Standard Security Life Insurance Company of New York
485 Madison Avenue, New York, NY 10022 212-355-4141

Group Insurance

Employer Application

Requested effective date: _____

A. Employer Information

Legal name of company		DBA	
Type of company ❑ LLC ❑ S-Corporation ❑ Non-profit ❑ Other: _____			
Street address (no PO box)		City	
County	State		ZIP code
Billing address (if different than street address)	City	State	ZIP code
Contact (must be an employee at the company)		Telephone number	Fax number
Contact e-mail address		Owner or proprietor	
Nature of business	SIC	Federal tax ID number	Number of years in business

B. Employers with Multiple Locations

If employees of any affiliated business organizations or separate locations are to be covered, please list the affiliate or location(s) below.

Affiliate name/address	Nature of business	Business relationship	Tax ID	Number of employees:
1.				Full-time: _____ Part-time: _____
2.				Full-time: _____ Part-time: _____

C. Waiting Period and Effective Date Provisions

Select a waiting period (Effective 1st of the month following) :

❑ 30 days ❑ 60 days ❑ 90 days ❑ Other _____ (Subject to underwriting approval) *(The waiting period may be changed only at renewal.)*

The waiting period selected will apply to:

❑ Employees hired after the effective date ❑ All current and future employees

D. Prior Coverage Information

Will this plan replace other group medical coverage?	❑ Yes ❑ No

If yes, please provide 12 months of information below and attach a copy of the most recent billing.

Prior medical carrier	Policy number	Effective date (mm/dd/yyyy)	Termination date (mm/dd/yyyy)	Major medical plan?
				❑ Yes ❑ No
				❑ Yes ❑ No

D. Prior Coverage Information *(Continued)*

Will this plan replace other group dental coverage?	❑ Yes ❑ No

If Yes, please provide 12 months of information below and attach a copy of the most recent billing.

Prior dental carrier	Policy number	Effective date (mm/dd/yyyy)	Termination date (mm/dd/yyyy)	Orthodontia coverage included?
				❑ Yes ❑ No
				❑ Yes ❑ No

E. Continuation/COBRA

1. Are any employees or dependents currently on COBRA or other continuation of coverage? If yes, list the individuals:	❑ Yes ❑ No
2. Are any employees or dependents currently in an election period for COBRA or other continuation? If yes, list the individuals:	❑ Yes ❑ No

Please note, an Application form and a copy of the COBRA election form must be submitted for each person to be covered under your group plan through COBRA.

F. Eligibility

Are any employees currently absent due to illness or injury, family medical leave or receiving disability benefits? If yes, provide names and details:	❑ Yes ❑ No

G. Employer Contribution

❑ Defined Contribution Amount

$_____ per employee per month $_____ per employee with dependents per month

❑ Percentage of Premium Contribution

_____ % of employee health premium and _____ % of dependent health premium

_____ % of employee dental premium and _____ % of dependent dental premium

H. Employee Participation

Total number of full-time employees	Total number of part-time employees
Total number of employees	Total number of full-time employees applying for medical coverage

All eligible employees are expected to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in their waiting period. As indicated earlier in the application, the employer may waive the waiting period at initial enrollment to maximize employee participation. Groups must meet the following participation guidelines at enrollment and stay above participation minimums while covered by the plan. For all size groups, 50 percent of full-time eligible employees must enroll, regardless of employees waiving due to other coverage.

Group size	Minimum required employee participation	Minimum required dependent participation - no maternity coverage	Minimum required dependent participation - with maternity coverage
2 - 4 employees	100%	50%	Plan not available
5 - 9 employees	75%	50%	75%
10 or more employees	75%	No requirement	No requirement

I. Acknowledgements

The employer hereby applies for coverage under the Group Master Policies ("policy") issued to Multiple Unit Security Trust ("trust") by Standard Security Life Insurance Company of New York ("Insurer"). The employer hereby joins the trust for the purpose of establishing an employee welfare benefit plan. Employer agrees that the insurance coverage which is to be placed inforce is subject to all of the provisions of the policy. Employer agrees to be bound by all of the terms, provisions and limitations of the policy and this application.

The employer also agrees that:

- Participation in the trust is subject to written approval of this employer application by Insurer or its designee; no liability is created for, or assumed by the trust or the insurer until this application has been approved in writing; acceptance of the check submitted with the application does not constitute approval or guarantee of insurance coverage; and if for any reason this application is not so approved in writing, the sole obligation of the trust and Insurer will be, and the employer shall be entitled to only a refund of any monies paid.
- The first premium payment is due as of the date coverage becomes effective; subsequent premiums are due on the first day of each succeeding month; a grace period of 31 days will be allowed for the payment of any premium due after the initial premium.
- The initial premium rates will remain in effect for the first six months of coverage, unless the employer elected the 12-month rate guarantee on the employer Application. The initial premium rate may change during the rate guarantee period if 1) the employer adds or deletes employees; 2) existing employees move to a higher age bracket; 3) employer moves to another geographic area; 4) employer modifies the plan's benefits; 5) the provider network fees change; 6) benefits change due to state or federal benefit mandates; or 7) any benefit changes occur during the period.
- Benefits under the policy begin on the employer's effective date and coverage ends as of the last day for which premium has been paid; and Insurer will not be liable for any health care claims incurred by any insured person after the date on which coverage has terminated.
- It will reimburse Insurer for any claims paid by Insurer for covered charges that are incurred by an employee after the date coverage under the policy is terminated.
- The Group Master Policy contains precertification requirements and an insured person's failure to comply with the precertification requirements may result in a reduction of benefits that may be payable under the terms of the policy.
- Coverage under the policy is available for U.S. residents only; employees must be legal U.S. residents and benefits are not payable for medical expenses for services received outside of the United States except for emergency care when traveling.
- It has reviewed all of the answers to the questions on this employer application; understands that it is employer's responsibility to provide truthful, complete and accurate information; represents that all of the information contained herein is true and complete; acknowledges that any material misstatements or failure to report information by employer or employees may be used as the basis of rescission or termination of employer's or any employee's coverage.
- Its agent is an independent insurance agent representing the employer, not the Insurer, and that no agent is authorized or has authority to 1) alter the terms of the policy or the trust; 2) waive, alter or modify any questions on this employer application; or 3) permit employer or employees to inaccurately answer any questions.
- All eligible employees are encouraged to apply for coverage during the employer's initial enrollment period, including those who may not be eligible for coverage yet because they are still in the "waiting period," and employer may only waive the "waiting period" for employees when the employer's coverage first becomes effective.
- It must maintain the minimum participation requirements stated herein; Insurer may periodically request and inspect payroll and personnel records to verify employee participation rates; employer will provide any such information that is requested; employer's failure or refusal to provide such information is grounds for termination of coverage; and employer's failure to maintain minimum participation requirements may result in coverage termination or loss of protection under the Health Insurance Portability and Accountability Act.

Fraud Warning: 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.
Arkansas Residents: 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.
Ohio and Pennsylvania Residents: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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.
New Mexico Residents: 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 civil fines and criminal penalties.
Oklahoma Residents: WARNING: Any person who knowingly, and with intent to injure, defraud or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete or misleading information is guilty of a felony.
Tennessee Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purposes of defrauding the company. Penalties include imprisonment, fines and denial of coverage.
Virginia Residents: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.

I acknowledge I am advised not to terminate any existing health or dental coverage plans until my agent receives notification that this application has been approved by Standard Security Life Insurance Company of New York.

Name of Owner or Officer - Print	Title
X Signature of Owner or Officer	Date

J. Agent Information and Statement

Name		IHC number	
Street address	City	State	ZIP code
E-mail address		Telephone number	

I certify that all of the information contained in this employer application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

X _____ _____

Signature of primary writing agent Date

If application is to be split, provide the secondary agent's information.

Secondary agent name		IHC number	
Street address	City	State	ZIP code
E-mail address		Telephone number	
Primary agent commission percentage		Secondary agent commission percentage	

I certify that all of the information contained in this employer application and any attached papers is correct to the best of my knowledge. I have complied with all of the underwriting rules and have explained the coverage fully.

X _____ _____

Signature of secondary writing agent Date

K. Submission Checklist

- ❑ Fully completed, signed and dated employer application.
- ❑ Fully completed, signed and dated employee Enrollment forms, which includes a section for those waiving coverage, for every eligible employee including those on or electing coverage through COBRA.
- ❑ Fully completed Multiple Unit Security Trust enrollment form.
- ❑ A premium proposal signed and dated by the employer or company representative.
- ❑ A business check, made payable to IHC Health Solutions.
- ❑ A copy of the prior carrier's most recent billing statement, if replacing coverage.
- ❑ A copy of the employer group's wage and tax form or payroll records. Additional records may be requested to verify participation requirements have been met.

Additional forms may be required at enrollment or any time while coverage is inforce to support the initial underwriting process or to verify that the participation requirements are maintained.