



Application for Group Insurance

PROPOSED PARTICIPATING ORGANIZATION INFORMATION *(please print clearly and legibly)*

1. Full legal name:

Name as preferred for billing/administrative purposes:

a) Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

Mailing Address (if different from above): _____

City: _____ State: _____ Zip: _____

Tax ID Number _____

b) Form of Organization: _____

Tax ID # _____

c) Nature of Business: _____

d) Please list any subsidiary or affiliated companies of the proposed Participating Organization to be included under the insurance policy.

If more space is needed, attach a separate sheet, signed and dated by the proposed Participating Organization.

1) Street Address: _____

City: _____ State: _____ Zip: _____ Telephone: _____

2) Proposed Participating Organization Tax ID #: _____

3) Nature of Business: _____

e) How long has the proposed Participating Organization been in existence? _____

f) Was the proposed Participating Organization formed for purposes other than obtaining insurance? Yes No

COVERAGE INFORMATION

2. The coverage(s) applied for shall become effective on _____(month)_____(day)_____(year)
 subject to the approval in writing by Security Mutual Life Insurance Company of New York.

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

Previous Company _____ Termination Date _____

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

Coverage _____ Carrier _____ Proposed Effective Date _____

a) Will other group insurance remain in force which provides benefits similar to those being applied for? Yes No (If "Yes", give details below.)

MEMBER/EMPLOYEE INFORMATION

5. Member/Employee Information

a. Are all active Members eligible for coverage? Yes No

b. Is any Member class (associate, honorary, lifetime, etc.) excluded from coverage? Yes No

Explain: _____

c. Are all Employees of the Participating Organization eligible for coverage? Yes No Not Applicable If "yes," specify minimum number of hours required for eligibility: _____ (less than 30 hours requires approval by Security Mutual Life.)

d. Are any Employees excluded? Yes No Explain: _____

e. Members' and Employees' spouses and children may be eligible for dependent coverage. The term "spouse" includes 1) parties to marriages validly performed outside of New York, and 2) a domestic partner, if the policyholder elects to provide coverage to domestic partners.

f. Are individuals who meet the definition of a "Domestic Partner" set forth in the group policy eligible for coverage? Yes No

6. Eligibility Waiting Period – (Waiting Period is the period of time that a Member must serve, or an Employee be employed by, the Participating Organization before becoming eligible for coverage):

None

Immediately following: _____ Days _____ Months _____ Years

1st of the Month Coinciding With or Following: _____ Days _____ Months _____ Years

Other: _____

7. Waiting Period Applies To: All Members and Employees Members and Employees who become eligible on or after the policy effective date.

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

Not Applicable Other _____

9. Please identify all Employees who will be eligible under this 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

Basic Life (and AD&D)

Supplemental Life

Dependent Life

10. Total Eligible Members _____

Total Enrolled Members _____

Total Eligible Employees _____

Total Enrolled Employees _____

11. Participating Organization premium contribution:

Basic Life (and AD&D) 100% (Non-Contributory) Other _____ %

Supplemental Life 100% Other _____ %

Dependent Life 100% Other _____ %

12. Classification

Description of Members and Employees by Class

Class description is by title or other conditions pertaining to membership or employment.

Class	Description
A	_____
B	_____
C	_____
D	_____
E	_____

BENEFIT SELECTION

13. Basic Certificate Holder Term Life Insurance:

- Flat Benefit \$ _____ for all Members and 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 \$ _____
- Age Reductions: Reduce to 50% at age 70, and to 25% at age 75
- Reduce to 65% at age 65, and to 50% at age 70
- Reduce to 65% at age 65, to 50% at age 70, and to 25% at age 75
- Reduce to 50% at age 70
- Other: _____
- Waiver of Premium: Yes No
- Continuation of Term Life Insurance: Yes No

14. Basic Certificate Holder Accidental Death and Dismemberment: Same as Basic Life Enhanced None Other _____

Termination: At Age _____

15. Supplemental Certificate Holder Term Life Insurance:

- Increments of \$ _____; maximum \$ _____
- Flat Benefit \$ _____ for all Members and Employees to be covered Other _____
- Choice of: 1X 2X 3X Other _____ annual earnings
- Reductions: Reduce to 50% at age 70, and to 25% at age 75
- Reduce to 65% at age 65, and to 50% at age 70
- Reduce to 65% at age 65, to 50% at age 70, and to 25% at age 75
- Reduce to 50% at age 70
- Other: _____
- Termination: At Age _____
- Continuation of Term Life Insurance: Yes No

16. Basic Dependent Life Insurance: Spouse \$ _____

- Age Reductions: Reduce to 50% at age 65; Terminate at age _____
- Other: _____
- Child \$ _____ Live birth to 6 months
- Child \$ _____ 6 months through age 18 or 6 months to age 25 if full-time student
- Continuation of Term Life Insurance: Yes No

17. Supplemental Dependent Life Insurance: Spouse increments of \$ _____ not to exceed 50% of the amount of the Supplemental Certificate Holder's Life Insurance

Child \$ _____ Other _____

18. DEPOSIT

Attached is a deposit of \$ _____ which will be credited to the first premium due only if the insurance as applied for is hereunder approved by Security Mutual Life Insurance Company of New York, and if insurance is not approved, the deposit will be refunded.

19. SPECIAL REQUESTS (if any)

20. 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.

21. PROPOSED PARTICIPATING ORGANIZATION STATEMENT

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

The Broker-of-Record of the Participating Organization is (are): _____

I understand and agree that:

- No agent or broker 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, if applicable.
- If a Member is hospital confined on the date the Member would normally become insured, the Member will become insured on the day after the hospital confinement ends, except as otherwise may be provided in the group policy.
- If an Employee is not Actively at Work on the day the Employee would normally become insured, the Employee will become insured on the day the Employee returns to Active Work, except as otherwise may be provided in the group policy.
- This application is subject to approval by Security Mutual Life Insurance Company of New York. Acceptance shall be in writing by the issuance of an amendment to Group Policy Number 000002276 with respect to the plan of insurance for the Participating Organization named herein as of the effective date as specified in the amendment.

A Participating Organization may request a change in the benefits and provisions of its Amendment only on the Participating Organization's Anniversary Date.

The Schedule of Benefits applicable to Members and Employees of a Participating Organization is contained in the Participating Organization Amendment to the Group Policy as issued by Security Mutual Life Insurance Company of New York. The Participating Organization Amendment is the form issued by Security Mutual Life Insurance Company of New York which approves the Organization as a Participating Organization and outlines the benefits and provisions of the coverage for the Members and Employees of the Participating Organization and their dependents, if any.

APPLICABLE ONLY TO AD&D INSURANCE:

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 Authorized Official of the Participating Organization

Witness

Signature of Authorized Official of the Participating Organization

22. AGENTS' 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 Participating Organization, or the Members, or dependents of such Members, or 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 #

Date

Agent #

Date

For Security Mutual Life Use Only:

Approved by: _____

Date: _____

Participating Organization Amendment Number: _____

Effective _____