

# AIA Trust



Insurance & Financial Programs for  
AIA Members & Components

## GROUP FIRM TERM LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE APPLICATION FOR EMPLOYEE

### To Apply, Please Complete and Return to:

AIA Trust Insurance Program  
P.O. Box 22859  
Santa Barbara, CA 93121-9912

**INSTRUCTIONS:** Gray-shaded portion to be completed by the Employer. The balance is to be completed by the Employee. Print clearly in dark ink, sign the form, and return as instructed. Be sure to initial all changes.



Request for Group Insurance from:  
New York Life Insurance Company  
51 Madison Ave., New York, NY 10010

### X Employer Information:

Name of Employer:

Group Plan No.   
Date of Hire

MONTH - DAY - YEAR

This form is being completed due to: *(Check all that apply)*

- Initial Enrollment    New Enrollee    Late Entrant  
 Address Change    Other:

Effective Date of Coverage/  
Change

MONTH - DAY - YEAR

### 1 Employee Information:

*If additional space is required, complete and attach a separate sheet of paper (signed and dated).*

Employee Name:   
(FULL NAME: FIRST - M.I. - LAST)

Address:

City, State, Zip:

Home Phone: (  )  -    Work Phone: (  )  -    Sex:  Male    Female

Social Security #:  -  -    Date of Birth:  -  -    Employee I.D. #:   
MONTH   DAY   YEAR

Marital Status:  Married    Divorced    Single    Widowed   Email:

Job Title or Occupation:    Annual Salary: \$  ,    Hours Worked per Week:     Active Full-Time  
 Active Part-time

### 2 Coverage Selection:

- BASIC LIFE / AD&D (Filled in by Employer)**    Employee Elect Coverage  
 Employee Decline Coverage

Amount of Coverage:

**Continued on back**

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**Be Sure to Complete All Pages and Sign Last Page**

### 3 Beneficiary Selection:

List one or more beneficiaries below.  
Use a signed and dated additional sheet if necessary.

Employee's Primary Beneficiary is:

Percent of Coverage:\* % Relationship to Employee:  Social Security Number:

Beneficiary's Date of Birth:  -  -   
MONTH DAY YEAR

Employee's Secondary Beneficiary is:

Percent of Coverage:\* % Relationship to Employee:  Social Security Number:

Beneficiary's Date of Birth:  -  -   
MONTH DAY YEAR

\*The total percentage of coverage for all beneficiaries must equal 100%.

#### Fraud Warning Statements

Any person who knowingly and with intent to defraud any insurance company or other person who 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.

**For AR and LA residents:** 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 CO residents, the following also applies:** Any insurance company or agent who defrauds or attempts to defraud an insured shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies. **For DC residents, the following also applies:** WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

**RESIDENTS OF KS:** 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 may be guilty of insurance fraud as determined by a court of law. An insurer may deny insurance benefits if false information materially related to a claim was provided by applicant.

**For ME residents:** It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties may include imprisonment, fines or denial of insurance benefits.

**For NJ residents:** WARNING: Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties.

**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.

**For TN residents:** 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.

**For VA residents:** Any person who, with 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.

**SIGN AND DATE BELOW:** To the best of my knowledge and belief the information on this form is correct. I understand that false or inaccurate information may result in the termination of coverage or the nonpayment of benefits. I am an active employee of the Employer shown above. I understand that the terms of the coverage for which I am enrolling are set forth in the Group Policy issued to my Employer. Also, subject to revocation by me by written notice to my Employer at any time, I authorize the required deduction (if any) from my wages for the insurance I have selected.

Employee's Signature:

Date:  -  -   
MONTH DAY YEAR

Signature or Name of Benefits Person:

Date:  -  -   
MONTH DAY YEAR