

- Initial Enrollment/Employee
- Newly Hired Employee
- Contract Staff
- Retiree
- Special Enrollment

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

**Enrollment Application
Group Limited Benefit Health Insurance**

Please Print or Type							
Name (Last)		(First)		(MI)	Gender	Date of Birth MM/DD/YY	Social Security No.
					<input type="checkbox"/> M <input type="checkbox"/> F	/ /	- -
Address		City		State	Zip		Home Phone
							() -
Plan Sponsor Name		Group Number		Eligibility Status		Date of Hire/Retirement	Business Phone
				<input type="checkbox"/> Salaried Employee <input type="checkbox"/> Hourly Employee <input type="checkbox"/> Contract Staff <input type="checkbox"/> Retiree		/ /	() -
Avg Weekly Hours	Earnings		Job Title			Dept. or Branch	
	\$ <input type="checkbox"/> Hourly <input type="checkbox"/> Annual						
<input type="checkbox"/> YES, I want the following Plan offered by the Plan Sponsor. _____ Plan 1; _____ Plan 2; or _____ Plan 3			Select Type of Coverage: <input type="checkbox"/> Eligible Person <input type="checkbox"/> Eligible Person + Spouse or Domestic Partner or Domestic Same Sex Partner <input type="checkbox"/> Eligible Person + Child/Children <input type="checkbox"/> Eligible Person + Family				
<input type="checkbox"/> No, I do not want any coverage. <i>I understand that if I want coverage, at a later date, I may be required to provide evidence of insurability to Standard Security Life Insurance Company of New York.</i> Is the reason you are declining coverage because you currently have other health coverage? <input type="checkbox"/> Yes <input type="checkbox"/> No							
Signature, if declining all coverages _____				Date _____			
If Life or Accidental Death benefits are offered, Your beneficiary will be the first of the following living persons: 1. Your spouse; 2. Your natural and adopted children, equally; 3. Your parents, equally; or 4. Your brothers and sisters, equally. If none of the above persons are living, then We will pay the benefit to Your estate. Beneficiary and relationship; if You wish to have any other beneficiary _____ You may designate or change Your Beneficiary at any time by filing a Change of Beneficiary Form. This designation or change must be made on forms or by means of a process We provide.							
LIST ALL DEPENDENTS TO BE COVERED. DOCUMENTATION IS NEEDED FOR ADOPTED/FOSTER/STEP CHILDREN OR SPOUSES OR DOMESTIC PARTNERS OR DOMESTIC SAME SEX PARTNERS WITHOUT THE SAME SURNAME.							
Name (Last, First, MI)		Date of Birth MM/DD/YY		Gender	Social Security No.		Relationship
		/ /			- -		Spouse/Domestic Partner Domestic Same Sex Partner
		/ /			- -		Child
		/ /			- -		Child
		/ /			- -		Child
		/ /			- -		Child
Are any of the children age 19 or over a full-time student? <input type="checkbox"/> No <input type="checkbox"/> Yes If Yes, <input type="checkbox"/> proof of school enrollment attached <input type="checkbox"/> proof to be provided							
I hereby declare that I am in an Eligible Class of the Plan Sponsor indicated above and that I work at or from the employment location indicated. All information given by me on this form at Standard Security Life Insurance Company of New York's request is true and complete and is offered to Standard Security Life Insurance Company of New York as inducement to grant insurance.							
Applicant Signature _____				Date _____			

Not Applicable

