not covered during the first two years. In the case of loss of life for sickness, premiums plus interest will be refunded. Since coverage is issued without medical underwriting, the premium rate being charged includes an extra mortality risk charge.

Termination

Coverage will end on the earliest to occur of: the date the Master Policy terminates; or the Premium Due Date on or next following the date You: a) cease to be an active member of FRA; b) attain age 90; the date You are no longer in a class eligible for coverage, or the class is canceled; or the Premium Due Date that You fail to pay any required premium, subject to the Individual Grace Period of 31 days. Your dependent's coverage will remain in effect as long as your coverage is active, premiums are paid, and they meet the eligibility requirements.

Exclusions

If a Covered Person commits suicide, while sane or insane, during his or her first two years of coverage under the policy, we will only pay an amount equal to the premium paid for coverage to the date of death. The life insurance benefit is payable if a covered person is insured under the policy and commits suicide after the two-year period.

The two-year suicide exclusion, stated above, will also apply if a covered person commits suicide during the two years immediately following an increase in coverage.

In that event, the amount of insurance payable will equal the amount of insurance in force prior to the increase plus an amount equal to the premium paid for the increase to the date of death.

Accelerated Death Benefit

If a Covered Person:

- a) is under age 80;
- b) is covered for a term life insurance benefit amount under the policy of at least \$5,000;
- c) is diagnosed as Terminally Ill while covered under the policy, with a life expectancy of 12 months or less, and gives us satisfactory proof of such terminal illness; and
- d) requests in writing a portion of the amount of his or her life insurance benefit be paid as an accelerated benefit; we will pay an Accelerated Death Benefit up to 50% (minimum \$3,000, maximum \$12,500) of the Covered Person's Life Insurance Benefit.

Upon satisfactory proof of the Covered Person's Terminal Illness, we will continue his or her life insurance amount. However, continued insurance will be subject to any reductions in amounts of insurance provision under the policy.

The Covered Person's Amount of Life Insurance payable upon his or her death will be reduced by any Accelerated Benefit Amount already received under this benefit. Receipt of accelerated benefits may be taxable. Seek assistance from your personal tax advisor for more information¹.

¹This written information is for promotion or marketing of the matter(s) addressed in this material. These materials are not intended to provide tax, accounting or legal advice and cannot be relied upon for any such purpose. You should consult your own tax or legal counsel for advice.

Accelerated benefits may be taxable. These materials are not intended to provide tax, accounting or legal advice and cannot be relied upon for any such purpose. We recommend that you consult with a qualified tax advisor.

Accelerated benefits may affect your or your family's initial or continued eligibility for public assistance, such as medical assistance (Medicaid), Aid to Families with Dependent Children (AFDC), supplementary social security income (SSI), we recommend that you consult with social service agencies with any questions regarding eligibility for public assistance.

Important Definitions

Injury means bodily injury resulting directly from an accident, and independently of all other causes, which occurs while covered under the policy.

Loss resulting from sickness or disease, except a pus-forming infection which occurs through an accidental wound, or medical or surgical treatment of a sickness or disease, is not considered as resulting from Injury.

Terminal Illness or Terminally Ill means a life expectancy of 12 months or less.

Conversion Provision

If a Covered Person ceases to be insured under the policy for any reason except nonpayment of premium, he or she may have the right to convert the coverage that terminated to an individual conversion policy without providing evidence of insurability. Conversion is not available for any Amount of Life Insurance for which the Covered Person was not eligible and covered under The Policy.

If coverage under the policy ends because the policy terminated or coverage for an eligible class of persons is terminated, the Covered Person must have been insured under the policy five years or more in order to be eligible to convert coverage. The amount which may be converted under these circumstances is limited to the lesser of:

- a) \$10,000; or
- b) the life insurance benefit under the policy less any amount of life insurance for which the covered person may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

If coverage under the policy ends for any other reason, except nonpayment of premium, the full amount of coverage which ended may be converted less any Amount of Life Insurance for which You or Your Spouse/Domestic Partner may become eligible under any group life insurance policy issued or reinstated within 31 days of termination of group life coverage.

Insurer, as used on this provision, means The Hartford or another insurance company which has agreed to issue conversion policies according to this conversion privilege.

To convert coverage, the Covered Person must complete a Notice of Conversion Right form and return it to the Insurer within 31 days after he or she ceases to be covered under the policy. The insurer will not accept requests for Conversion if they are received more than 91 days after the Life Insurance terminates. After the Insurer verifies eligibility for conversion coverage, they will send the Covered Person a conversion policy Proposal. The Covered Person must:

- a) complete and return the request form in the proposal; and
- b) pay the required premium for coverage; within the time period specified in the proposal.

Any individual policy issued to You or Your dependents under the conversion provision will be effective as of the 32nd day after the date coverage ends, and will be in lieu of coverage for this amount under the policy.

The conversion policy will:

- a) be issued on one of the Life Insurance policy forms the Insurer is issuing for this purpose at the time of conversion; and
- b) base premiums on the Insurer's rates in effect for new applicants of the Covered Person's class and age at the time of conversion.

The conversion policy will not provide:

- a) the same terms and conditions of coverage as the policy;
- b) any benefit other than a life insurance benefit; and
- c) term insurance unless You request a single premium term insurance policy for a period of 1 year prior to the issuance of the Conversion Policy.

If a Covered Person dies before coverage is converted, and his or her death occurs within 31 days of the date coverage under the policy terminates, we will pay the deceased person's amount of life insurance he or she would have had the right to apply for under this provision.

If the conversion policy has already taken effect, no life insurance benefit will be payable under the policy.

This brochure explains the general purpose of the insurance described, but in no way changes or affects the policy as actually issued. In the event of a discrepancy between this brochure and the policy, the terms of the policy apply. All benefits are subject to the terms and conditions of the policy. Policies underwritten by Hartford Life and Accident Insurance Company detail exclusions, limitations, reduction of benefits and terms under which the policies may be continued in full or discontinued. Complete details are in the Certificate of Insurance issued to each insured individual and the Master Policy issued to the policyholder. This program may vary and may not be available to residents of all states.

This is private insurance. This insurance is not associated with SGLI.

Program Offered by:



Association Member Benefits Advisors, LLC., which acts as the insurance broker for the Group Policyholder, is appointed by The Hartford, and is compensated for the placement of insurance.

In CA d/b/a Association Member Benefits & Insurance Agency

CA Insurance License #0196562

AR Insurance License #100114462

P.O. Box 14536
Des Moines, IA 50306

QUESTIONS?

1-800-424-1120
fra.service@getamba.com

Underwritten by:



Hartford Life and Accident Insurance Company
Hartford, CT 06155

The Hartford Insurance Group, Inc. (NYSE: HIG) operates through its subsidiaries under the brand name, The Hartford, and is headquartered in Hartford, Connecticut. For additional details, please read The Hartford's legal notice at www.thehartford.com.

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

AGL-1931
FRASRP

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Group Senior Term Life Insurance Enrollment Form

With Graded Death Benefit

Members ages 50-74

Group Policyholder: Fleet Reserve Association

Policy Number: AGL-1931

SECTION 1			
Member Information			
Member Name:		FRA Membership Number:	
Street:	City:	State:	Zip Code:
Member Social Security Number:	Member Date of Birth:	Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	
Email Address:		Preferred Phone Number:	

SECTION 2	
Is Spouse or Domestic Partner coverage desired? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse or Domestic Partner Full Name (if enrolling):	Spouse or Domestic Partner Date of Birth:
Gender: <input type="checkbox"/> Male <input type="checkbox"/> Female	Spouse or Domestic Partner Social Security Number:

By enrolling for this insurance, do you intend to replace, discontinue or change an existing policy of Life Insurance? If not, simply check "No".	
Member: <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse or Domestic Partner: <input type="checkbox"/> Yes <input type="checkbox"/> No (if applying)

SECTION 3	
Coverage Information	
Life Insurance	
FRA Member	
Age Coverage	
50-64 <input type="checkbox"/> \$5,000 (00C1) <input type="checkbox"/> \$10,000 (00E1) <input type="checkbox"/> \$15,000 (00F1) <input type="checkbox"/> \$20,000 (00G1) <input type="checkbox"/> \$25,000 (00H1)	
65-74 <input type="checkbox"/> \$5,000 (Y0C1) <input type="checkbox"/> \$10,000 (Y0E1)	
At age 80, coverage, if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.	
FRA Spouse or Domestic Partner	
Age Coverage	
50-64 <input type="checkbox"/> \$5,000 (00C5) <input type="checkbox"/> \$10,000 (00E5) <input type="checkbox"/> \$15,000 (00F5) <input type="checkbox"/> \$20,000 (00G5) <input type="checkbox"/> \$25,000 (00H5)	
65-74 <input type="checkbox"/> \$5,000 (Y0C5) <input type="checkbox"/> \$10,000 (Y0E5)	
At age 80, coverage, if greater than \$5,000, will reduce to \$5,000 with an appropriate adjustment in premium.	

Mail your completed enrollment form to: **FRA-ENDORSED INSURANCE PROGRAMS**, P.O. Box 14536, Des Moines, IA 50306

Questions? **CALL:** 1-800-424-1120, **EMAIL:** fra.service@getamba.com, **WEBSITE:** www.frainsure.com

SECTION 4

Confirmation

I acknowledge that I have been given the opportunity to enroll in the Senior Term Life Insurance Plan. I certify that I am age 74 or younger, an FRA Member and that the above information is true and complete to the best of my knowledge. If I enroll today and want to upgrade coverage at a later date, I may be required to submit Evidence of Insurability.

I understand and agree that insurance will go into effect upon receipt of my first premium payment and this form and remain in effect only in accordance with the provisions, terms and conditions of the insurance policy. I understand and agree that only the insurance policy issued to FRA can fully describe the provisions, terms, conditions, limitations and exclusions of my insurance. In the event of any difference between the enrollment form and the insurance policy, I agree to be bound by the insurance policy.

I understand that the policy permits the policyholder to change, reduce, restrict or terminate my rights or benefits under the policy without my consent. Such change, reduction, restriction or termination may occur at a time when a covered person's health status has changed and may affect his or her ability to procure individual coverage.

I also understand that at age 80 coverage is reduced to \$5,000, with a corresponding premium adjustment.

Member Signature:		Date:
Spouse or Domestic Partner Signature (if enrolling):		Date:

SECTION 5

Payment Options

Automatic Bank Withdrawal (Electronic Funds Transfer):

Name:	Banking Institution:	Routing Number:
Account Number:	Bank Account Type:	<input type="checkbox"/> Checking <input type="checkbox"/> Savings

For your convenience you will be billed quarterly

I request that you pay and charge my account debits drawn from my account by the Plan Administrator to its order. This authorization will stay in effect until I revoke it in writing. Until you receive such notice, I agree that you shall be fully protected in honoring any such debits. I also agree that you may, at any time, end this agreement by giving 30 days advanced written notice to me and to the Plan Administrator. You are to treat such debit as if it were signed by me. If your dishonor such debit with or without cause, I will not hold you liable even if it results in loss of my insurance.

**Read your certificate carefully.
Certain war risks are not covered.**

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

Member Signature:		Date:
Spouse or Domestic Partner Signature (if enrolling):		Date:

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries.

AGL-1931
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Fraud Notice(s)**For Residents of Florida:**

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.

For Residents of Kentucky:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.

For Residents of Louisiana:

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.

For Residents of Maryland:

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or 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.

For Residents of New Jersey:

Any person who knowingly files a statement of claim containing any false or misleading information is subject to criminal and civil penalties. Any person who includes any false or misleading information on an application for insurance is subject to criminal and civil penalties.

For Residents of New York (Not applicable to Life Insurance):

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 is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

For Residents of Virginia:

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 statement may have violated the state law.

Life Form Series includes GBD-1000, GBD-1100, or state equivalent.

Domestic Partnership Affidavit

Name of Applicant _____

Name of Domestic Partner _____

The undersigned member and domestic partner, being of sound mind, hereby state the following:

1. That the undersigned member and domestic partner have an exclusive mutual commitment to share responsibility for each other's welfare and financial obligations and that this commitment is of at least six months duration and is expected to continue indefinitely.
2. That the undersigned member and domestic partner share a single permanent residence (attach one copy of evidence such as driver's license).
3. That the undersigned member and domestic partner are financially interdependent as demonstrated by at least two of the following (check all that apply and attach copy of evidence):
 - ☐ Common ownership of a motor vehicle.
 - ☐ Joint bank or credit accounts.
 - ☐ Assignment of durable power of attorney in favor of one another.
 - ☐ Common ownership of real estate or common leasehold interest in property.
 - ☐ Joint ownership or holding of stocks, bonds, or other investments.
 - ☐ Execution of will naming each other as executor and/or beneficiary.
 - ☐ Designation as beneficiary under the other's retirement or pension benefits account.
4. That the undersigned member and domestic partner (check one):
 - ☐ have filed a domestic partner declaration with the (City/Council/Borough) of _____ and that such domestic partner declaration remains in effect (attach copy of declaration).
 - ☐ do not reside in a jurisdiction which provides for the registration of domestic partnership declarations.
5. That neither the undersigned member nor domestic partner would be able to affirm questions 1 through 4 above with respect to any person except the other.
6. That neither the undersigned member nor domestic partner has executed or filed a declaration or affidavit of domestic partner status with any other person within the past 12 months.
7. That the undersigned member and domestic partner are each no less than 18 years of age, and are under no legal disability which would prevent them from making this affidavit.
8. That neither the undersigned member nor domestic partner are now, or have been within the past six months, married to any other person, including common law marriage.
9. That the undersigned member and domestic partner are not related by blood in any degree which would prevent their marriage to each other.

The undersigned member and domestic partner represent that the statements made herein are true and correct to the best of their knowledge, information and belief. Member and domestic partner understand that these statements are given for the purpose of establishing their eligibility and understand that any misrepresentation, whether or not made with intent to deceive, may result in the ineligibility of the domestic partner for coverage under such policy, and in the voiding of such coverage. The member and domestic partner agree to furnish upon the Company's request evidence to substantiate any statement made herein, and that the Company may require the member and/or domestic partner, if living, to reaffirm all statements made herein periodically and/or when a claim is submitted. In the event any coverage is voided due to any misrepresentation herein, the Company's liability shall be limited to a return of any premiums paid on behalf of the domestic partner for any period of ineligibility.

Applicant's Signature _____ **Date** _____

Domestic Partner's Signature _____ **Date** _____



DEPARTMENT OF FINANCIAL SERVICES OF THE STATE OF NEW YORK

IMPORTANT REPLACEMENT NOTICE

THIS NOTICE IS FOR YOUR BENEFIT AND REQUIRED BY
INSURANCE REGULATION NO. 60

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 a paid-up 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 contemplating 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 to decide whether the replacement is in your best interest.

I HAVE READ THE IMPORTANT REPLACEMENT NOTICE THAT
ACCOMPANIED THIS APPLICATION.

Do you intend to replace, in whole or in part, any existing life insurance or annuity?

Yes _____ No _____

Date: _____ Signature of Applicant: _____

Date: _____ Signature of Applicant: _____

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BENEFICIARY DESIGNATION FORM INSTRUCTIONS

You must select your beneficiary – the person (or more than one person) or legal entity (or more than one entity) who receives a benefit payment if you die while covered by the plan. Please make sure that you also name a contingent beneficiary – who would receive your benefit if your primary beneficiary dies first.

The completion of this Beneficiary Form will revoke any previous beneficiary designation(s), if any, for your group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group.

Please make sure your beneficiary designation is clear so that there will be no question as to your meaning. If you name more than one primary or contingent beneficiary, show the percentage of your benefit to be paid to each beneficiary. The listed percentages must add up to 100%. Please provide all of the information requested. If your beneficiary is not related either by blood or by marriage, insert the words, “Not Related” as their stated relationship. If you need assistance, contact the company’s representative or your own legal advisor.

A beneficiary designation may be changed at any time upon written request.

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.

Sample wording for common beneficiary designations are shown below:

Example #1:

Jane Doe	Relationship: Spouse	Benefit Percentage: 100%
----------	----------------------	--------------------------

Example #2:

Jane Doe	Relationship: Spouse	Benefit Percentage: 50%
Susan Doe	Relationship: Daughter	Benefit Percentage: 25%
John Doe	Relationship: Son	Benefit Percentage: 25%

If additional space is required, write “See attached”, on the beneficiary line on the beneficiary designation form and attach a separate sheet, listing all the required beneficiary information for each beneficiary listed. **This separate sheet should be signed by you (the Insured/Member) and dated.**

BENEFICIARY DESIGNATION

☐ Initial Beneficiary Designation(s) OR ☐ Change of all prior beneficiary designations(s) (check only one box), I hereby revoke any previous beneficiary designation(s), if any, for my group term life insurance and/or accidental death and dismemberment (AD&D) insurance issued to this group and direct that the insurance proceeds payable under the policy be paid as indicated below.

Insured/Member Name:	Date of Birth:	Social Security Number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Insured/Member Address:	Telephone Number: ()	
Policyholder:	Policy Number:	

NAMING YOUR LIFE BENEFICIARY

It is important that your beneficiary designation be clear so there will be no question as to your intent. It is also important that you name a primary and contingent beneficiary. If you need assistance, contact the company representative or your own legal counsel. Benefits payable for a Dependent's death are payable, where applicable, to You if living, otherwise, according to the terms under the policy.

PRIMARY BENEFICIARY(IES)

Name: _____	Date of Birth: _____
Address: _____	Telephone: ()
Social Security Number: _____ Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____
Address: _____	Telephone: ()
Social Security Number: _____ Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____
Address: _____	Telephone: ()
Social Security Number: _____ Relationship: _____	Benefit Percent: _____ %

CONTINGENT BENEFICIARY(IES)

Name: _____	Date of Birth: _____
Address: _____	Telephone: ()
Social Security Number: _____ Relationship: _____	Benefit Percent: _____ %
Name: _____	Date of Birth: _____
Address: _____	Telephone: ()
Social Security Number: _____ Relationship: _____	Benefit Percent: _____ %

Disclaimer: Spousal consent does not apply to ERISA plans.

Spousal Consent For Community Property States Only: If you live in a community property state – Alaska, Arizona, California, Idaho, Louisiana, Nevada, New Mexico, Puerto Rico, Teas, Washington, or Wisconsin – you may complete the Spousal Consent section, which allows your spouse to waive his or her rights to any community property interest in the benefit. Certain tribal jurisdictions may also require spousal consent. Please see your Benefits Administrator for details.

This will certify that, as spouse to the Insured named above, I hereby consent to my spouse designating the person(s) listed above as beneficiaries of the group life term and/or accidental death insurance under the above policy and waive any rights I may have to the proceeds of such insurance under applicable community property laws. I understand that this consent and waiver supersede any prior spousal consent or waiver under this plan.

Signature of Insured/Member's Spouse: _____ **Date:** _____

I, the undersigned, reserve the right to change the beneficiary(ies) without the consent of said beneficiary(ies).

Signature of Insured/Member: _____ **Date:** _____

Please note that a Power of Attorney (POA) may not have the authority to change a beneficiary.