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

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: ❑ Corporation ❑ Partnership ❑ Proprietorship ❑ Labor Union ❑ Association
❑ Trustee of a fund established by employer members or a trade association ❑ Other _____
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 #: _____ ❑ Corporation ❑ Partnership ❑ Proprietorship
❑ Other_____

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
   - Are all active Members eligible for coverage? ❑ Yes ❑ No
   - Is any Member class (associate, honorary, lifetime, etc.) excluded from coverage? ❑ Yes ❑ No
     Explain: _____
   - Are all Employees of the Participating Organization eligible for coverage? ❑ Yes ❑ No If "yes," specify minimum number of hours required for eligibility: _____ (less than 30 hours requires approval by Security Mutual Life.)
   - Are any Employees excluded? ❑ Yes ❑ No Explain: _____
   - Members' and Employees' spouses and children are 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.
   - 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 ❑ Future Members and Employees Only
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. Please identify all Members and 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

	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** will contribute:
    Basic Life (and AD&D) ❑ 100% ❑ Other_____ %
    Supplemental Life ❑ 100% ❑ Other_____ %
    Dependent Life ❑ 100% ❑ Other _____ %

12. **Classification**

Class	Description of Members and Employees by Class Class description is by title or other conditions pertaining to membership or employment.
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 $ _____

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 ❑ increment 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 hereunder is 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 undersigneds' 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)

_____
Name

_____
Signature

_____
Agent #

_____
Date

General Agent(s)

_____

_____
Agent #

_____
Date

For Security Mutual Life Use Only:

Approved by:_____ **Date:** _____

Participating Organization Amendment Number: _____ **Effective**_____