Application for Group Supplemental Accident & Sickness Benefit Insurance to:
Monitor Life Insurance Company of New York
70 Genesee Street, Utica, NY 13502

The Information provided by the Applicant in this Application will be the basis on which any insurance is issued. Incorrect information could void Insurance.

Legal Name of Employer (include d/b/a):	Employer Identification Number
Principal Business or Activity	SIC Code

Physical Address: (Street Number and Name)	Billing Address: (If bill is to be split and sent to more than one billing address please indicate here and give addresses on an attached sheet.)
City	City
State Zip	State Zip

Executive Contact Person:	Billing Contact Person:
Title:	Title:
Telephone:	Telephone:
Email Address:	Email Address:
Fax Number	Fax Number

Employer's Major Medical or Comprehensive Plan Data

Major Medical Plan Carrier _____

Major Medical Deductible Amount $_____

Major Medical Coinsurance %_____ to Maximum Out of pocket (Coinsurance Limit) Amount $ _____

Are Major Medical Deductibles & Coinsurance per Plan Year or per Calendar Year? _____

Major Medical Plan Anniversary Date _____

Number of Covered: Employees _____ Dependent Spouses_____ Dependent Children_____

Eligibility

Eligible Person as used in the Policy means a person who is insured under a Major Medical Plan or Comprehensive Health Plan (CHAMPUS/ TRICARE or Medicaid is not a comprehensive medical plan) and who is:

Eligible Person - If enrollment is voluntary, (all premiums are paid by the employee) -
[All active full-time employees working 18 hours or more per week and who are under age seventy will be eligible for coverage. Each Insured will be eligible for Dependent coverage on the later of the following dates:
1.   The day the Insured becomes eligible for insurance; or
2.   The day the Insured acquires his or her first dependent]
Eligible Person - If employer participates in paying the premiums -
1.   [An employee of the Policyholder who is insured by the employer's major medical plan;
2.   An employee's dependent spouse or dependent children who were insured by the employer's major medical plan.] Eligible new employees or dependents may be added subject to the terms of the Policy.

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{Eligible Classes: _____}

The first premium must be paid before any insurance is effective. Insurance provided hereunder will terminate with regard to any individual when that individual is no longer an Eligible Person in accordance with the "Termination of Coverage" provisions of the Policy.

Insurance Applied For

Employer Contribution ___{Premium Saver Plan}

Employer will pay _____% or $_____ of Employee Costs and_____% or $_____ of Dependent Costs

Important Note: All persons (100 % participation) insured by the Employer's Major Medical or Comprehensive Health Plan must be covered on Employer Contribution plans listed above.

Plan Design Selection

<u>ATTACH FLIER OR PROPOSAL THAT DESCRIBES THE SPECIFIC BENEFITS</u>

Applicable to all Benefits

**Deductible: $_____ Coinsurance: _____% Out-of-Pocket Maximum (Coinsurance Limit) $_____
Maximum Total Benefit Amount $_____
Per Year Benefit Maximum Basis:** ☐ **Plan Year** ☐ **Calendar Year**

Comments _____

{Prior Plan Deductible Credit Rider} {☐Yes ☐ No}

Policy/Certificate Delivery

Send Policy & Certificate to: _____Agent _____Employer

Payroll and Billing Information

**{Billing is alphabetical -12 monthly Premiums}
Effective Date can be {the 1st or the 15th of the month}**

Make check payable to Monitor Life Insurance Company of New York.
$_____ Amount of Attached Check.

ALL PREMIUMS ARE PAYABLE IN ADVANCE. THE FIRST PREMIUM MUST BE PAID PRIOR TO THE EFFECTIVE DATE OF INSURANCE.

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Agreements, Representations and Understanding

I represent that all statements made herein are complete and true as of the date I signed this Application, and I understand that Monitor Life Insurance Company of New York (MLICNY) will rely on these statements and this information as the basis for approving this Application.

I understand that the Group Supplemental Accident & Sickness Insurance Policy for which I have applied is a limited benefit Policy that pays only the benefits selected and set forth in the Policy itself. Our agent has explained the Policy's limitations and exclusions, if any.

I understand that only those employees and dependents covered under our company's major medical or comprehensive health plan are eligible for coverage.

> Check One
> {I **represent** that {100%} of eligible employees and dependents will be enrolled in the plan}. _____
> {I **represent** that this plan will be offered on a voluntary basis} _____

I understand that coverage is effective when: a) the Policy is issued by MLICNY; b) the Policy is received and accepted by the Policyholder; c) the full first premium is paid and accepted by MLICNY.

{We agree to make any necessary payroll deductions for any employee's share of the cost of this insurance and to remit the total premium for all insurance as premiums become due. We request that the Administrator bill our share of the premiums and any applicable administrative fee due under the insurance Policy issued.}

I understand that the Policyholder may terminate the Policy and any Rider(s) by giving written notice to the other party. The Policyholder is responsible for notifying the Insureds of the termination or non-renewal of the Policy.

I understand that MLICNY and the Policyholder may agree to amend the Policy at any time without the consent of any employee or other person.

I represent that the information herein is true and complete, as of the date I signed this Application, and that I have read and understand this form.

{I acknowledge and understand that any misrepresentation on this Application by my agent or me may result in the cancellation or rescission of any Policy issued based on this Application.}

WARNING: Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

On behalf of the Employer, this Application for Group Insurance is signed by

X _____Print Name _____

Official Title _____ this _____ day of _____

Agent Name (print)_____ Signature_____

Agent State License - Identification Number_____

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