Small Employer Group Health Plans Underwritten by
Standard Security Life Insurance Company of New York

Employee Application

Indicate Plan Selection: _____

❑ New Group
❑ Addition to Existing Group
Group # _____

Group Name: _____

A. Employee Information

Name (last, first, MI)	Social Security Number	Marital Status ❑ Single ❑ Married

Home Address	City	State	Zip code

Best time for us to call ❑ AM ❑ PM	Telephone Number ( )	E-mail Address

Date of full-time employment	Job Title/Occupation	Weekly hours worked

Compensation Status	Are you an owner, officer or partner in the company? ❑ Yes ❑ No If "Yes", are you covered by Worker's Compensation? ❑ Yes ❑ No	Employee Status ❑ Actively at work ❑ Other: _____ ❑ COBRA - Termination Date: _____
❑ Salary ❑ Hourly ❑ 1099		

B. Application Intentions

	Applying for coverage for:			Waiving coverage for:		
Coverage Type	Myself/Employee	Spouse	Children	Myself/Employee	Spouse	Children
Medical	❑	❑	❑	❑	❑	❑
Life	❑	❑	❑	❑	❑	❑
Dental*	❑	❑	❑	❑	❑	❑
Vision	❑	❑	❑	❑	❑	❑

*Have you and all dependents you are enrolling been covered under a Dental plan within the past 12 months? ❑ Yes ❑ No

C. Applicant, Spouse and Dependent Children Information

Name (last, first, MI)	Sex	Height	Weight	Relationship	Date of Birth	Tobacco Use/ Full-Time Student
Self	❑ M ❑ F			Employee		❑ Non-Tobacco ❑ Tobacco User
	❑ M ❑ F			Spouse		❑ Non-Tobacco ❑ Tobacco User
	❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		❑ Yes- FT Student ❑ No
	❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		❑ Yes- FT Student ❑ No
	❑ M ❑ F			❑ Child ❑ Stepchild ❑ Adopted ❑ Other		❑ Yes- FT Student ❑ No

- If you and all eligible dependents are applying for medical and/or life insurance coverage, complete all sections of the application except Section G, Request to Waiver Coverage. Be sure to sign and date at the bottom of Section J.
- If you and all dependents are waiving/declining coverage, complete Section G. Be sure to sign and date at the bottom of Section G.
- If you are applying for coverage but have eligible dependents waiving, complete all sections of the application.

D. Preferred Provider Network

Network Selected

E. Life Insurance Beneficiary

Beneficiary Name	Relationship

Administrative Use Only	Timely EE	Spec Enroll	Late Enroll	24-hour cov	Life Amount	PCEFDT	Pre-Ex Ends	Eff Date	UW Apprvl	Part #	Entered by

F. Prior Insurance Coverage Information

1. Have you and all dependents you are enrolling been covered under a Major Medical plan with another carrier(s) other than your current employer coverage within the past 12 months? *If "No", continue to Section H. If "Yes", attach a copy of the certification of group health insurance plan coverage or other documentation of creditable coverage AND complete the following:*	❑ Yes ❑ No

Name(s) of Covered Family Member	Effective Date	Termination Date (if applicable)	*Type of Coverage*				
			Employer Group Coverage	Individual Medical	Government Sponsored Plan	COBRA	Other
			❑	❑	❑	❑	❑
			❑	❑	❑	❑	❑

Prior Carrier Name:	Policy Number:

2. If applying for dental coverage, do you currently have employer group dental coverage? ❑ Yes ❑ No
If "Yes", was coverage for orthodontia included? ❑ Yes ❑ No

G. Request to Waive Coverage

I, and/or my dependents, request to decline coverage because of:

	Other Group Coverage	Covered under Individual Medical	Covered under Government Sponsored Plan	COBRA Coverage	Other	No Coverage
Employee	❑	❑	❑	❑	❑	❑
Spouse	❑	❑	❑	❑	❑	❑
Child(ren)	❑	❑	❑	❑	❑	❑

If declining coverage due to other coverage, please list the name and phone number of the insurance company (or employer if covered through a self-funded plan) and policy number :

Name(s) of covered family members	Insurance company name, if known, or employer if self-funded	Primary Insured & SSN	Policy Number, if known

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. If I am a Late Applicant, I will be subject to an 18-month pre-existing exclusion limitation period. 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 future, be able to enroll myself or my dependents in this plan if the other health insurance coverage terminates. The other health coverages must have terminated because of either: 1) the "loss of eligibility" for coverage, or 2) the termination of the employer plan by the employer. I understand that I must apply for coverage within 30 days of a qualifying life event or termination of other coverage to be eligible for a special enrollment period. "Loss of eligibility" includes a loss of coverage due to legal separation, 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 in the event of termination of coverage for cause. Examples of a loss of coverage for cause include the making of a fraudulent claim or an intentional 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.

X

Signature of Employee *(if declining coverage)* _____ Date _____

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.

1. 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)?	❑ Yes ❑ No
2. Are you or any enrolling dependents currently disabled, or confined to a hospital, medical facility or your home due to a medical condition or disability?	❑ Yes ❑ No
3. Have you or any applying dependents incurred medical expenses over $10,000 in the last 12 months?	❑ Yes ❑ No
4. Are you or your enrolling dependents currently taking or have been prescribed medications within the past 12 months? *If yes, complete the medications chart below.*	❑ Yes ❑ No

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

5. Does any person to be insured currently have or had within the <u>past five years</u> symptoms, diagnosis, consultation, treatment, or taken any medication or received counseling for any disorder or disease of the following: (*Remember to provide details to any "Yes" answers in Section I - Health History Details)*

Circulatory System	a. Abnormal heart beat/palpitations, blood disorder/hemophilia, hypertension, chest pain, heart disease/murmur/heart attack or coronary artery disease, lymphadenopathy/immune disorder, stroke, vascular disease	❑ Yes ❑ No
	b. High blood pressure, high cholesterol or high triglycerides *(If yes, please provide the most recent readings and date)* Blood pressure reading: _____/_____ Cholesterol Reading: _____ Triglyceride Reading: _____ Date : _____ Date: _____ Date: _____	❑ Yes ❑ No
Cyst, Polyp, Tumor	c. Cancer, tumors/cysts/polyps/growths	❑ Yes ❑ No
Endocrine Disorders	d. Diabetes/pancreatic disorders, thyroid, goiter	❑ Yes ❑ No
Gastrointestinal Disorders	e. Colitis, hepatic, spastic colon, polyps, digestive disorder/reflux, gallbladder disorder, hernia, ulcerative colitis, Chron's/regional ileitis, ulcers, Hepatitis (A, B, or C), liver disorder	❑ Yes ❑ No
Genitourinary Disorders	f. Abnormal Pap Smear, breast disorder, infertility testing/treatment, menstrual disorder, reproductive organ disorder, endometriosis, sexually transmitted diseases, Acquired Immune Deficiency Syndrome (AIDS), bladder disorder, kidney disorder, prostate/rectal disorder	❑ Yes ❑ No
	g. Current pregnancy *If yes, please provide the expected due date*_____	❑ Yes ❑ No
Nervous Disorders	i. Anorexia/bulimia, mental, nervous, emotional disorder/anxiety, depression/attention deficit disorder, mental retardation/down's syndrome, neurological disease, sleep disorders	❑ Yes ❑ No
	j. Epilepsy and/or seizure, headaches/migraines, muscular dystrophy, cerebral palsy, neurological disease, paralysis	❑ Yes ❑ No
Other Disorders	k. Abnormal tests results, alcoholism/alcohol abuse, drug addiction, ear/throat disorders, eye disorders, transplants	❑ Yes ❑ No
Respiratory Disorders	l. Allergies, asthma/respiratory disorder, cystic fibrosis, emphysema/lung disorder, sinus disorder, tuberculosis	❑ Yes ❑ No
Skeletal/Muscular Disorders	m. Arthritis, back/muscle/joint disorder, bone disease/deformity, congenital disorder, fracture/dislocation, Lupus/systemic or discoid, rheumatism, skin disorder, spinal disorder, back/neck strain.	❑ Yes ❑ No

I. Health History Details, *(details required for "Yes" answers above).*

Ques. #	Person's Name	Condition and Treatment	Date of Onset Mo/Yr	Recovery Date Mo/Yr	Complete name and address of Physicians and Hospitals

J. Agreement and Signature

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.

This group health plan contains a pre-existing condition exclusion period of 12 months (18 months for late enrollees). This exclusion period can be reduced by the number of days you maintained prior creditable coverage. When applying creditable coverage to the pre-existing condition limitation, the plan will not take into account any days of creditable coverage that precede a break in coverage of 63 days or more. To determine if any pre-existing condition limitation will apply to you or your covered dependents, you must submit a certificate of creditable coverage. Creditable coverage can include coverage under another group health plan, an individual medical 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 the purpose of pre-certification 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 the new plan.

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 30 hours per week) at my employer's place of business.
Pre-certification: I understand that failure to pre-certify 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 Insurance Company of New York, or organization performing business or legal services in connection with my application or claim, including but not limited to pre-certification 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.)
U.S. Resident: I understand that the coverage under this plan is available for United States residents and benefits are not payable for medical expenses outside of the United States except for Emergency Care when traveling.
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 material misstatements or failure to report information 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 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 for 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 inforce 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.

X_____ _____

Signature of Employee *(and parent if applicant is under age 18)* Date

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

Authorization for Release of Health-Related Information.

I authorize the disclosure of health information regarding, or related to the following individuals for whom an application for insurance has been submitted:

Print Name(s): (Last) (First) (MI)	Date of Birth (Month/Day/Year)	Social Security Number
1.		
2.		
3.		
4.		
5.		
6.		
7.		

I authorize the disclosure of any and all information that: (i) is created or received by a health care provider, health plan including health insurer or health insurance agent, public health authority, employer, life insurer, school or university, or health care clearinghouse; and (ii) relates to the past, present, or future physical or mental health or condition of an individual listed above; the provision of health care to an individual listed above; or the past, present, or future payment for the provision of health care to an individual listed above. This authorization permits the disclosure of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, and prescription drug information.

I specifically authorize the disclosure of information related to (i) communicable diseases, including HIV, AIDS or AIDS related complex (to the extent permitted by both state and federal law); (ii) drug and alcohol abuse and treatment; (iii) mental illness and treatment; and (iv) genetic conditions including genetic testing (to the extent permitted by both state and federal law). Notwithstanding the above, this authorization does not authorize the release of psychotherapy notes.

I authorize any and all health care providers including without limitation physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, pharmacy benefit managers, pharmacies or pharmacy-related facilities; and any and all health plans, insurance companies, insurance support organizations (such as MIB Group), business associates of health plans or insurance companies and those persons or entities providing services to such business associates to disclose the information described above.

I authorize Standard Security Life Insurance Company of New York ("SSL"), including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to receive the disclosure of information authorized herein and use the information disclosed pursuant to this authorization.

The purpose of the disclosure authorized herein is to permit SSL, including its affiliated companies, subsidiaries and business associates, including those persons or entities providing services to its business associates, to obtain and use the information described above to make prospective and retrospective eligibility, underwriting and risk rating determinations, including whether the individual is subject to a pre-existing condition exclusion.

This authorization shall expire twenty-four (24) months after the date on which it is executed below.

I understand that eligibility for the health plan is conditioned on my execution of this authorization for the use or disclosure of the information described above for the purpose of making eligibility, underwriting and risk rating determinations. Except as otherwise stated herein, treatment, payment, enrollment in a health plan, or eligibility for benefits is not conditioned on an authorization for the use or disclosure of the information described above.

I understand that I may revoke this authorization by sending written notice of my intent to revoke this authorization to P.O. Box 37587, Phoenix, AZ 85069, Attention Privacy Officer.

I understand that there is a possibility of re-disclosure of any information disclosed pursuant to this authorization and that information, once disclosed, may no longer be protected by federal rules governing privacy and confidentiality.

A copy or facsimile of this authorization shall be as valid as the original.

Signature of each Individual over the age of 18 or the Individual's Legal Representative: Date:

X_____ _____

X_____ _____

X_____ _____

If signed by the individual's legal representative (e.g. a parent on behalf of a child), please describe the representative's authority to sign on behalf of the individual:

Name: _____ Authority: _____