



**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 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 \_\_\_\_\_



**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.

**APPLICABLE TO INSURANCE OTHER THAN LIFE INSURANCE:**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claims 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 shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

\_\_\_\_\_ 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