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

Please complete ALL areas noted with ❄ and mail to:
Chapter 82 - RETIREES
63 Colvin Ave, Albany, NY 12206

GROUP ENROLLMENT FORM (Please Print)

Employer Section

Name of Employer: COUNCIL 82 CHAPTER 82 RETIREES	Group I.D. No.: N/A	Billing Class: N/A
❄ Unit Name and Number: N/A	Policy Numbers: G000104049-00001	

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

Date of Hire or Rehire (mm/dd/yyyy)	Hours Worked Per Week	Earnings
❄	N/A	Earnings $ N/A Per: ☐ Hour ☐ Week ☐ Month ☐ Year ☐ Other N/A

Applicant Section

Check all boxes and complete all sections that apply.

❄ Your Name (Last, First, MI)		Phone cell/home (circle one) (____) ____-________		
❄ Street Address	City	State	Zip	
❄ Your Social Security Number	Date of Birth (mm/dd/yyyy)	☐ Male ☐ Female	Job Title/Occupation	

Coverage Elections

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

☑ 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: $ N/A Spouse: $ N/A Child: $ N/A

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

Beneficiary

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

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. See Reverse Side->

Refusal of Insurance

N/A

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 and with intent to defraud any insurance company or other person files an application for insurance or statement of claims 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, and shall also be subject to civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Living 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 ________

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GROUP INSURANCE BENEFICIARY FORM

If more space is needed to list your beneficiaries, please attach a separate sheet to this form.

Insured ____________________ Telephone Number ____________________ Social Security Number ____________________

Address ____________________
Street City State Zip

Employer COUNCIL 82 CHAPTER 82 RETIREES Group Policy No. G000104049-00001

In accordance with the Group policy shown above, I hereby revoke any previous designations of primary and contingent beneficiaries, if any, and designate as primary and contingent beneficiaries, if any, in the event of the insured's death, the following:

BENEFICIARY CLASSES:

PRIMARY BENEFICIARY(IES)

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Must Total 100% ________*

CONTINGENT BENEFICIARY(IES): I wish the following to receive proceeds only if the primary beneficiary(ies) stated above all die before the insured:

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Name ____________ Relationship ____________ % ______ Gender ☐M ☐F DOB ________ Phone ( )

Address ____________________ Soc. Sec. No ________

Must Total 100% ________*

***Add Future Children as Split Beneficiaries.** ☐ Yes ☐ No. **(Please refer to the definition of child in your certificate of insurance.)**
If you elect to **Add Future Children as Split Beneficiaries**, all current and future children will be added as beneficiaries with the percentage of benefit equally split among all child beneficiaries.

TRUST AS BENEFICIARY: (Complete this section only if you are naming a trust as beneficiary and the trust document will govern the disposition of the death benefit proceeds. A valid trust document must be in existence **prior** to naming the trust as Beneficiary.) **Must check one:** ☐ Primary ☐ Contingent **Must check one:** ☐ Revocable Trust ☐ Irrevocable Trust

Trust Name ________ Trust Date ________ Trust Tax Identification Number ________

Trustee Name (s) ________ Address (Street, City, State, Zip) ________ Percentage ________

Unless otherwise provided, all beneficiaries in a class who survive the Insured shall share the death benefit equally, and no beneficiary in a subsequent class shall receive payment unless all beneficiaries in the preceding class have predeceased the Insured.

This Designation is subject to the following checked (x) paragraph:

☐ Deferred Survival – If any beneficiary designated shall survive the Insured but shall die before the ________ day (not to exceed 90 days) after the death of the Insured (exclusive of the date of death), proceeds shall be paid in the same manner as if the beneficiary had predeceased the Insured.

☐ *Payment of a minor Child's Share to Trustee – Any payment which becomes due a child under the age of twenty-one shall be made to ________, (s)he currently resides at ________ as Trustee under a Trust Agreement dated ________.

* This option cannot be selected unless a legal Trust Agreement has been entered into by you and the elected Trustee in advance of the Trustee being named in this form. Security Mutual Life Insurance Company of New York will not accept this designation unless the date of the Trust Agreement appears on this form.

SIGNATURE AND DATE REQUIRED FOR PROCESSING

Dated at ____________________ **this** ________ **day of** ________ , ________ .
City and State

____
Witness (Recommended in All States)

____
Certificate Holder

____
Spouse, if resident of a community property state (see Page 1)

Insureds: Do Not Write Below This Line

For Company use only:
Original filed with the Security Mutual Life Insurance Company of New York on (Date) ________ (Signature) ________

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GROUP INSURANCE BENEFICIARY FORM

GENERAL INSTRUCTIONS

- Complete this form if:
  1. More than one beneficiary is to be named under the certificate of insurance; or
  2. The present beneficiary designation(s) for proceeds payable on the death of the Insured under the certificate of insurance is intended to be replaced by the new designation(s).
- A separate Group Insurance Beneficiary Form must be used for each certificate of insurance.
- Please type or print in black or blue ink.
- Cross outs are not acceptable.
- **Surviving Beneficiary(ies).** Unless otherwise provided, all surviving beneficiaries in each class shall share equally and no beneficiary in a subsequent class shall receive payment unless all beneficiaries in the preceding class have predeceased the Insured.
- By providing all of the requested information, Security Mutual Life Insurance Company of New York will be better able to promptly process the payment of a death benefit in the event of the Insured's death and minimize requests for additional information.
- **Split Beneficiary(ies).** If you wish the proceeds to be split among beneficiaries, use percentages totaling 100%. ***Do not use dollar amounts.***
- **Children of the Insured.** Insurance regulation requires that we request specific identifying information for all children specified as beneficiaries. Therefore, "Children of the Insured" is not an acceptable designation. Please name each living child and include their gender, date of birth, phone number, social security number, address and relationship to the Insured. Be sure to complete a new Group Insurance Beneficiary Form to add additional children born or legally adopted.
- The maximum period for Deferred Survival is 90 days.
- Spouse of Certificate Holder residing in the following community property states must sign the Group Insurance Beneficiary Form: AZ, CA, ID, LA, NV, NM, TX, WA, WI.
- If group insurance is through employment, the employer may not be named beneficiary.
- It is important that you review your beneficiary designation periodically to ensure that the beneficiary information supplied is current.
- You may change or revoke your beneficiary designation at any time by completing a new Group Insurance Beneficiary Form.

SUGGESTED PHRASEOLOGY FOR DESIGNATION OF BENEFICIARIES

	Type	Language
1.	Insured's estate	Executors or Administrators of Insured's Estate
2.	One beneficiary of a class	Mary Doe, wife (not Mrs. John Doe)
3.	Two or more beneficiaries of a class	Jane Doe, daughter, and James Doe, son
4.	Unequal portions	Jane Doe, daughter, three-fourths (75%) and James Doe, son, one-fourth (25%)
5.	Deceased primary beneficiary's share to go to secondary beneficiary and not to be divided between surviving primary beneficiaries	Jane Doe, daughter, and James Doe, son, however, if Jane Doe shall predecease the Insured, her share shall go to her children.
6.	Creditor	ABC Bank, as its interest may appear; balance, if any, to ______________________.
7.	Trustee	ABC Bank, as trustee under trust agreement dated ______________.
8.	Testamentary Trustee	The qualified testamentary trustee(s), under the Insured's Last Will and Testament

Do you know that if death occurs and you have named a minor child (a person under age twenty-one) or your estate as beneficiary, it may be necessary to have a guardian or 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. You may wish to consult an attorney regarding a designation under your state's Uniform Transfers to Minors Act, if available.

CONDITIONS OF THIS DESIGNATION

1. This designation is subject to any Collateral Assignment of the certificate accepted by and filed with Security Mutual Life Insurance Company of New York, whether made prior or subsequent to the date of this designation.
2. Security Mutual Life Insurance Company of New York assumes no responsibility for the proper use of money by any Trustee, Custodian, Guardian, Executor or other beneficiary named herein and is released from all liability from making payment in accordance with this designation.
3. Unless otherwise expressly provided herein, the Certificate Holder reserves the right, without consent of any beneficiary, to revoke this designation and to change the beneficiary at any time by notifying the Company in writing at its Home Office. Such change shall be without prejudice to Security Mutual Life Insurance Company of New York on account of any payment made or action taken by it before filing such change in its Home Office.
4. The Company has the right to refuse to file any designation which does not comply with its rules and regulations.
5. Once received by Security Mutual Life Insurance Company of New York, the designation will take effect as of the date the Certificate Holder signed the designation. Until the designation is received, Security Mutual Life Insurance Company of New York will not be liable for any action taken in good faith contrary to directions contained in the designation.
6. All designations are subject to the terms and conditions of the group policy.