

GROUP INSURANCE
Enrollment/Statement of Insurability Form

Group Division

Please Print. Provide required information. Incomplete information will delay your application.

Coverage Requested: Employee: Life/AD&D WDI LTD Dependent: Life
 Amount or Plan #: _____

Participating Employer		Participating Employer Unit Number	
Employee's Name	<input type="checkbox"/> Male <input type="checkbox"/> Female	Birthdate	Social Security No.
Employee's Home Address (Street Address, City, State, Zip)			
Employee's Occupation	Annual Earnings	Date Employed	Hours Worked/Week
Spouse's Name (if Dependent Life Insurance requested)		Spouse's Date of Birth	Spouse's Soc. Sec. No.

Name of Employee's Beneficiary (Instructions on Page 2)	Relationship/Home Address	Social Security No.

HEALTH INFORMATION: The following information must be provided *only* for the individual(s) applying for:
Check appropriate box(s)

<input type="checkbox"/> An amount above the No Evidence Limit:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
<input type="checkbox"/> Coverage as a late applicant:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse
<input type="checkbox"/> An increase in existing coverage:	<input type="checkbox"/> Employee	<input type="checkbox"/> Spouse

1. During the past 7 years, have you been diagnosed by a member of the medical profession as having any of the following conditions or received treatment from a member of the medical profession for high blood pressure, heart disease, arteriosclerosis or stroke; alcoholism, drug abuse, mental, or nervous condition or emotional disorder; cancer or diabetes; AIDS or AIDS Related Complex; or lung, liver or kidney disease or disorder?	Employee		Spouse	
	Yes	No	Yes	No
2. Do you have any physical, mental, or emotional condition for which you regularly take prescription drugs or medications, or for which you plan to see a member of the medical profession for diagnosis or treatment?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. During the past 5 years, have you consulted or been treated by a member of the medical profession for any physical, mental, or emotional condition not mentioned above?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has any insurance company ever declined your application or reinstatement for any type or amount of insurance coverage?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to sickness or injury?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Employee: Height _____ Weight _____ Spouse: Height _____ Weight _____				

COMPLETE DETAILS OF "YES" ANSWERS FOR QUESTIONS 1 – 5. If more space is required, please attach a signed and dated separate sheet.

Quest. No.	Employee or Spouse	Problem/History – If for Blood Pressure Give Recent Reading	Date	Duration or Date Resolved	Treatment	Names and Addresses of Physicians & Hospitals

I understand that satisfactory Evidence of Insurability is required to become insured for an amount above the No Evidence Limit or if I apply for insurance as a late applicant. I understand that a Certificate of Coverage will be issued to me showing the amount of insurance approved by Security Mutual and the effective date of my insurance. I understand that Security Mutual will use the information on this enrollment form as the basis for determining my eligibility for coverage. I authorize the necessary deductions from my wages to cover my portion of the cost of this insurance.

I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I understand the insurance applied for does not become effective until approved in writing by Security Mutual Life Insurance Company of New York.

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 a false or deceptive statement is guilty of insurance fraud.

 X _____ X _____
 Signature of Employee (Required) Date Signature of Spouse (if applying for coverage) Date

BENEFICIARY SECTION:

Please print full name, relationship, address, and Social Security number of your beneficiary.

Examples:

- A. One beneficiary Dorothy Q. Smith, wife (not Mrs. John Smith)
- B. Two beneficiaries Peter Smith, father, and Anna Smith, mother, equally, or the survivor
- C. Beneficiaries in unequal shares Peter Smith, father, 75%, and Anna Smith, mother, 25%, or the survivor
- D. Trustee Dorothy Q. Smith, trustee under trust agreement dated _____ .
- E. Your Estate My Estate

Do you know that if death occurs and you have named a minor (a person not of legal age) or your estate as beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid? This could mean legal expenses for the beneficiary and possible delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.



PLEASE RETAIN THIS NOTICE FOR YOUR RECORDS.