



Please complete this form and return to:

ASCE Plan Administrator, 1200 East Glen Avenue, Peoria Heights, IL 61616-5348 / Questions: Please call 1.800.650.2723

ASCE GROUP 20-YEAR LEVEL TERM LIFE APPLICATION

NOTE: PLEASE PRINT IN INK OR TYPE. DO NOT USE CORRECTION FLUID OR GEL PENS. INITIAL AND DATE ANY CHANGES YOU MAKE.

1. MEMBER INFORMATION:

Full Name: _____ Social Security #: _____
Last First MI

Street Address: _____

City: _____ State (or Province): _____ Zip: _____

Home Phone: (____) _____ Work Phone: (____) _____ Fax: (____) _____

Email: _____ Are you presently enrolled in this plan? Yes No

For internal use only. Email address will never be sold or shared.

	First / MI / Last	Date of Birth: MO / DAY / YR	Height:	Weight: LBS	Sex:
<input type="checkbox"/> Member Name†:	_____	____/____/____	____ft. ____in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Spouse Name*:	_____	____/____/____	____ft. ____in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child*:	_____	____/____/____	____ft. ____in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F
<input type="checkbox"/> Child*:	_____	____/____/____	____ft. ____in.	_____	<input type="checkbox"/> M <input type="checkbox"/> F

†Member date of birth must also be provided when requesting spouse coverage only.

*See Plan information for definition of eligible dependents. If more than two children are proposed for insurance, attach a separate sheet. Please sign and date the additional sheet.

In the next 12 months does any person proposed for insurance intend to reside outside the U.S. or Canada?

Member: Yes No Country(ies): _____ If "Yes," for how long? _____

Spouse: Yes No Country(ies): _____ If "Yes," for how long? _____

2. MEMBER AFFILIATION:

Membership in ASCE is required for participation in this plan: ASCE Membership #: _____

3. INSURANCE REQUESTED: Refer to Plan Information for eligibility, principal sums, premium, and coverage description.

A. I hereby apply for the following Group 20-Year Level Term Life Insurance coverage:

Member Option: Insurance Requested: \$ _____
 Spouse Option: Insurance Requested: \$ _____ Child Option*: \$10,000 None

**Member coverage must be in force to request child coverage.*

B. TOBACCO/NICOTINE USE: Have you or your spouse (if proposed for coverage) used tobacco or any nicotine substitute in any form (including nicotine patches and nicotine chewing gum)? Member: Yes No Spouse: Yes No

If "Yes," Please state when you last used tobacco or nicotine products and specify the product used:

Nicotine Products Used: _____ Member: ____/____/____ Spouse: ____/____/____
MM / YYYY MM / YYYY

C. INSURANCE REPLACEMENT: IMPORTANT REPLACEMENT INFORMATION FOR 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.

6. FRAUD NOTICE (CONTINUED):

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.

7. AUTHORIZATION AND SIGNATURE:

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.

AUTHORIZATION: I authorize any physician, medical practitioner, hospital, medical or medically related facility, laboratory, insurance company or MIB, Inc. 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 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 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 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 and Fraud Notices indicated above, including how information is exchanged with MIB, and that to the best of his/her knowledge and his/her belief, the answers provided to the questions are true and complete.

Member's Signature X: _____ Date: _____
(PLEASE SIGN AND DATE IN INK)

Spouse's Signature X: _____ Date: _____
(NECESSARY ONLY IF SPOUSE COVERAGE IS REQUESTED)

OWNER INFORMATION, REQUIRED IF OWNER IS OTHER THAN THE MEMBER (IF OWNER IS A TRUST, PLEASE SUBMIT A COPY OF THE DOCUMENT WITH THIS APPLICATION).

Full Name: _____ Relationship to proposed insured: _____
Last First MI

Mailing Address: _____
Street City State Zip

Tax ID#: _____ Date of Birth: ____/____/____ Social Security #: - -

Owner's Signature X: _____ Date: _____

Do Not Send Payment: Upon approval, you will be notified of the premium due.
 Choose one payment option (additional forms will be sent to you for EFT and CC option):
 Direct Billing (semiannually 3/1 & 9/1) Electronic Funds Transfer Credit Card