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

GROUP ENROLLMENT FORM (Please Print)

Employer Section

Name of Employer	Group I.D. No.	Billing Class

Unit Name and Number	Policy Numbers

Human Resources Department – Complete this section. Retain copy for your records.

Date of Hire or Rehire (mm/dd/yyyy)	Hours Worked Per Week	Earnings $_____ Per: ❑ Hour ❑ Week ❑ Month ❑ Year ❑ Other _____

Check all boxes and complete all sections that apply. Return completed form to your Human Resources Department.

Applicant Section

Your Name (Last, First, MI)

Street Address	City	State	Zip

Your Social Security Number	Date of Birth (mm/dd/yyyy)	❑ Male ❑ Female	Job Title/Occupation

Check with your Human Resources Department about coverage options available to you and Evidence of Insurability requirements.

Coverage Elections

❑ Basic Life/AD&D ❑ Basic Dependent Life/AD&D ❑ Short Term Disability ❑ Long Term Disability
❑ Supplemental Life/AD&D ❑ Supplemental Spouse Life/AD&D ❑ Supplemental Child Life/AD&D

Supplemental Life Coverage Amount Selected: Employee: $ Spouse: $ Child: $

❑ Spouse ❑ Domestic Partner *(Check one box only)*	Name (Last, First, MI)	Date of Birth (mm/dd/yyyy)	Social Security Number

Complete only if Life/AD&D coverages are selected.

Beneficiary

Name (Last, First, MI)	Relationship to You	Social Security Number

If more than one Beneficiary is to be named, please complete Beneficiary Designation form 0005578GR.

Refusal of Insurance

I have been offered this insurance coverage and decline to purchase it at this time. I understand that in the event I desire such insurance at a later date, I will be required to furnish Evidence of Insurability at my own expense, and the insurance company will have the right to refuse any request.

Coverage Refused *(Check all that apply)*:

❑ Basic Life/AD&D ❑ Basic Dependent Life/AD&D ❑ Short Term Disability ❑ Long Term Disability
❑ Supplemental Life/AD&D ❑ Supplemental Spouse Life/AD&D ❑ Supplemental Child Life/AD&D

Fraud Notice

APPLICABLE TO INSURANCE OTHER THAN LIFE INSURANCE

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Accelerated Benefits Notice

Receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable. The portion of the death benefit which is accelerated will be discounted.

Signature

I hereby authorize my employer to deduct from my salary or wages, if applicable, the necessary premium for the coverage(s) checked above, for which I and my dependent(s) are eligible.

I understand that if I apply at a later date for coverage(s) which I had originally declined, that I may be required to furnish Evidence of Insurability at my own expense for my dependent(s) (if applicable) and myself, and that the insurance company has the right to refuse my request.

By my signature, I am verifying that the information provided is true and correct.

Applicant's Signature Date