STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 Madison Avenue, New York, NY 10022

GROUP HEALTH PLANS
EMPLOYEE APPLICATION

Please check one.

❑ Requesting coverage as an employee/dependent for a new employer group plan.

❑ Requesting coverage as an employee/dependent to be added to an existing employer group plan. Case #___________________.

❑ Requesting to decline coverage.

Failure to complete this application in its entirety could result in a delay.

A. EMPLOYEE/DEPENDENT INFORMATION (All eligible employees must complete Section A.)

LAST NAME (IF DIFFERENT) FIRST MI	SEX	HEIGHT	WEIGHT	RELATIONSHIP	DATE OF BIRTH	FULL-TIME STUDENT
	❑ M ❑ F			❑ EMPLOYEE		N/A
	❑ M ❑ F			❑ SPOUSE ❑ CHILD		❑YES ❑NO
	❑ M ❑ F			❑ CHILD		❑YES ❑NO
	❑ M ❑ F			❑ CHILD		❑YES ❑NO
	❑ M ❑ F			❑ CHILD		❑YES ❑NO

B. EMPLOYEE INFORMATION (All eligible employees must complete Section B.)

HOME ADDRESS	HOME PHONE NUMBER	BEST TIME FOR US TO CALL ❑ AM ❑ PM
CITY/STATE/ZIP	WORK PHONE NUMBER	BEST TIME FOR US TO CALL ❑ AM ❑ PM
COUNTY	MOBILE NUMBER	E-MAIL ADDRESS
SOCIAL SECURITY NUMBER	MARITAL STATUS ❑ SINGLE ❑ MARRIED	JOB TITLE OR OCCUPATION
EMPLOYER	DATE OF FULL-TIME EMPLOYMENT	
Are you a/an (leave blank if not applicable) ❑ OWNER ❑ PARTNER ❑ CORPORATE OFFICER	MONTHLY EARNINGS	WEEKLY HOURS WORKED

ADMINISTRATIVE USE ONLY	TIMELY EE ❑	SPEC ENROLL ❑	LATE ENROLL ❑	24-HR CVG ❑ Yes ❑ No	LIFE AMOUNT	PCEFDT	PRE-EX ENDS	EFF DATE	UW APPRV	PART #	ENTERED BY

→ ***If applying for coverage GO TO SECTION D.***
↓ ***If requesting to decline coverage for yourself and/or your eligible dependent(s), COMPLETE ALL OF SECTION C AND SIGN.***

C. REQUEST TO DECLINE COVERAGE

1. I, or my dependents, decline coverage because of the following:

EMPLOYEE	SPOUSE	CHILD(REN)	**MEDICAL**
❑	❑	❑	a) Have coverage under another health plan.
❑	❑	❑	b) Choose not to have health plan coverage currently.
			DENTAL
❑	❑	❑	a) Have coverage under another group dental plan.
❑	❑	❑	b) Choose not to have dental coverage currently.
			VISION
❑	❑	❑	a) Have coverage under another group vision plan.
❑	❑	❑	b) Choose not to have vision coverage currently.

2. If declining offer of coverage due to other coverage, please list name and phone number of insurance company (or employer if self-funded plan and policy number.)

	INSURANCE COMPANY NAME IF KNOWN **OR** EMPLOYER IF SELF-FUNDED	PHONE NUMBER	PRIMARY INSURED & SSN	POLICY NUMBER (IF KNOWN)
❑ Employee ❑ Spouse ❑ Child				
❑ Employee ❑ Spouse ❑ Child				
❑ Employee ❑ Spouse ❑ Child				

This is to acknowledge I have been given the opportunity to apply for the available coverages and have elected not to enroll myself or my dependents, if any. I understand that by applying for coverage at a later date I may be considered a Late Applicant and I will be subject to an 18-month pre-existing condition limitation or exclusion period if I am considered a late applicant. If I apply for coverage during an annual enrollment period I may be subject to a 12-month preexisting condition limitation. I represent I have not been persuaded to waive coverage by my employer or the producing agent.

I understand that if I waive coverage for myself or my dependents because of being covered under other health Insurance coverage, I may, in the the future, be able to enroll myself or my dependents in this plan if the other health coverage terminates. The other health coverages must have terminated because of either: 1) the “loss of eligibility” for coverage, or 2) the termination of employer plan by the employer. I understand I must apply for coverage within 30 days after my other coverage ends to be eligible for this Special Enrollment Period. “Loss of eligibility” includes a loss of coverage due to, divorce, death, termination of employment, or a reduction in the number of hours of employment. Loss of eligibility does not include an individual’s failure to pay premiums on a timely basis or by the termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an initial misrepresentation of fact in connection with a group health plan.

In addition, if I have a new dependent as a result of marriage, birth, adoption or placement for adoption, I understand I may be able to enroll myself and certain dependents, provided that I apply within 30 days after the marriage, birth, adoption or placement for adoption.

______________________________________ ______________
Signature of Employee (if declining coverage) **DATE**

ALL APPLICANTS WAIVING COVERAGE MUST SIGN AND DATE SECTION C.

D. COVERAGE REQUESTED

I am applying for:

❑ **Health and Life Insurance:**
❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

❑ **Employee Life Insurance only and not Health Insurance** (Complete all sections of the application also)

❑ **Dental Coverage:**
❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

❑ **Vision Coverage**
❑ Employee Only ❑ Employee & Spouse ❑ Employee & Child(ren) ❑ Employee, Spouse & Child(ren)

Employee Choice – If your employer offers employee choice, please mark your plan selection below:

❑ Plan Choice 1 ❑ Plan Choice 2 ❑ Plan Choice 3

E. LIFE INSURANCE

BENEFICIARY	RELATIONSHIP

F. PROVIDER NETWORK

PROVIDER NETWORK: ____.

G. PRIOR INSURANCE COVERAGES INFORMATION

1. Has anyone applying, been covered through any other plan of health insurance within the past 63 days?

❑ NO (Go to Section H)

❑ YES 1) Attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage.
2) Please complete the following:

NAME & PHONE NUMBER OF HEALTH INSURANCE COMPANY		NAME & SOCIAL SECURITY NUMBER OF PRIMARY INSURED	
PLAN NUMBER	TYPE OF COVERAGE ❑ INDIVIDUAL ❑ EMPLOYER GROUP	EFFECTIVE DATE	TERMINATION DATE

2. If applying for dental coverage – Do you as the employee currently have employer group dental coverage? ❑ Yes ❑ No

This group health plan contains a pre-existing condition exclusion period of 12 months (18 months for late enrollees). This exclusion does not apply to any individual who was continuously covered for an aggregate period of 12-months under creditable coverage that was in effect up to a date not more than 63-days before your proposed effective date, excluding any waiting period. This exclusion period can be reduced by the number of days you were covered under creditable coverage if the prior coverage was in effect at any time during the 12-months preceding your proposed effective date of coverage under this plan. To determine if any pre-existing condition limitation will apply to you, you must submit your certificate(s) of prior creditable coverage. Creditable coverage can include coverage under another group health plan, an individual health policy, short term health plans, student health plans, Medicare, Medicaid, TriCare (formally CHAMPUS), a medical health care program of the Indian Health Service or tribal organization, a state health benefits risk pool, any public health plan, a health plan issued under the Peace Corp Act or an S-CHIP. You may request a Certificate of Creditable Coverage from a previous employer's insurance company or Health Maintenance Organization (HMO). If you submit a Certificate of Creditable Coverage (or documentation of creditable coverage through other means) then we will make a determination regarding the length of any pre-existing condition exclusion that applies to you or your dependents. If you cannot obtain a copy of your certificate of creditable coverage you may contact the Plan Administrator for assistance. We reserve the right to modify an initial determination of creditable coverage if we determine that your claimed coverage is in error, provided that we send you a notice of reconsideration. Until the final determination is made, we will, for purpose of pre-authorization under the plan, act in a manner consistent with the initial determination.

If applying for dental insurance, employees who are covered under their employers group dental plan on the date immediately prior to the effective date of coverage on this Plan will be given credit for the satisfaction of any calendar year deductible amounts and waiting periods under this new Plan.

H. HEALTH QUESTIONS

Please provide complete details to any question marked "Yes" in the appropriate space provided in Section I. We may need to request additional information regarding your health history from you and/or your attending physician.

A. ❒ Yes ❒ No Are you or any enrolling dependents receiving treatment or been advised of a condition that will require medical attention or to have medical test(s)? If yes, list names and explain in Section I.

B. ❒ Yes ❒ No Are you or any enrolling dependents currently disabled, confined to a hospital, medical facility or the home? If yes, list names and explain in Section I.

C. ❒ Yes ❒ No Have you or any applying dependents incurred medical expenses over $10,000 in the last 12 months? Please provide a list of names and explain in Section I.

D. ❒ Yes ❒ No Have you or any applying dependents tested positive for HIV infection or been diagnosed as having AIDS related complex (ARC) or Acquired Immune Deficiency Syndrome (AIDS) caused by the HIV infection.

E1. ❒ Yes ❒ No Are you or your enrolling dependents currently taking or have been prescribed medications within the past 12 months? If yes, please fill in the appropriate information.

E2. MEDICATIONS CURRENTLY PRESCRIBED OR BEING USED (List details/medication below.)

Person's Name	Medication	Frequency and Dosage	Length of time on medication?	Complete Names and Addresses of Physicians

F. Within the past five years, has any person to be insured had any symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for:

F1. CIRCULATORY SYSTEM:
a) ❒ Yes ❒ No Abnormal Heart Beat/Palpitations, Blood Disorder/ Hemophilia/ Hypertension, Chest Pain, Heart Disease/ Murmur/ Heart Attack or Coronary Artery Disease, Lymphadenopathy/Immune Disorder, Stroke, Vascular Disorder

b) ❒ Yes ❒ No High Blood Pressure (Current Readings ______/_______), (______/______)
High Cholesterol (Current Reading __________)
High Triglycerides (Current Reading _________)

F2. CYST/POLYP/TUMOR: ❒ Yes ❒ No Cancer, Tumors/ Cysts/ Polyps/ Growths

F3. ENDOCRINE DISORDERS: ❒ Yes ❒ No Diabetes/ Pancreatic Disorders, Thyroid or Goiter

F4. GASTROINTESTINAL DISORDERS: ❒ Yes ❒ No Colitis, Hepatic, Spastic Colon, Polyps, Digestive Disorder/ Reflux, Gallbladder Disorder, Hernia, Ulcerative Colitis/Crohn's/ Regional Ileitis, Ulcers, Hepatitis (A, B or C), Liver Disorder

F5. GENITO URINARY DISORDERS:
a) ❒ Yes ❒ No Abnormal Pap Smear, Bladder Disorder, Breast Disorder, Infertility Testing/Treatment, Kidney Disorder, Menstrual Disorder, Prostate/Rectal Disorder, Reproductive Organs Disorder/ Endometriosis, Sexually Transmitted Diseases

b) ❒ Yes ❒ No Current Pregnancy (Expected Due Date ___________)

F6. NERVOUS DISORDERS: ❒ Yes ❒ No Anorexia/Bulimia, Epilepsy and/or Seizure, Headaches/ Migraines, Mental, Nervous, Emotional Disorder/Anxiety/ Depression/ Attention Deficit Disorder, Mental Retardation/Down's Syndrome, Muscular Dystrophy/ Cerebral Palsy, Neurological Disease, Paralysis, Sleep Disorders

F7. OTHER DISORDERS: ❒ Yes ❒ No Abnormal Test Results, Alcoholism/Alcohol Abuse, Drug Addiction, Ear/Throat Disorders, Eye Disorders, Transplants

F8. RESPIRATORY DISORDERS: ❒ Yes ❒ No Allergies, Asthma/ Respiratory Disorder, Cystic Fibrosis, Emphysema/ Lung Disorder, Sinus Disorder, Tuberculosis

F9. SKELETAL/ MUSCULAR DISORDERS: ❒ Yes ❒ No Arthritis, Back/Muscle/Joint Disorder, Bone Disease/Deformity, Congenital Disorder Fractures/Dislocations, Lupus/Systemic or Discoid, Rheumatism, Skin Disorder, Spinal Disorder/ Back/ Neck Strain

I. HEALTH HISTORY

INSTRUCTIONS: Please complete the *HEALTH HISTORY SECTION* for any "yes" responses in Section H.

Ques. No.	Person's Name	Condition(s) and Treatment	Date of Onset Mo./Yr.	Recovery Date Mo./Yr.	Complete Names and Addresses of Physicians & Hospitals

WARNING: It is a crime to provide false or misleading information to an insurer for the purpose of defrauding the insurer or any other person. Penalties include imprisonment and/or fines. In addition, an insurer may deny insurance benefits if false information materially related to a claim was provided by the applicant.

J. YOUR ACKNOWLEDGEMENTS

PREMIUM PAYMENT: I authorize my employer to deduct the requested premium contribution, if any, from my earnings.
FULL-TIME EMPLOYMENT: I understand that one of the requirements for eligibility on the effective date and for continued eligibility under the plan is that I am actively at work and employed full-time (at least thirty (30) hours per week) at my employer's place of business.
PRE-AUTHORIZATION: I understand that failure to pre-authorize treatment results in reduced benefits pursuant to the terms of the Group Master Policy.
BENEFIT AVAILABILITY: I understand that my benefits under this plan begin with a specific effective date of coverage applicable to me and coverage ends at the end of a month in which due premium has not been paid. I understand if I attempt to utilize the benefit plan or prescription drug card when coverage is no longer effective under the plan, I will be personally responsible for those expenses incurred and can be billed by the providers or insurance company for those services.
AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician or medical practitioner, hospital, Optum®, Med-Valu, Express Scripts, or other organization, institution or person that has any medical information or knowledge of me or my family as to diagnosis, treatment and prognosis regarding any physical, mental, drug or alcohol condition or any and all such information to be given to Standard Security Life or their authorized Administrator or legal representative. Any information obtained will not be released by the Insurance Company except to persons or organizations performing business or legal services in connection with my application or claim, including but not limited to Pre-authorization of hospital admissions, Continued Stay Review, On-Site Concurrent Review or as may be otherwise lawfully required or as I further authorize. (Photocopy of this authorization shall be valid as the original and is valid for thirty (30) months from the date shown below.)
WORKING IN THE U.S.: I understand that the coverage under this plan is available for individuals who are legally working in the United States and benefits are not payable for medical expenses outside of the United States except when traveling.
PRE-EXISTING CONDITIONS LIMITATION PROVISIONS: I understand that my coverage and that of my dependents, if approved, may be subject to pre-existing conditions limitation provisions regardless of the medical conditions disclosed on the application pursuant to the terms of the Group Master Policy.
MY ANSWERS ARE TRUE AND CORRECT: I have personally reviewed all of my answers to the questions on this application and represent that all of the information I have provided is true and complete. I understand that it is my responsibility to provide truthful, complete and accurate information and I represent I have fully understood all questions asked. I understand that any intentional misrepresentations or fraud may be used as the basis of rescission or termination of coverage for me or my dependents. I understand that under no circumstances is any agent allowed to (a) waive, alter or modify any questions; (b) permit me to inaccurately answer any questions; or (c) instruct me not to disclose any particular medical condition on the application. I understand that no agent is authorized or has authority to alter the terms of the Group Master Policy.
APPLICATION FOR GROUP: I understand that my employer agreed to participate in the Group to which the Group Policy was issued, and I am simultaneously applying for insurance to which I am now or may be eligible for under the provisions of the Group Policy issued to that Group by Standard Security Life Insurance Company of New York I understand that my insurance will not be in force until the application is approved by Standard Security Life Insurance Company of New York, or their authorized Administrator in accordance with the underwriting guidelines in effect. (For health insurance no health status related factor will be taken into consideration in the approval process)

K. SIGNATURE

______________________________	______________
Signature of Employee (and parent if applicant is under age 18)	DATE

BEFORE YOU RETURN THE APPLICATION – SOME *IMPORTANT* ITEMS!

✓ **Section E…Beneficiary** - If life insurance coverage is included as an employer benefit, it is in your best interest to designate a personal beneficiary. Only if no beneficiary exists, should you indicate "Estate" in this section.

✓ **Section H, I…**To help reduce requests for additional information about your medical history you have provided in Section I, ask your Agent about completing a Health History Questionnaire.

PLEASE COMPLETE AND SIGN THE APPLICATION WHETHER YOU APPLY FOR OR ARE DECLINING COVERAGE.