NATIONAL AUTOMOBILE DEALERS ASSOCIATION SPONSORED INSURANCE

TIERED GROUP LIFE INSURANCE PLAN

Request for Group Insurance from New York Life Insurance Company
51 Madison Avenue New York, NY 10010 – Group Policy # G-29616

DEALERSHIP INFORMATION

NAME OF DEALERSHIP	TELEPHONE NUMBER	FAX NUMBER

DEALERSHIP ADDRESS (Street, City, State, Zip)	REQUESTED EFFECTIVE DATE

DEALERSHIP CONTACT	EMAIL ADDRESS

DEALERSHIP NUMBER:	NUMBER OF FULL-TIME EMPLOYEES (working min. 20 hrs/week)

Employer Paid Tiered Group Life Insurance
Please select the Coverage Plan option below that you would like to provide to your eligible full-time employees:

Group 1: Owners, Partners, Chairman of the Board, President, Officer or their Successors owning 10% of an INCLUDED EMPLOYER'S stock
Group 2: Managers
Group 3: All Other Employees

☐ Plan 1		☐ Plan 2		☐ Plan 3	
Group 1	$200,000	Group 1	$100,000	Group 1	$50,000
Group 2	$100,000	Group 2	$50,000	Group 2	$25,000
Group 3	$50,000	Group 3	$25,000	Group 3	$10,000

Optional AD&D: ☐ Yes ☐ No **Dependent Coverage** ($10,000 Spouse / $5,000 Child(ren): ☐ Yes ☐ No

Premiums will automatically be billed to the Dealership. (Note: Amounts above $50,000 may subject to imputed income.)

Please select Employee Waiting Period:

☐ 30 Days ☐ 60 Days ☐ 90 Days ☐ Other _____________

Billing Option:

Monthly Draft [Requires Pre-Authorized Checking (PAC) Form]

☐ Yes! Send me information on supplemental employee-paid life insurance coverage that I can share with my employees.

Send to this email address: ____

Note: Information for new employees must be submitted within 31 days from the date they are eligible using the Tiered Group Employee Enrollment Form (or spreadsheet including all information below). If submitted after 31 days from the date they are eligible, the employee will have to complete a Request For Coverage Form and will be subject to underwriting for life coverage.

Last Name	First Name	Date of Birth	Date of Hire	Group

May attach separate spreadsheet to include above information for all employees.

Agreed to By:

DEALERSHIP NAME: ________________________________ DATE: ________________________

AUTHORIZED SIGNATURE ________________________________ TITLE: ________________________

Please return this completed form to: **NADA Insurance Program Administer**
P.O. Box 998 Covington, LA 70434