STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

PO Box 5008, Madison, WI 53705 • 1-800-356-9601 (Phone)
Home Office: 485 Madison Avenue, New York, NY 10022

GROUP APPLICATION

EMPLOYER GROUP INFORMATION

Legal Name of Employer: (Please print)		**Requested Effective Date:** / /	**IRS Tax ID No.**
Street Address:		**PO Box No:**	**SIC No.**
City:	**State**	**Zip Code:**	**Nature of Business:**
Group Contact Name:	**Title:**	**Phone No.** ( )	
Business Type: ☐ Corporation ☐ Partnership ☐ Non-Profit ☐ Other:			**Years in Business:**
Subsidiaries Included:			
Bill Type: ☐ List Bill ☐ Self Bill	**Bill Frequency:** ☐ Monthly ☐ Quarterly ☐ Semi-Annually ☐ Other:		

Will this coverage replace existing coverage? ☐ Yes ☐ No
If "Yes", please complete the following:

Coverage:	**Insurer:**	**Termination Date:** / /
Coverage:	**Insurer:**	**Termination Date:** / /

(A copy of the current Insurer's policy/booklet and the most recent billing statement must accompany this Application.)

EMPLOYEE ELIGIBILITY INFORMATION

Please note that temporary, seasonal and part-time employees and retirees and employees residing outside of the United States are generally excluded unless specifically identified.

Employees Must Work the following Minimum No. of Hours Per Week: ☐ 30 ☐ 40 ☐ Other:

On the Requested Effective Date, current employees ☐ are eligible immediately ☐ must satisfy the Employee Waiting Period.

Employee Waiting Period:
☐ Date of hire (eligible immediately)
☐ First day of the month coinciding with or following ☐ _____ days ☐ _____ months of employment
☐ Other: _____

On the Requested Effective Date, are there any employees not actively at work? ☐ Yes ☐ No
If "Yes", please complete the "Actively at Work Statement" section of this Application.

FOR INSURER USE ONLY:	
Underwriting Decision:	**Notes:**
Effective Date of Coverage:	**Plan No.**
Underwriter's Signature:	**Date:**

ACTIVELY AT WORK STATEMENT

This statement certifies that as of the Requested Effective Date, all employees who are eligible for insurance as described in this Application are Actively-At-Work with the following exceptions:

Employee	Date of Birth	Last Day Worked	Return to Work Expected Date	Reason for Absence

I understand that insurance coverage for the Employees listed above is not guaranteed without written acceptance by an authorized representative of Standard Security Life Insurance Company of New York.

Printed Name of Authorized Employer Representative

Title

Signature of Authorized Employer Representative

Date

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LIFE AND AD&D INSURANCE

Please "✓" who will receive the Life and AD&D insurance coverage:

☐ Employee | ☐ All Dependents OR ☐ Dependent Spouse only OR ☐ Dependent Child only

Class	Class Description	Basic Life Benefit	AD&D Benefit	Dependent Life Benefit Amount		
				Spouse	Child over 6mo	Child under 6mo
1		**$**	**$**	**$**	**$**	**$**
2						
3						

	Employee Insurance:		Dependent Insurance:	
Class	**Guarantee Issue:**	**Maximum Issue:**	**Guarantee Issue:**	**Maximum Issue:**
1				
2				
3				

Insurance Reduction Schedule:

☐ Benefits reduce 35% at age 65, 50% at age 70 and terminate at retirement

☐ Other: _____

SUPPLEMENTAL LIFE AND AD&D INSURANCE

Please "✓" the Supplement Life insurance coverage being applied for:

☐ Supplemental Life Insurance OR ☐ Supplemental Life and Accidental Death and Dismemberment Insurance

Please "✓" who will receive the Supplement Life insurance coverage:

☐ Employee | ☐ All Dependent Life OR ☐ Dependent Spouse Life only OR ☐ Dependent Child Life only

	Employee Supplemental Life:		Dependent Supplemental Life:	
Class	**Guarantee Issue:**	**Maximum Issue:**	**Guarantee Issue:**	**Maximum Issue:**
1				
2				
3				

	Employee Supplemental AD&D:		Dependent Supplemental AD&D:	
Class	**Guarantee Issue:**	**Maximum Issue:**	**Guarantee Issue:**	**Maximum Issue:**
1				
2				
3				

PREMIUM CONTRIBUTIONS

Life and AD&D Insurance

	Employee Insurance:		Dependent Insurance:	
Class	**Employer Contribution**	**Employee Contribution**	**Employer Contribution**	**Employee Contribution**
1				
2				
3				

Please complete the below information, based on the coverage(s) you chose, for Total number of Eligible Employees and Enrollees:

COVERAGES:	TOTAL NO. ELIGIBLE EMPLOYEES:	TOTAL NO. ENROLLED EMPLOYEES:
Life/AD&D:		
Dependent Life:		
Supplemental Life/AD&D:		
Dependent Supplemental Life/AD&D:		

If Benefits are based on Earnings, Earnings are defined as:

☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)
☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other: _____

PREMIUM RATES

Basic Life - per $1,000 of coverage $	Basic AD&D - per $1,000 of coverage $	Basic Dependent Life/AD&D - per family unit $
Supplemental Life - per $1,000 of coverage or attached rate schedule **$**	Supplemental AD&D - per $1,000 of coverage **$**	Supplemental Dependent Life/AD&D - per $1,000 of coverage or attached rate schedule **$**

Rate Guarantee Period: ☐ _____ months ☐ _____ years

FOR INSURER USE ONLY:
Notes:

SHORT TERM DISABILITY INSURANCE

Class	Class Description	% of Earnings	Flat Benefit/ Max Benefit	Benefits Begin on Accident / Sickness	Duration # of weeks
1		%	$	day / day	
2		%	$	day / day	
3		%	$	day / day	

Class	Employer Contribution	Employee Contribution
1	%	% made ☐ Pre-tax ☐ Post-tax
2	%	% made ☐ Pre-tax ☐ Post-tax
3	%	% made ☐ Pre-tax ☐ Post-tax

If Benefits are based on Earnings, Earnings are defined as:

☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)
☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other:

Definition of Disability: ☐ Total ☐ Partial ☐ Zero Day Residual

Short Term Disability Coverage: Total number of eligible employees:_____ Total number enrolled:_____

First Day Hospital: ☐ In-patient only ☐ Out-patient included

Waiver of Premium: ☐ Yes ☐ No

Pre-existing Condition Clause: ☐ 3/12 months ☐ 6/12 months ☐ 12/12 months ☐ 12/24 months ☐ Other:_____

If applicable, other Employer Requirement: Please describe: _____

_____

If applicable, other Employer Requirement: Please describe: _____

_____

Rate: $_____ per $10 Weekly benefit **Rate Guarantee Period:** ☐ _____ months ☐ _____ years

FOR INSURER USE ONLY:
Notes:

LONG TERM DISABILITY INSURANCE

Class	Class Description	% of Earnings	Maximum Benefit	Guarantee Issue
1		%	$	$
2		%	$	$
3		%	$	$

Class	Elimination Period	Own-Occupation Period	Benefit Duration
1	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ To age 65 (ADEA) ☐ Other:
2	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ To age 65 (ADEA) ☐ Other:
3	☐ 90 days ☐ 180 days ☐ Other:	☐ 2 years ☐ Other:	☐ To age 65 (ADEA) ☐ Other:

Class	Employer Contribution	Employee Contribution
1	%	% made ☐ Pre-tax ☐ Post-tax
2	%	% made ☐ Pre-tax ☐ Post-tax
3	%	% made ☐ Pre-tax ☐ Post-tax

Does the Employer gross up the Employee's salary in order to contribute toward premium? ☐ Yes ☐ No

If Benefits are based on Earnings, Earnings are defined as:
☐ Base Salary Only ☐ Base Salary plus Commissions (using a 12-month rolling average)
☐ Base Salary plus Bonuses (using a 36-month rolling average) ☐ Other: _____

Definition of Disability: ☐ Total ☐ Partial ☐ Zero Day Residual

Long Term Disability Coverage: Total number of eligible employees: _____ Total number enrolled: _____

Minimum Benefit: ☐ Greater of 10% or $100 ☐ Greater of 15% or $50 ☐ Flat $100 ☐ Other:_____

Integration with Income from Other Source: ☐ Full Family ☐ Primary Only ☐ Other:_____% All Sources

Integration with Work Earnings: ☐ Proportionate Formula ☐ 50%

Work Incentive Benefit: ☐ 12 months ☐ 24 months

Survivor Benefit: ☐ 3 months ☐ 6 months ☐ 12 months

Conversion Benefit: ☐ Yes ☐ No

Pre-existing Condition Clause: ☐ 3/12 months ☐ 6/12 months ☐ 12/12 months ☐ 12/24 months ☐ Other:_____

Cost of Living Adjustment: ☐ _____% for _____years or ☐ Other: _____

Buy-Up: ☐ Please describe: _____

Other: ☐ Please describe: _____

Rate: $_____ per $100 Monthly Covered Payroll **Rate Guarantee Period:** ☐ _____ months ☐ _____ years

FOR INSURER USE ONLY:

Notes:

TERMS AND CONDITIONS

- The Employer agrees that any insurance applied for shall not become effective unless this Application and any attached page(s) are received, accepted and approved by Standard Security Life Insurance Company of New York (hereinafter referred to as "Insurer"). The Employer further agrees that insurance applied for shall not become effective or remain effective unless the Employer: a) is actively engaged in business for profit within the meaning of the Internal Revenue Code, or is established as a legitimate nonprofit corporation within the meaning of the Internal Revenue Code; and b) meets the participation and contribution requirements.
- The Employer understands receipt and deposit of advanced payment is not a guarantee of coverage. If Certificates of Insurance are issued from this Application, and are accepted by the Employer, we will apply the premium deposit to the first premium due for such coverage. If no coverage is put into force, the premium deposit will be refunded.
- Your agent or broker cannot change or waive any provision of this Application or the Policy or policies without the written approval of an officer of the Insurer.
- The Employer acknowledges and understands that if this Application is approved, the Group Policy, and Certificates will determine the rights and benefits, and that this Application is subject to the terms and conditions of such contract documents.
- The Employer agrees to offer and allow all eligible employees to apply for coverage in accordance with, and within, the Employer's rules regarding classes eligible for coverage at the time of hire and during his/her probationary (waiting) period. The Employer will require that any Employee, who declines to apply at this time, sign a statement to that effect, which will be maintained by the Employer. Should the Insurer's guidelines require an Employee to submit evidence of insurability, such Employee must complete and submit to the Insurer an Evidence of Insurability form. No coverage shall be in effect for said Employees until Insurer approves and accepts the enrollment form and Evidence of Insurability form.
- The Employer agrees to timely notify the Insurer of any Employee termination, status change, or other material changes that may affect the eligibility of Employees or their dependents. Timely notification is no more than 31 days past the actual date of such change.
- The Employer agrees to notify Employees and other Insured Persons who cease to be eligible for coverage under its policies(s) of their right, if any, to continue group coverage and their right, if any, to apply to Insurer for an individual conversion policy. The Employer shall provide such Employees and other insured persons with the forms and applications necessary to continue group coverage or to apply for such conversion coverage as may then be available.
- The Employer understands that failure to pay premium when due will be considered a default in premium payment and coverage will terminate at the end of the grace period. If coverage is terminated for nonpayment of premium, premium through the grace period is due and will be collected. The Employer understands that coverage may also be terminated for other reasons as provided in the Group Policy.
- The person signing this form below certifies that he or she is fully authorized by the Employer to execute this Agreement on the Employer's behalf.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files a 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.

The undersigned Employer hereby makes application for insurance coverages described within this Application. This Application is subject to the Terms and Conditions stated above.

Printed Name of Authorized Employer Representative	**Title**
Signature of Authorized Employer Representative	**Date**

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AGENT'S STATEMENT

Is the insurance being applied for replacing any insurance now in force? ☐ **Yes** ☐ **No**

I have fully explained to the Employer the coverage and provisions of the selected group insurance product benefits. I have also fully explained to the Employer that completing this Application does not guarantee insurance and does not bind Standard Security Life Insurance Company of New York (hereinafter referred to as "Insurer") to issue a contract or otherwise extend any insurance. I understand I have no authority to alter this Application to bind the Insurer by making any promise and/or representation, or to waive or change the terms, conditions and/or provisions of any insurance contract or other requirement imposed by the Insurer.

I hereby certify that either the Employer fully completed this Application on its own, or that I have truly and accurately recorded in this Application the information supplied to me by the Employer.

Agent's Name as printed on the license	**State of license and Agent license number**
Signature of Licensed Agent	**Date**

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