# National Guard Insurance Program


Administered by:
National Guard Association of Kansas
125 SE Airport Drive
Topeka, KS 66619
316-288-9496
Insurance@ngaks.net

**Supplemental life insurance** for you and **dependent life insurance** for your spouse and children can be a cost-effective way to help protect your family and finances in the event something happens to you or one of your family members.

**Eligibility:** All Active National Guard Association of Kansas members in good standing are eligible to enroll. Once you have enrolled you may also apply for coverage for your lawful spouse (not to exceed your coverage) and for each of your unmarried dependent children from birth through age 25.

## Coverage Available for You

**$1,000 Basic Life Member Death Benefit**
Non-Contributory, provided by the National Guard Association of Kansas

**Up to $50,000 Supplemental Life**
Contributory coverage paid for by you

| Coverage | Monthly Contribution |
|---|---|
| $5,000 | $2.00 |
| $10,000 | $3.66 |
| $15,000 | $5.33 |
| $20,000 | $7.00 |
| $25,000 | $8.67 |
| $30,000 | $10.34 |
| $35,000 | $12.01 |
| $40,000 | $13.67 |
| $45,000 | $15.34 |
| $50,000 | $17.01 |

## Coverage Available for Your Dependents

**Dependent Life for your Spouse and/or Children**
Contributory, paid for by you.

| Coverage | Monthly Contribution |
|---|---|
| $5,000 | $3.33 |
| $10,000 | $6.66 |

**Life coverage for your Spouse**
Contributory, paid for by you.

| Coverage | Monthly Contribution |
|---|---|
| $5,000 | $2.00 |
| $10,000 | $3.66 |
| $15,000 | $5.33 |
| $20,000 | $7.00 |
| $25,000 | $8.67 |

MetLife

**Is a medical exam required?** If you complete our Simplified Issue enrollment form and you and your spouse (if applicable) are able to answer no to the hospitalization and medical questions and your height and weight are within underwriting guidelines then that application could be all that is needed.

**Are there any exclusions to my coverage?** There are no exclusions for war, aviation, hazardous duty or civilian occupation restrictions, however, benefits will not be paid if the member's or dependent's health is misrepresented within 2 years from the date life insurance for you or your dependent takes effect.

**Are there any reductions to my coverage?** Yes. Member's Supplemental life Benefit reduces to 50% at Age 60, 25% at Age 70, and 12.5% at Age 75. Spouse's Dependent life benefit matches Member's reduction schedule but is based on Spouse's attained age.

**When do benefits terminate?** The Member's $1,000 Basic Life non-contributory benefit ends when you are no longer an active member of the National Guard. The Supplemental Life contributory coverage ends the date the group policy ends, the day you cease to be eligible for coverage, or the first day you do not make any required premium payment. In addition, Dependent Life coverage ends the date the dependent no longer meets the definition of dependent, the date the dependent becomes a member of any military branch or the date the dependent becomes insured as a member under the group policy.

**Are there any additional plan benefits?** Yes. **Grief Counseling**[1] provides you and your dependents up to five private counseling sessions with a professional grief counselor – per event – to help cope with a loss, no matter what the circumstances, whether it's a death, an illness or divorce. Sessions may also be held over the phone. **Funeral Planning Assistance**[1]**:** services designed to simplify the funeral planning process for your loved ones and beneficiaries to assist them with organizing an event that will honor a loved one's life from a self-paced funeral planning guide to services such as locating funeral homes, florists and local support groups. **Will Preparation Services**[2] offers you and your spouse unlimited face-to-face or telephone meetings with an attorney from MetLife Legal Plans' network of over 18,500 participating attorneys, to prepare or update a will, living will and Power of Attorney. **Estate Resolution Services**[2] estate representatives and beneficiaries may receive unlimited face-to-face legal assistance with probating your and your spouse's estate. Beneficiaries can also consult an attorney, from MetLife Legal Plans' network of over 18,500 participating attorneys, for general questions about the probate process. **Conversion Privilege:** if life insurance ceases because of termination of membership in the classes eligible for insurance, coverage may be converted to individual coverage.

Rates may be changed on the entire group plan or on a class basis and on any premium due date on which benefits are changed. A class is a group of people defined in the group policy. Benefits are subject to change upon agreement between Metropolitan Life Insurance Company and the participating organization. Rates are as of 8/1/2025.

The association incurs costs in connection with providing oversight and administrative support for this sponsored plan. To provide and maintain this valuable membership benefit, MetLife may compensate the association for these and/or other costs.

All applications for coverage are subject to review and approval by MetLife. If you choose to apply for increased coverage, the increase may be subject to underwriting. MetLife will review your information and evaluate your request for coverage based upon your answers to the health questions, MetLife's underwriting rules and other information you authorize us to review. In certain cases, MetLife may request additional information to evaluate your request for coverage. Coverage will be effective in accordance with the applicable policy and certificate after approval by MetLife.

Nothing in these materials is intended to be advice for a particular situation or individual. Please consult with your own advisors for such advice. Like most group insurance policies, insurance policies offered by MetLife contain certain exclusions, exceptions, reductions, limitations, waiting periods and terms for keeping them in force. Please contact your plan administrator National Guard Association of Kansas at 316-288-9496 for costs and complete details.

1. Grief Counseling and Funeral Assistance services are provided through an agreement with TELUS Health. TELUS Health is not an affiliate of MetLife, and the services TELUS Health provides are separate and apart from the insurance provided by MetLife. TELUS Health has a nationwide network of over 30,000 counselors. Counselors have master's or doctoral degrees and are licensed professionals. The Grief Counseling program does not provide support for issues such as: domestic issues, parenting issues, or marital/relationship issues (other than a finalized divorce). For such issues, members should inquire with their human resources department about available company resources. This program is available to insureds, their dependents and beneficiaries who have received a serious medical diagnosis or suffered a loss. Events that may result in a loss are not covered under this program unless and until such loss has occurred. Services are not available in all jurisdictions and are subject to regulatory approval. Not available on all policy forms.
2. Will preparation and MetLife Estate Resolution Services are offered by MetLife Legal Plans, Inc., Cleveland, Ohio. In certain states, legal services benefits are provided through insurance coverage underwritten by Metropolitan General Insurance Company, Warwick, Rhode Island. For New York situsued or principally located cases, the Will Preparation service is an expanded offering that includes office consultations and telephone advice for certain other legal matters beyond Will Preparation. Tax planning and preparation of living trusts are not covered by the will preparation service. Certain services are not covered by Estate Resolution Services, including matters in which there is a conflict of interest between the executor and any beneficiary or heir and the estate; any disputes with the group policyholder, MetLife and/or any of its affiliates; any disputes involving statutory benefits; will contests or litigation outside probate court; appeals; court costs, filing fees, recording fees, transcripts, witness fees, expenses to a third party, judgments or fines; and frivolous or unethical matters.

MetLife Group Term Life insurance is issued by Metropolitan Life Insurance Company, 200 Park Avenue, New York, NY 10166, under Policy Form GPN99/G2130-S. Policy number 251888-1-G



MetLife

National Guard Association of Kansas

MetLife
Metropolitan Life Insurance Company, New York, NY 10166

# ENROLLMENT • CHANGE FORM

## GROUP CUSTOMER INFORMATION

| Name of Policyholder: **Patriots Insurance Trust** | Customer #: **251888** | Group/Report #: **260990** |
|---|---|---|

## YOUR ENROLLMENT INFORMATION (To be Completed by the Member)

| Rank/Title: | AGR: ☐ Yes ☐ No | NG Unit: | Unit Location: |
|---|---|---|---|
| Member's Name (First, Middle, Last) | | | |
| ☐ New Enrollment ☐ Change in Enrollment | ☐ Male ☐ Female | Member's SSN #: – – | DOB: |
| Mailing Address (Street, City, State, Zip Code): | | | |
| Home/Cell Phone #: | Email: | Spouse Email: | |
| Are you an Active Member of the Kansas National Guard? ☐ Yes ☐ No | | Date of Enlistment: | |

**I have read my enrollment materials and I request coverage for the benefits for which I am or may become eligible. I understand that I may be eligible for Basic Life coverage described elsewhere in my enrollment materials for which no contributions are required. I understand that contributions are required for the benefits I select below.**

► **If you are enrolling for Supplemental/Optional Life (for member) or Spouse Life Insurance, you must complete the Health Information section of this form for all amounts you are requesting.**

### Term Life Insurance

☐ Supplemental/Optional Life (for member)
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000 ☐ $30,000 ☐ $35,000 ☐ $40,000 ☐ $45,000 ☐ $50,000

**NOTE: Your Spouse may be insured up to a total maximum of $35,000 (maximum of $25,000 for Spouse Life coverage and up to a maximum of $10,000 for your Spouse and/or Child Life coverage). The total amount of Spouse Life coverage cannot exceed the Member's total benefit amount.**

☐ Spouse Life [1]
☐ $5,000 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ $25,000
The maximum amount of coverage cannot exceed the Member's benefit.

☐ Spouse and/or Child Life [1]
☐ $5,000 ☐ $10,000
Cannot exceed 50% of Member's benefit.

### Dependent Information

**If you are applying for coverage for your Spouse and/or Child(ren), please provide the information requested below:**

Name of your Spouse (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

Name(s) of your Child(ren) (First, Middle, Last) _____ Date of Birth (MM/DD/YYYY) _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

_____ _____ ☐ Male ☐ Female

☐ Check here if you have dependents listed on a separate form. If so, return it with your enrollment form.

1. Amounts will be subject to state limits, if applicable.

**GEF02-1**
**ADM**

## HEALTH INFORMATION

**Please complete all questions below. Omitted information will cause delays. In this section, "you" and "your" refers to the person for whom insurance is being requested.**

Member height ___ feet ___ inches Member weight ____ pounds Spouse height ___ feet ___ inches Spouse weight ____ pounds

| | Member | Spouse |
|---|---|---|
| 1. Have you had any application for life, accidental death and dismemberment or disability insurance postponed, rated, modified, or issued other than as applied for? | ☐Yes ☐No | ☐Yes ☐No |
| 2. Are you now receiving or applying for any disability benefits, including workers' compensation? | ☐Yes ☐No | ☐Yes ☐No |
| 3. Have you been **Hospitalized** as defined below (not including well-baby delivery) in the past 90 days? | ☐Yes ☐No | ☐Yes ☐No |

**Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis.

| | | |
|---|---|---|
| 4. **For residents of all states except CT, please answer the following question:** Have you ever been diagnosed or treated by a physician or other health care provider for Acquired Immunodeficiency Syndrome (AIDS), AIDS Related Complex (ARC) or the Human Immunodeficiency Virus (HIV) infection? | ☐Yes ☐No | ☐Yes ☐No |

**GEF09-1**
**HEA**

### SUBMISSION INSTRUCTIONS

After completion, **sign and date the form on the last page where indicated.** Return the original to National Guard Association of Kansas, 125 SE Airport Drive, Topeka, KS 66619, Phone: 316-288-9496, Email address: Insurance@ngaks.net.

| 5. Have you ever been diagnosed, treated or given medical advice by a physician or other health care provider for: | Member | Spouse |
|---|---|---|
| a. cardiac or cardiovascular disorder, stroke or circulatory disorder, high blood pressure, cancer, Hodgkin's disease, lymphoma or tumors, diabetes, asthma, COPD, emphysema or other lung disease? | ☐Yes ☐No | ☐Yes ☐No |

**If you answered "yes" to any of the above questions MetLife may request additional information to evaluate your request for coverage.**

**GEF09-1**
**HEA**

## FRAUD WARNINGS

Before signing this enrollment form, please read the warning for the state where you reside and for the state where the contract under which you are applying for coverage was issued. **Kansas**: Any person who knowingly presents a materially false statement in an application for insurance may be guilty of a criminal offense and may be subject to penalties under state law. **Missouri:** 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 subjects such person to criminal and civil penalties.

**GEF09-1**
**FW**

## BENEFICIARY DESIGNATION FOR MEMBER INSURANCE

I designate the following person(s) as primary beneficiary(ies) for any amount payable upon my death for the MetLife insurance coverage applied for in this enrollment form. With such designation any previous designation of a beneficiary for such coverage is hereby revoked. I understand I have the right to change this designation at any time.

☐ Check if you need more space for additional beneficiaries, attach a separate page. Include all beneficiary information, and sign/date the page.

| Full Name (First, Middle, Last) | Social Security # | Date of Birth (Mo./Day/Yr.) | Relationship | Share % |
|---|---|---|---|---|
| Address (Street, City, State, Zip) | | | Phone # | |
| Full Name (First, Middle, Last) | Social Security # | Date of Birth (Mo./Day/Yr.) | Relationship | Share % |
| Address (Street, City, State, Zip) | | | Phone # | |
| **Payment will be made in equal shares or all to the survivor unless otherwise indicated.** | | | **TOTAL:** | 100% |

## DECLARATIONS AND SIGNATURE

By signing below, I acknowledge:

1. I have read this enrollment form and declare that all information I have given, including any medical information, is true and complete to the best of my knowledge and belief. I understand that this information will be used by MetLife to determine insurability. 2. I declare that I am able to perform the normal activities of a person of such age and sex with a like occupation or retired status on the date I am enrolling. I understand that if I am unable to perform such normal activities on the scheduled effective date of insurance, such insurance will not take effect until I am able to resume performing such activities. 3. I understand that, on the date dependent insurance for a person is scheduled to take effect, the dependent must not be confined at home under a physician's care, receiving or applying for disability benefits from any source, or Hospitalized. If the dependent does not meet this requirement on such date, the insurance will take effect on the date the dependent is no longer confined, receiving or applying for disability benefits from any source, or Hospitalized. **Hospitalized** means admission for inpatient care in a hospital; receipt of care in a hospice facility, intermediate care facility, or long term care facility; or receipt of the following treatment wherever performed: chemotherapy, radiation therapy, or dialysis. 4. I understand that if I do not enroll for the maximum amount of coverage for which I am eligible, evidence of insurability satisfactory to MetLife may be required to enroll for or increase such coverage after the initial enrollment period has expired. Coverage will not take effect, or it will be limited, until notice is received that MetLife has approved the coverage or increase. 5. I have read the Beneficiary Designation section provided in this enrollment form and I have made a designation if I so choose. 6. I have read the applicable Fraud Warning(s) provided in this enrollment form.

Sign Here

| Signature of Member | Print Name | Date Signed (MM/DD/YYYY) |
|---|---|---|
| | | |

**GEF09-1**
**DEC**

# AUTHORIZATION

**This Authorization is in connection with an enrollment in group insurance and information required for underwriting and claim purposes for the proposed insured(s) ("member", spouse, and/or any other person(s) named below). Underwriting means classification of individuals for determination of insurability and/or rates, based upon physician health reports, prescription drug history, laboratory test results, and other factors. Notwithstanding any prior restriction placed on information, records or data by a proposed insured, each proposed insured hereby authorizes**:

- Any medical practitioner, facility or related entity; any insurer; MIB, LLC ("MIB"); any employer; any group policyholder, contract holder or benefit plan administrator; any pharmacy or pharmacy related service organization; any consumer reporting agency; or any government agency to give Metropolitan Life Insurance Company ("MetLife") or any third party acting on MetLife's behalf in this regard:
  - personal information and data about the proposed insured including employment and occupational information;
  - medical information, records and data about the proposed insured including information, records and data about drugs prescribed, medical test results and sexually transmitted diseases;
  - information, records and data about the proposed insured related to alcohol and drug abuse and treatment;
  - information, records and data about the proposed insured relating to Acquired Immunodeficiency Syndrome (AIDS) or AIDS related conditions including, where permitted by applicable law, Human Immunodeficiency Virus (HIV) test results;
  - information, records and data about the proposed insured relating to mental illness, except psychotherapy notes; and
  - motor vehicle reports.

**Note to All Health Care Providers:** The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

**Expiration, Revocation and Refusal to Sign:** This authorization will expire 24 months from the date on this form or sooner if prescribed by law. The proposed insured may revoke this authorization at any time. To revoke the authorization, the proposed insured must write to MetLife at P.O. Box 14069, Lexington, KY 40512-4069, and inform MetLife that this Authorization is revoked. Any action taken before MetLife receives the proposed insured's revocation will be valid. Revocation may be the basis for denying coverage or benefits. If the proposed insured does not sign this Authorization, that person's enrollment for group insurance cannot be processed.

**By signing below, each proposed insured acknowledges his or her understanding that:**

- All or part of the information, records and data that MetLife receives pursuant to this authorization may be disclosed to MIB. Such information may also be disclosed to and used by any reinsurer, employee, affiliate or independent contractor who performs a business service for MetLife on the insurance applied for or on existing insurance with MetLife, or disclosed as otherwise required or permitted by applicable laws.
- While this authorization is in force, we may use the information we receive under this authorization to improve our underwriting and claims processes generally.
- Medical information, records and data that may have been subject to federal and state laws or regulations, including federal rules issued by Health and Human Services, setting forth standards for the use, maintenance and disclosure of such information by health care providers and health plans and records and data related to alcohol and drug abuse, once disclosed to MetLife or upon redisclosure by MetLife, may no longer be covered by those laws or regulations.
- Information relating to HIV test results will only be disclosed as permitted by applicable law.
- Information obtained pursuant to this authorization about a proposed insured may be used, to the extent permitted by applicable law, to determine the insurability of other family members.
- A photocopy of this form is as valid as the original form. Each proposed insured (or his/her authorized representative) has a right to receive a copy of this form.

**I authorize MetLife, or its reinsurers, to make a brief report of my personal health information to MIB.**

Sign Here

| Signature of Member | | Date Signed (MM/DD/YYYY) |
|---|---|---|
| Print Name | State of Birth | Country of Birth |

Sign Here

| Signature of Spouse | | Date Signed (MM/DD/YYYY) |
|---|---|---|
| Print Name | State of Birth | Country of Birth |



**Patriots Insurance Trust (NG of Kansas)-260990**
**AUTH-XDP110M-NW (06-24)**

# AUTHORIZATION TO START, STOP OR CHANGE AN ALLOTMENT

## PRIVACY ACT STATEMENT

**AUTHORITY:** 37 U.S.C. Section 701, E.O. 9397.

**PRINCIPAL PURPOSE:** To permit starts, changes, or stops to allotments. To maintain a record of allotments and ensure starts, changes, and stops are in keeping with member's desires.

**ROUTINE USES:** In addition to those disclosures generally permitted under 5 U.S.C. Section 552a(b) of the Privacy Act, these records of information contained therein may specifically be disclosed outside the DoD as a routine use to the Federal Reserve banks to distribute payments made through the direct deposit system to financial organizations or their processing agents authorized by individuals to receive and deposit payments in their accounts. It may also be disclosed to the Treasury Department, Internal Revenue Service, Social Security Administration, Department of Veterans Affairs, Federal, state and local agencies for civil or criminal law enforcement. In addition it can be released for any of the blanket routine uses published at the beginning of the DFAS compilation of system of record notices.

**DISCLOSURE:** Voluntary; however, failure to provide the requested information as well as the Social Security number may result in the member not being able to start, change, or stop allotments.

## TO BE COMPLETED BY ALLOTTER

**1. BRANCH OF SERVICE** *(X One)*

| | | | |
|---|---|---|---|
| | AIR FORCE | | MARINE CORPS |
| | ARMY | | NAVY |

**2. NAME OF ALLOTTER** *(Last, First, Middle Initial) (Print or Type)*

**3. SSN**

**4. PAY GRADE**

**5. ADDRESS OF ALLOTTER** *(Street or Box Number, City, State, Zip Code)*

**6. DAYTIME TELEPHONE NUMBER** *(Include Area Code)*

**7. EFFECTIVE DATE** *(YYYYMM)*

**8. MONTHLY AMOUNT OF ALLOTMENT**

$

**9. NAME OF ALLOTTEE** *(First, Middle Initial, Last)*

**NGAKS**

**10. ALLOTMENT ACTION** *(X One)*

| | | | | | |
|---|---|---|---|---|---|
| | START | | STOP | | CHANGE |

**11. TERMS IN MONTHS**

**12. CREDIT LINE** *(If Applicable)*

**13. ALLOTMENT OF CLASS AUTHORIZED** *(X One)*

| | |
|---|---|
| | C - CHARITY/CFC |
| X | D - DISCRETIONARY ALLOTMENTS *(Includes dependent support, payment to financial institution, insurance, repayment of home loan, rent, etc. (Notes 1 and 2))* |
| | F - CHARITY - EMERGENCY/ASSISTANCE FUND CONTRIBUTION |
| | L - REPAYMENT OF LOAN TO SERVICE ORGANIZATION *(Red Cross, Relief Society, etc. - Navy and Marine Corps only)* |
| | N - NSLI OR USGLI INSURANCE PREMIUM |
| | T - PAYMENT OF DEBTS TO U.S., DELINQUENT STATE OR LOCAL INCOME/EMPLOYMENT TAXES |
| | - OTHER *(Specify)* |

**14. ALLOTTEE'S MAILING ADDRESS** *(Street or Box Number, City, State, Zip Code)*

**125 SE AIRPORT DR**
**TOPEKA, KS 66619**

**15. IF FOREIGN ADDRESS COMPLETE AS FOLLOWS** *(Province, Country)*

**16. REMARKS**

**17. COMPANY CODE/FINANCIAL INSTITUTION/ROUTING TRANSIT NUMBER**

101100728 2003627

**18. ACCOUNT NUMBER/POLICY NUMBER**

| | |
|---|---|
| | CHECKING |
| | SAVINGS |

**19. TOTAL CLASS L AMOUNT**

**20. TOTAL CLASS T AMOUNT**

## STATEMENT OF UNDERSTANDING

I understand that this allotment is legal and that by voluntarily completing this form, I am responsible for:

- **Ensuring** that the information is correct;
- **Reviewing** my Leave and Earnings Statement to ensure the allotment stops, starts, or changes as directed including amount and payee;
- **Collecting** overpayments from the receiver (payee) of the allotment, if I do not change or stop the allotment after a loan is repaid;
- **Contacting** the receiver (payee) of the allotment, at my expense, to obtain monthly statements for my personal records.

I also understand that any problems once the allotment is delivered to the receiver (payee) are beyond the control of the Defense Finance and Accounting Service (DFAS) and that DFAS is only responsible for ensuring proper delivery of any voluntary allotment for the period directed. I further understand that pursuant to conditions listed in the DoD 7000.14-R, Volume 7A, changes can be made by DFAS to an allottee's name, address, or account number.

Under penalty of the Uniform Code of Military Justice, I certify that this allotment is NOT for the purchase, lease, or rental of personal property or payment toward personal property.

**21. SIGNATURE OF ALLOTTER**

**22. DATE** *(YYYYMMDD)*

**NOTE 1.** Must be different address than allotter. Each dependent allotment must have a different credit line. Only one support allotment per dependent is allowed.
**NOTE 2.** This is a voluntary allotment and can be to any payee you desire.