



**SECURITY MUTUAL LIFE**  
**INSURANCE COMPANY OF NEW YORK**  
 SECURITY MUTUAL BUILDING • 100 COURT ST.  
 P.O. BOX 1625 • BINGHAMTON, NY 13902-1625  
 607.723.3551 • www.smlny.com

For Home Office Use Only
Policy # _____
Group ID # _____

## Application for Group Insurance

### POLICYHOLDER INFORMATION *(please print clearly and legibly)*

1. Full legal name:

\_\_\_\_\_

Full name as preferred for billing/administrative purposes (if D.B.A. name please print):

\_\_\_\_\_

a) Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

Mailing Address (if different from above): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

b) Policyholder Status:  Corporation  Partnership  Proprietorship  Other \_\_\_\_\_

c) Employer Tax ID#: \_\_\_\_\_

d) Nature of Business: \_\_\_\_\_

e) How long has the company been in business? \_\_\_\_\_

2. Please list any subsidiary or affiliated companies of the Employer to be included under the sponsoring company's plan.

\_\_\_\_\_

If more space is needed, attach a separate sheet, signed and dated by the policyholder

a) Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Telephone: \_\_\_\_\_

b) Tax ID#: \_\_\_\_\_  Corporation  Partnership  Proprietorship  Other \_\_\_\_\_

c) Nature of Business: \_\_\_\_\_

d) How long has the company been in business? \_\_\_\_\_

### COVERAGE INFORMATION

3. I request that the coverage(s) chosen take effect on \_\_\_\_\_ (month) \_\_\_\_\_ (day) \_\_\_\_\_ (year)  
 Subject to the approval in writing by Security Mutual Life Insurance Company of New York.

4. Is the coverage applied for in this application replacing other group insurance?  Yes  No (If "Yes", give details below.)

Previous Company \_\_\_\_\_ Termination Date \_\_\_\_\_

5. Are you applying for any other group insurance at this time?  Yes  No (If "Yes", give details below.)

Coverage \_\_\_\_\_ Carrier \_\_\_\_\_ Proposed Effective Date \_\_\_\_\_

**EMPLOYEE INFORMATION**

6. Employees who are regularly scheduled to work at least \_\_\_\_\_ hours per week in the U.S.A. at the applicant's place of business will be eligible for coverage (less than 30 hours requires Home Office approval.)

7. Is any class of full-time employees to be excluded from coverage?  Yes  No (If "Yes", list each class by salary, job title, union membership, or other conditions pertaining to employment) \_\_\_\_\_

8. Definition of Earnings:  Base only (excludes commissions, bonuses, overtime and extra compensation)  
 Base plus  Commission  Bonus  Overtime  Extra Compensation  
 averaged over  12 months  24 months  
 Other \_\_\_\_\_

9. Are any union employees to be included?  Yes  No

10. Are retired employees to be covered?  Yes  No (**Home Office Approval Required**) A retired employee is a formerly active employee  who has attained age \_\_\_\_\_ and has \_\_\_\_\_ years of service.  Other \_\_\_\_\_

11. Eligibility Waiting Period – (Waiting period is the period of time that an employee must have worked for the policyholder, before becoming eligible for coverage):  
 None  
 Immediately following: \_\_\_\_\_ Days \_\_\_\_\_ Months \_\_\_\_\_ Years  
 1<sup>st</sup> of the Month Coinciding With or Following: \_\_\_\_\_ Days \_\_\_\_\_ Months \_\_\_\_\_ Years  
 Other: \_\_\_\_\_

12. Waiting Period Applies To:  All Employees  Future Employees Only

13. Does Waiting Period Apply to All Classes of Employees?  Yes  No Define: \_\_\_\_\_

14. Does Waiting Period Apply to All Coverages?  Yes  No Define: \_\_\_\_\_

	Basic Life and AD&D	Supplemental Life and AD&D	Dependent Life	STD	LTD
15. Total Eligible Employees	_____	_____	_____	_____	_____
Total Eligible Employees Enrolled	_____	_____	_____	_____	_____

16. Please identify all employees covered by your current group policy who are not actively at work. (Coverage will begin on the day after the employee is again actively at work.)

Name	Date of Disability	Date of Birth	Amount of Group Life	Nature of Illness or Injury	Expected Return to Work Date

17. **Employer** will contribute:

- Basic Life and AD&D  100%  Other \_\_\_\_\_ %
- Supplemental Life and AD&D  100%  Other \_\_\_\_\_ %
- Dependent Life and AD&D  100%  Other \_\_\_\_\_ %
- STD  100%  Other \_\_\_\_\_ %
- LTD  100%  Other \_\_\_\_\_ %

Are employee contributions (if applicable) on a pre-tax basis?  Yes  No

**EMPLOYEE INFORMATION (continued)****18. Classification****Description of Employees by Class**

Class	(Class description is by salary, job title, union membership, or other conditions pertaining to employment)
A	_____
B	_____
C	_____
D	_____
E	_____

**BENEFIT SELECTION****19. Basic Employee Life Term Insurance:** Flat Benefit \$ \_\_\_\_\_ for all employees to be covered Graded Benefits by Class: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_ D) \$ \_\_\_\_\_ E) \$ \_\_\_\_\_ Multiple of Annual Earnings:  1X  2X  3X  Other \_\_\_\_\_Rounded to the next  Higher  Nearest \$ \_\_\_\_\_ subject to a maximum of \$ \_\_\_\_\_ and a minimum of \$ \_\_\_\_\_Reductions:  Reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75 Reduce to 65% at age 65, and to 50% at age 70 Reduce to 50% at age 70 Reduce to 55% at age 70, to 35% at age 75, and to 25% at age 80 Other: \_\_\_\_\_**20. Basic Employee Accidental Death and Dismemberment:**  Same as Basic Life  Enhanced  None 24 Hour  Non-Occupational  Other \_\_\_\_\_**21. Supplemental Employee Life Term Insurance:** Flat Benefit \$ \_\_\_\_\_ for all employees to be covered Graded Benefits by Class: A) \$ \_\_\_\_\_ B) \$ \_\_\_\_\_ C) \$ \_\_\_\_\_ D) \$ \_\_\_\_\_ E) \$ \_\_\_\_\_ Increments of \$ \_\_\_\_\_ not to exceed \_\_\_\_\_ times annual earnings; maximum \$ \_\_\_\_\_ Choice of:  1X  2X  3X  Other \_\_\_\_\_ annual earningsRounded to the next  higher  nearest \$ \_\_\_\_\_ subject to a maximum of \$ \_\_\_\_\_ and a minimum of \$ \_\_\_\_\_Reductions:  Reduce to 65% at age 65, to 40% at age 70, and to 25% at age 75 Reduce to 65% at age 65, and to 50% at age 70 Reduce to 50% at age 70 Reduce to 55% at age 70, to 35% at age 75, and to 25% at age 80 Other: \_\_\_\_\_**22. Supplemental Employee Accidental Death and Dismemberment:**  Same as Supplemental Life  Enhanced  None**23. Basic Dependent Life Insurance:** Spouse \$ \_\_\_\_\_Child \$ \_\_\_\_\_ (select one):  Live birth to 6 months (required if dependent AD&D is elected), or 15 days to 6 months. (For AD&D, coverage is from day one for newborn children.)Child \$ \_\_\_\_\_ (select one):  6 months through age 18 or to age \_\_\_\_\_ if full-time student**24. Supplemental Dependent Life Insurance:** Spouse  increment of \$ \_\_\_\_\_ not to exceed 50% of the amount ofSupplemental Employee Life Insurance  Other \_\_\_\_\_ Child \$ \_\_\_\_\_**25. Basic Dependent AD&D:**  Same as Life  Other \_\_\_\_\_  None**26. Supplemental Dependent AD&D:**  Same as Supplemental Life  Enhanced  None  Other \_\_\_\_\_

**BENEFIT SELECTION (continued)****26. Employee Short Term Disability**

- a) \_\_\_\_\_% of weekly earnings not to exceed a weekly benefit of \$\_\_\_\_\_
- b) Flat Benefit \$\_\_\_\_\_ for all employees to be covered
- c) Benefits by Class: A) \$\_\_\_\_\_ B) \$\_\_\_\_\_ C) \$\_\_\_\_\_ D) \$\_\_\_\_\_ E) \$\_\_\_\_\_
- d) From a Minimum Gross Weekly Benefit of \$\_\_\_\_\_ to a Maximum Gross Weekly Benefit of \$\_\_\_\_\_ in any multiple of \$\_\_\_\_\_ not to exceed \_\_\_\_\_% of Weekly Earnings
- e) Benefits commence on \_\_\_\_\_ day for accident and \_\_\_\_\_ day for sickness    First day hospital     Yes     No
- f) Duration of payments \_\_\_\_\_ weeks maximum
- g) Disability definition:     Total Disability     Partial Disability     Zero Day Residual
- h) Pre-existing conditions limitation     None     Other \_\_\_\_\_
- i) Other (*describe – attach additional pages if necessary*): \_\_\_\_\_

**27. Employee Long Term Disability**

- a) \_\_\_\_\_% of basic monthly earnings not to exceed a monthly benefit of \$\_\_\_\_\_
- b) From a Minimum Gross Monthly Benefit of \$\_\_\_\_\_ to a Maximum Monthly Gross Benefit of \$\_\_\_\_\_ in any multiple of \$\_\_\_\_\_ not to exceed \_\_\_\_\_% of Monthly Earnings
- c) Benefits commence after (elimination period):     90 days     180 days     Other \_\_\_\_\_
- d) Benefit Duration:     Social Security Normal Retirement Age (SSNRA)     65/5/70  
 ADEA Reducing Benefit Duration (RBD)     2 Years     5 Years  
 Other \_\_\_\_\_
- e) Disability Definition:     Partial     Partial Plus     Edge 1     Progressive Partial  
Own Occupation Period:     24 Months for Class \_\_\_\_\_     Entire Benefit Period for Class \_\_\_\_\_  
 Other (specify period) \_\_\_\_\_ for Class \_\_\_\_\_
- f) Minimum Net Monthly Benefit:     Greater of 10%/\$100     \$100     Other \_\_\_\_\_
- g) Pre-existing Conditions:     3/12     3/6/12     12/6/24     6/12     6/12/24     5 day     Other \_\_\_\_\_
- h) Social Security Integration:     Primary and Family     Primary Only     All Sources (70%)
- i) Survivor Benefit:     3 Months     6 Months     1 Year     2 Years
- j) Mental Illness Limitation:     12 Months     24 Months     Unlimited
- k) Drug & Alcohol Limitation:     12 Months     24 Months     Unlimited
- l) Self-reported Illness Limitation:     12 Months     24 Months     Unlimited
- m) COLA:     No     Yes    If "Yes", \_\_\_\_\_%     5 adjustments     To end of maximum benefit period  
Other \_\_\_\_\_
- n) Supplemental disability:     None     10%     20%
- o) Retirement Savings Benefit:     No     Yes \_\_\_\_\_%
- p) Other (*describe – attach additional pages if necessary*): \_\_\_\_\_

**28. For all of the employees to be covered under this policy, are you as the applicant/employer:**

- a) Contributing to Social Security for these employees?     Yes     No
- b) Insuring these employees under Workers Compensation?     Yes     No
- c) Providing a retirement plan for these employees?     Yes     No
- d) Providing benefits under another Short Term, Long Term, and/or Sick Leave Plan?     Yes     No    If "Yes" is checked, please provide complete details below or supply copies of the plan(s).
- \_\_\_\_\_

**DEPOSIT PREMIUM**

Attached is a deposit of \$ \_\_\_\_\_ which will be applied to the first premium when due.

**ACCELERATED BENEFITS NOTICE**

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The portion of the death benefit which is accelerated will be discounted.

**POLICYHOLDER'S STATEMENT**

To the best of my knowledge and belief, all the statements and answers given in this application are true and complete.

The appointed agent(s) of the policyholder is (are): \_\_\_\_\_

I understand and agree that:

- No agent may change or waive any of the provisions of this application;
- Any change or waiver may be made only by an officer of Security Mutual Life Insurance Company of New York;
- Security Mutual Life Insurance Company of New York may **NOT** be designated as the "Plan Administrator" or "Fiduciary", of the employee welfare benefit plan under ERISA;
- No employee who is not actively at work on the Effective Date will be insured until the employee is again actively at work for at least one day; and
- Security Mutual relies on the statements and answers given in this application in making its determination whether or not to issue the policy and the terms of the policy.

**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.**

\_\_\_\_\_

Date

\_\_\_\_\_

Print Name and Title of Officer, Partner or Proprietor

\_\_\_\_\_

Witness

\_\_\_\_\_

Signature of Officer, Partner, or Proprietor

**AGENT'S STATEMENT**

To the best of the undersigned's knowledge and belief, all the statements and answers given in this application are true and complete. The undersigned has no knowledge or information about the policyholder, the employees, or dependents of such employees that is inconsistent with any statement made in this application.

**Soliciting Agent(s)****General Agent(s)**

\_\_\_\_\_

Name

\_\_\_\_\_

\_\_\_\_\_

Signature

\_\_\_\_\_

\_\_\_\_\_

Agent #

\_\_\_\_\_

Agent #

\_\_\_\_\_

Date

\_\_\_\_\_

Date