4/1[illegible]

NEW YORK LIFE INSURANCE COMPANY

REQUEST FOR EMPLOYEE PROTECTION PLAN INSURANCE
(Please Print — Use Black Ink)

1. Name of Proposed Insured (Employee)?	2. Date of Birth?	3. Place of Birth?	4. Male? / Female?	5. Account Number?
NORAN EUGENE (SKIP) HALL	Mo. 1 Day 4 Year 30	NEWTON KANSAS	Male? [x] Female? [ ]	G S

6. Name of Employer?	7. Exact Job Title?	8. Are you an active full-time employee of the employer, working at least 30 hours per week?
Duffy's Frontere Village	BARTender	Yes [x] No [ ]

9. Date Full-Time Employment Began?	10. Basic Weekly Earnings?	11. If Married, Give Age of Spouse?	12. Number of Eligible Children, if any?
Mo. 6 Day 4 Year 67	120.00	46	——— (writing)

13. Beneficiary (subject to change as provided in policy). Full Name & Relationship to you?	14. Term Insurance Amount?
ANN ELIZEBETH HALL (WIFE)	$ 2,000

I hereby declare that to the best of my knowledge and belief I am eligible for Employee Protection Plan Insurance, and hereby request the insurance to which I am entitled, or to which I may become entitled, under the terms of the group policy or policies issued to my employer by New York Life Insurance Company.

Date Signed 7-23-67

Your Signature Loran E. Skip Hall

EPP-50-C 12-65 Printed in U.S.A.

For New York Life Use Only	Account Number	Eff. Date	ID No.	Class	Due Date	DC	Yes [ ] No [ ]

ELIGIBILITY FOR MEDICARE

Employee Eligible for Medicare Yes ☐ No ☐

Spouse Name________________________________

Date of Birth________________________________

Eligible for Medicare Yes ☐ No ☐