SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
607.723.3551 • www.smlny.com

THIS DOCUMENT IS FORM FILLABLE

Clear Form

GROUP INSURANCE
Enrollment/Statement of Insurability Form

Please Print. Provide required information. Incomplete information will delay your application.

Coverage Requested: Employee: Life/AD&D ☐ WDI ☐ LTD ☐ Dependent: Life ☐
Amount or Plan #: _____ _____ _____ _____

Participating Employer			Participating Employer Unit Number	
Employee's Name	☐ Male ☐ Female	Birthdate	Social Security No.	Marital Status
Employee's Home Address (Street Address, City, State, Zip)				
Employee's Occupation			Annual Earnings / Date Employed / Hours Worked/Week	
Spouse's Name (if Dependent Life Insurance requested)			Spouse's Date of Birth / Spouse's Soc. Sec. No.	

Name of Employee's Beneficiary (Instructions on Page 2)	Relationship/Home Address	Social Security No.

HEALTH INFORMATION: The following information must be provided *only* for the individual(s) applying for:
Check appropriate box(s)

☐ An amount above the No Evidence Limit: ☐ Employee ☐ Spouse
☐ Coverage as a late applicant: ☐ Employee ☐ Spouse
☐ An increase in existing coverage: ☐ Employee ☐ Spouse

	Employee		Spouse	
	Yes	No	Yes	No
1. During the past 7 years, have you been diagnosed by a member of the medical profession as having any of the following conditions or received treatment from a member of the medical profession for high blood pressure, heart disease, arteriosclerosis or stroke; alcoholism, drug abuse, mental, or nervous condition or emotional disorder; cancer or diabetes; AIDS or AIDS Related Complex; or lung, liver or kidney disease or disorder?	☐	☐	☐	☐
2. Do you have any physical, mental, or emotional condition for which you regularly take prescription drugs or medications, or for which you plan to see a member of the medical profession for diagnosis or treatment?	☐	☐	☐	☐
3. During the past 5 years, have you consulted or been treated by a member of the medical profession for any physical, mental, or emotional condition not mentioned above?	☐	☐	☐	☐
4. Has any insurance company ever declined your application or reinstatement for any type or amount of insurance coverage?	☐	☐	☐	☐
5. Have you been absent from work for a period of 5 or more consecutive days during the last 2 years due to sickness or injury?	☐	☐	☐	☐

6. Employee: Height_____ Weight_____ Spouse: Height_____ Weight_____

COMPLETE DETAILS OF "YES" ANSWERS FOR QUESTIONS 1 – 5. ***If more space is required, please attach a signed and dated separate sheet.***

Quest. No.	Employee or Spouse	Problem/History – If for Blood Pressure Give Recent Reading	Date	Duration or Date Resolved	Treatment	Names and Addresses of Physicians & Hospitals

I understand that satisfactory Evidence of Insurability is required to become insured for an amount above the No Evidence Limit or if I apply for insurance as a late applicant. I understand that a Certificate of Coverage will be issued to me showing the amount of insurance approved by Security Mutual and the effective date of my insurance. I understand that Security Mutual will use the information on this enrollment form as the basis for determining my eligibility for coverage. I authorize the necessary deductions from my wages to cover my portion of the cost of this insurance.

I represent that the statements contained herein are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the group policy for which Evidence of Insurability is required. I understand the insurance applied for does not become effective until approved in writing by Security Mutual Life Insurance Company of New York.

Any person who, knowingly and with intent to defraud or deceive any insurance company, submits an insurance application containing any false, incomplete, or misleading information may be subject to civil or criminal penalties, depending upon state law.

X _____ _____ X _____ _____

Signature of Employee (Required) Date Signature of Spouse (if applying for coverage Date

Original to Insurance Company; 1 copy to employee; 1 copy to employer

BENEFICIARY SECTION:

Please print full name, relationship, address, and Social Security number of your beneficiary.

Examples:

A.	One beneficiary	Dorothy Q. Smith, wife (not Mrs. John Smith)
B.	Two beneficiaries	Peter Smith, father, and Anna Smith, mother, equally, or the survivor
C.	Beneficiaries in unequal shares	Peter Smith, father, 75%, and Anna Smith, mother, 25%, or the survivor
D.	Trustee	Dorothy Q. Smith, trustee under trust agreement dated _____ .
E.	Your Estate	My Estate

Do you know that if death occurs and you have named a minor (a person not of legal age) or your estate as beneficiary, it may be necessary to have a guardian or a legal representative appointed before any death benefit can be paid? This could mean legal expenses for the beneficiary and possible delay in the payment of the insurance. Please take this into consideration when naming your beneficiary.

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PLEASE RETAIN THIS NOTICE FOR YOUR RECORDS.