



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
 1st 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 Choice of: 1X 2X 3X Other _____ annual earningsReductions: 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. **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

23. **Supplemental Dependent Life Insurance:** Spouse increment of \$ _____ not to exceed 50% of the amount of
 Supplemental Employee Life Insurance Other _____
 Child \$ _____

24. **Basic Dependent AD&D:** Same as Life Other _____ None25. **Supplemental Dependent AD&D:** Same as Supplemental Life Enhanced None Other _____

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

- a) Weekly benefit equal to _____% of weekly earnings
- b) Flat Benefit \$_____ for all employees to be covered
- c) Graded 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).
- _____

29. DEPOSIT PREMIUM

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

30. LIVING 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.

31. 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, with a purpose to injure, defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete, or misleading information is subject to prosecution and punishment for insurance fraud, as provided in RSA 638:20.

_____ Date _____ Print Name and Title of Officer, Partner or Proprietor

_____ Witness _____ Signature of Officer, Partner, or Proprietor

32. 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

_____ Name

_____ Signature

_____ Signature

_____ Agent #

_____ Agent #

_____ Date

_____ Date