



## New Case Submission Checklist

Add  Change

Employer Name: _____	State: _____
Number of Eligible Employees: _____	SIC Code: _____
Describe what the employer does: _____	
Requested Effective Date: _____	Phone number: _____
Employer Application completed and signed?	<input type="checkbox"/> Yes <input type="checkbox"/> No

### Life Insurance

Life Coverage selected? <input type="checkbox"/> Yes <input type="checkbox"/> No	Coverage Amount \$ _____
<i>(If selected, provide copy of quote or worksheet)</i>	<i>(Flat benefit only)</i>
AD&D Coverage? <input type="checkbox"/> No	No. of participating employees _____
<i>(Applies only for SIC codes 241X-242X)</i>	<i>(2-4 employees 100% required; all others 75% participation required)</i>
Beneficiary Information Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Enrollment Cards Signed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Employer Contribution: Employee _____%	Dependent _____%
Life Premium Submitted \$ _____	

### Disability

Disability Coverage Selected? <input type="checkbox"/> Yes <input type="checkbox"/> No	No. of participating employees _____
<i>(If selected, provide copy of quote or worksheet)</i>	<i>(75% participation required)</i>
Disability Plan Selected <input type="checkbox"/> 15 days <input type="checkbox"/> 30 days	
Evidence of Insurability Completed? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<i>(Required for all groups 2-5 lives)</i>	
Employer Contribution: Employee _____%	Dependent _____%
Disability Premium Submitted \$ _____	

### Agent Information

Agent Name: _____	Agent # : _____
Company Name: _____	
Street Address: _____	
City: _____	State: _____ Zip: _____
Telephone Number: (____) _____	Fax Number: (____) _____
General Agent Name: _____	Agent # : _____
Company Name: _____	
Street Address: _____	
City: _____	State: _____ Zip: _____
Telephone Number: (____) _____	Fax Number: (____) _____



485 Madison Avenue  
New York, NY 10022

## APPLICATION FOR GROUP INSURANCE

### A. APPLICANT INFORMATION

1. Full Legal Name of Applicant(YOU): \_\_\_\_\_
2. Address: \_\_\_\_\_  

No. and Street
City
State
Zip
3. Telephone No.: \_\_\_\_\_ Fax No.: \_\_\_\_\_ Employer I.D. # (EIN): \_\_\_\_\_
4. Applicant is a:  Corporation  Partnership  Other: \_\_\_\_\_
5. Nature of Business (Specify): \_\_\_\_\_
6. Are the employees of any affiliates or subsidiaries to be covered?  Yes  No  
 If yes, please provide details below. If necessary, please continue list on another sheet.

Name of Company	Nature of Business	Full Address
_____	_____	_____
_____	_____	_____

7. Did you previously have Group Insurance with Standard Security Life Insurance Company of New York?  
 Yes  No If yes, please provide details below:

Group Policy No(s):	Coverages	Date Insurance Ended/Declined
_____	_____	_____

8. List each Group Life and Accidental Death & Dismemberment insurance plan you now have. Include plans with non-profit organizations. If you do not have a particular coverage, please state NONE.

Type of Coverage	Name of Insurer	Effective Date	Proposed Date Coverage Will End
<b>LIFE:</b> _____	_____	_____	_____
<b>AD&amp;D:</b> _____	_____	_____	_____

9. Are you now applying for any other Group Insurance?  Yes  No If yes, please provide details below:

Highest Amount of Life Insurance	Insurer	Proposed Effective Date
_____	_____	_____

10. Is the coverage applied for in this application replacing other Group Insurance?  Yes  No

If yes, please provide reason: \_\_\_\_\_

\*Please attach a copy of present carrier's last bill and certificate.

**B. EMPLOYEE ELIGIBILITY**

11. A full-time employee is one who:
- works a minimum of 30 hours per week; and
  - works the Applicant's regular work schedule; and
  - performs his job for full pay; and
  - works at the Applicant's place of business.

12. Do you want to exclude any classes of full-time employees from coverage?  Yes  No

If yes, list each class by salary, job title, union membership, or any other condition pertaining to employment:

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**Please note: All part-time, temporary, and seasonal employees are excluded from coverage.**

13. A Waiting Period is a period of time, chosen by the employer, that an employee must work on a full-time basis in an eligible class, before becoming eligible for coverage. CURRENT EMPLOYEES mean employees who are at work on a full-time basis in an eligible class on the effective date.

Waiting Period:

- For Current Employees: \_\_\_\_\_
- For Employees hired after effective date: \_\_\_\_\_

14. Each full-time employee who is at work on the effective date and has NOT satisfied the Waiting Period will be eligible on the first day after he satisfies the Waiting Period.

- Total Number of full-time employees: \_\_\_\_\_
- Total Number of full-time employees in the waiting period as of the requested effective date: \_\_\_\_\_
- Total Number of full-time employees excluded by class: \_\_\_\_\_
- Total Number of full-time employees waiving coverage: \_\_\_\_\_
- Total Number of full-time employees to be insured: \_\_\_\_\_

**C. CONTRIBUTION DATA**

15. Will employees be required to contribute toward the cost of the insurance?  Yes  No

If yes, please indicate the percentage of the cost the employee must pay.

**Note: If the employer pays the entire cost for the employees, then 100% of the eligible employees must be covered.**

Coverage % Employee Will Pay	Basic Life and AD&D	Dependent Life	Supplemental Life

16. Premium will be paid:  Monthly  Quarterly  Semi-Annually  Annually

**D. EMPLOYEE / DEPENDENT DATA**

17. Are there any employees who, during the past year, have been out of work due to injury or sickness for at least 5 consecutive days, or currently are out of work due to injury or sickness?  Yes  No

If yes, please specify below:

Name	Date Disability Began	Current Amount of Group Life Insurance In Force	Describe Nature of Injury/Sickness

**E. LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE**

18. Coverage Requested:  Basic Life  Basic AD&D  Dependent Life  Supplemental Life  Other: \_\_\_\_\_

**19. INSURANCE SCHEDULE**

Benefits:		
Description of Classes	Life Amount	AD&D Amount
( ) All Eligible Full-time Employees	_____	_____
Schedule Below to be used for Multiple Classes Only		
Class One: _____	_____	_____
Class Two: _____	_____	_____
Class Three: _____	_____	_____

- Basic Life and AD&D will be written in equal amounts. The AD&D maximum is \$250,000 (unless otherwise agreed to in advance by the Home Office of Standard Security).
- Basic Annual Earnings means the employee's annual salary or wages paid by the Employer. Basic Annual Earnings do not include bonuses, overtime pay, or other special compensation such as commissions.
- If there are additional classes to be covered, please continue on another sheet.
- If not otherwise specified, Life and AD&D Amounts will be rounded to the next higher \$1,000.

20. Dependent Life Schedule: Spouse: \$ \_\_\_\_\_  
 Children 15 days - 6 months: \$ \_\_\_\_\_  
 6 mos. - 19 years\*: \$ \_\_\_\_\_  
 \* To Age \_\_\_\_\_ if full-time student.

21. Initial Monthly Payable Rates: Life: \_\_\_\_\_/\$1,000 Accidental Death & Dismemberment: \_\_\_\_\_/\$1,000  
 Dependent Life: \_\_\_\_\_/per unit Supplemental Life: \_\_\_\_\_/\$1,000 (if step rates are to be used, please attach).

**REDUCTION FORMULA**

22. Age Reduction Schedule for Basic Life and AD&D Coverage:

- 35% at age 65, 50% of the original amount at age 70, with benefits terminating at retirement.
- 35% at age 65, 50% of the original amount at age 70, 70% of the original amount at age 75, 80% of the original amount at age 80, with benefits terminating at retirement.
- 35% at age 65, reduced face amount further decreased by 35% every 5 years, with benefits terminating at retirement.
- Other: \_\_\_\_\_

**CHANGE IN AMOUNT OF INSURANCE:**

A change in the amount of Basic Life, AD&D, Dependent Life, or Supplemental Life will take effect on the next Policy Anniversary following the date of change.

**F. REQUESTED EFFECTIVE DATE**

23. You request that the coverage chosen above take effect on:

- the date it is approved in writing by Standard Security; or
- \_\_\_\_\_. This date will be the effective date if approved in writing by Standard Security. Premiums will be due as of this effective date.

24. It is agreed that:

- (a) Necessary information concerning employees and/or dependents to be insured shall be furnished to Standard Security monthly.
- (b) The issuance of insurance requested is subject to the approval of Standard Security. The underwriting decision will be based upon all of the information supplied by the applicant for requested benefits as detailed in this application, plus any other information obtained from outside sources which Standard Security deems appropriate for making its decision.
- (c) Any conflict between the terms of this application and the Policy will be decided in favor of the Policy. Benefits shown on this application must agree with a valid proposal prepared by or on behalf of Standard Security. Any changes to a proposal must be specifically approved in advance by Standard Security.
- (d) All benefits terminate at retirement unless specifically noted otherwise.

**G. APPLICANT'S DECLARATION**

**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 subjects such person to criminal and civil penalties.**

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

The agent(s) appointed for this application is (are):\_\_\_\_\_

You understand that:

- no agent may change or waive any provisions of this application or of any policy; and
- any change or waiver must be approved in writing by an officer of Standard Security; and
- this application will be accepted or declined on the basis of the statements and answers given above.

Date	Print Name of Officer, Partner, or Proprietor
Witness	Signature of Officer, Partner, or Proprietor

**H. PRODUCING AGENT'S DECLARATION**

• **Producing Agent**

To the best of my/our knowledge and belief, all the statements and answers in this application are true and complete. I/We have no knowledge or information about the applicant, his employees, the dependents of such employees, which is not fully set forth above.

Date	Print Name of Producing Agent (as licensed)	License #
City and State Where Signed	Signature of Producing Agent	

Mailing Address:\_\_\_\_\_

Telephone #:\_\_\_\_\_ Facsimile #:\_\_\_\_\_

• **General Agent**

General Agent's Name:\_\_\_\_\_ License #:\_\_\_\_\_

Print Name

Telephone #:\_\_\_\_\_ Facsimile #:\_\_\_\_\_