

Oklahoma Society of Certified Public Accountants-Endorsed
Group Accident Disability Insurance Plan

GUARANTEED ACCEPTANCE ENROLLMENT FORM

It's easy to enroll.

- Complete this form and return it in the postage-paid envelope provided, to:
Beale Professional Services, P.O. Box 60809, Oklahoma City, OK 73146.
- Keep in mind...you risk nothing by enrolling now. You'll have a full 30-day review period to make sure this coverage is just right for your needs.



Any questions?
Call **1-800-530-4863**

IMPORTANT: Your response is requested within 30 days for your earliest effective date.

Request for Group Insurance from:



New York Life Insurance Company
51 Madison Avenue
New York, New York 10010

Please print in ink or type all answers. Please initial and date any changes you make in ink. Do not use correction fluid.

1

MEMBER INFORMATION

Please state full name and street address.

First Name Middle Initial Last Name

Street Address

City

State

Zip Code

Social Security No.

Home Phone Number

Date of Birth

M F
Sex

Occupation

SPOUSE INFORMATION (If enrolling)

First Name Middle Initial Last Name

Social Security No.

Occupation

Date of Birth

M F
Sex

2

PREMIUM PAYMENT

You will be billed annually for the premium due .

3

INSURANCE REQUESTED: (Refer to the summary for eligibility, options and coverage description.)
I hereby enroll for the coverage indicated below, based on all my statements made in this Enrollment Form:

Group Accident Only Disability Income

You may choose any Monthly Benefit Option for which you are eligible, provided it and any other disability income coverage you may have does not exceed 66 2/3% of your AVERAGE MONTHLY INCOME, as defined in the summary.

Monthly Benefit Amount

For myself: \$3,000.00 \$2,000.00 \$1,000.00

For my Spouse: \$3,000.00 \$2,000.00 \$1,000.00
(if enrolling)

Waiting Period

For myself: 30-day 60-day

For my Spouse: 30-day 60-day
(if enrolling)

G-29304

(Continued on back)

GMA-GI L/H1

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I request the group insurance shown above. To the best of my knowledge and belief I am eligible for such insurance. **I understand** that insurance will become effective on the first day of the month following receipt of the enrollment form by New York Life provided the initial contribution is paid within 31 days of such date and the member, and any enrolling spouse, is actively at work. **I have read** my state's fraud statement below. **I represent** that I am: (a) not currently receiving benefits in the form of periodic cash payments for a disability, (b) actively working FULL-TIME at least 20 hours each week (for at least 90 consecutive days), and (c) the monthly benefit elected, when added to any other disability coverage I may have, does not exceed 66 2/3% of my Average Monthly Income. **I represent** that I am not on active duty with the armed forces.

By signing and dating this form, I request the insurance indicated, I understand when the insurance coverage will begin, and represent that to the best of my knowledge and belief, the statements made are true and complete.

Member's Signature X

(Please sign and date in ink)

Date

By signing and dating this form, I request the insurance indicated, I understand when the insurance coverage will begin, and represent that to the best of my knowledge and belief, the statements made are true and complete.

Spouse's Signature X

(Necessary Only if the spouse is enrolling)

Date

Fraud Statement:

RESIDENTS OF OK: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.