SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
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Voluntary Emergency Service Organizations
VESOLIFE
TERM LIFE INSURANCE FOR VOLUNTEERS

GROUP ENROLLMENT FORM (Please Print)

Participating Organization

Name of Organization	Group I.D. No.
Unit Name and Number	Policy Number

Check all boxes and complete all sections that apply.

Applicant Section

Your Name (Last, First, MI) ❑ Member ❑ Employee

Street Address	City	State	Zip

Your Social Security Number	Date of Birth (mm/dd/yyyy)	❑ Male ❑ Female	Job Title/Occupation

Coverage Elections

❑ Basic Certificate HolderTerm Life Insurance /AD&D ❑ Basic Dependent Spouse and Child Term Life Insurance

Supplemental Life Coverage Amount Selected: Applicant: Spouse: Child:

❑ Spouse*	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Social Security Number

**The term "spouse" includes 1) parties to marriages validly performed outside of New York, and 2) a domestic partner, if the policyholder elected to provide coverage to individuals who meet the definition of "domestic partner" set forth in the group policy.*

Beneficiary

Name (Last, First, MI)	Relationship to You	Social Security Number
Address	Telephone Number	Date of Birth

If more than one Beneficiary is to be named, please complete Beneficiary Designation form 0005578GROUP.

Refusal of Insurance

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish Evidence of Insurability at my own expense, and the insurance company will have the right to refuse any request.

Coverage Refused *(Check all that apply)*:

❑ Basic Certificate Holder Term Life Insurance /AD&D ❑ Basic Dependent Spouse and Child Term Life Insurance /AD&D

❑ Supplemental Certificate Holder Life Insurance ❑ Supplemental Dependent, Spouse and Child Life Insurance

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.

Changes to Policy

The policy permits the Policyholder to change, reduce, restrict or terminate the certificate holder's rights or benefits under the policy without the certificate holder's consent. Such change, reduction, restriction or termination may occur at a time the certificate holder's health status has changed and may affect his or her ability to procure individual coverage.

Signature

I understand that if I apply at a later date for coverage(s) which I had originally declined, that I may be required to furnish Evidence of Insurability at my own expense for my dependent(s) (if applicable) and myself, and that the insurance company has the right to refuse my request.

By my signature, I am verifying that the information provided is true and correct to the best of my knowledge and belief.

If this form is to be signed electronically, I agree that, by typing my name on the "Applicant's Signature" line and entering my birth month and year below, I will be signing this Group Enrollment Form and that such signature will be as legally binding as if I had manually signed the Group Enrollment Form.

Applicant's Signature Birth Month/Year Date