The Standard Life Insurance Company of New York

Reset

Enrollment and Change

To Be Completed By Human Resources

Group Number			Date of Employment
445344			

To Be Completed By Applicant

☐ Apply for Coverage ☐ Name Change Former Name _____

☐ Add Dependent ☐ Delete Dependent Date of Add/Delete _____

☐ Reinstatement ☐ Beneficiary Change ***Complete Beneficiary Section***

Your Full Name	Social Security Number	Birth Date	
Address	City	State	ZIP
Phone Number	Job Title/Occupation	☐ Male ☐ Female	
Employer Name **New York State Business Group, Inc.**	Hours Worked Per Week	Are You Actively At Work? ☐ Yes ☐ No	

Coverage

Check with your Human Resources Department about coverage options, minimum and maximums available to you and, if applicable, Evidence Of Insurability requirements.

Accident Insurance (Employee Paid)

☐ You only ☐ You and your Spouse ☐ You and your Child(ren) (no Spouse) ☐ You, your Spouse and Child(ren)

Your Full Name

Eye Care Insurance

Coverage Requested

☐ Balanced Care Vision I – VSP (Employee Paid)

☐ Balanced Care Vision II – EyeMed (Employee Paid)

☐ Balanced Eye Care III (Employee Paid)

Are you or your dependents covered for eye care insurance under another plan? ☐ Yes ☐ No

List Dependents to enroll or drop for Eye Care, if applicable. (Attach sheet for additional dependents, if needed.)

Full Name (Last name if different, First, Middle Initial)	Eye Care (Employee paid)		Gender		Date of Birth
	Add	Drop	M	F	
Spouse	☐	☐	☐	☐	
Child 1	☐	☐	☐	☐	
Child 2	☐	☐	☐	☐	
Child 3	☐	☐	☐	☐	

Eye Care Insurance Waiver: Contributory Eye Care Insurance

The insurance coverage available to me and my Dependents has been explained to me and I do not want to enroll at this time. I understand that if I elect to enroll in the future, the insurance coverage may be subject to a Late Entrant Penalty.

I decline ☐ Eye Care insurance for myself.

I decline ☐ Eye Care insurance for one or more dependents.

Your Full Name

Beneficiary

This designation applies to your Life and Accidental Death and Dismemberment Insurance and Voluntary Accidental Death and Dismemberment Insurance, if any, available through your Employer. This designation also will apply to your Supplemental Life and Accident Insurance, if any, available through your Employer, unless replaced by a separate and later designation. Designations are not valid unless signed, dated, and delivered in accordance with the terms of the Group Policy during your lifetime.

Primary — Full Name	Address	SSN *if known*	Relationship	% of Benefit*	DOB	Phone No.

Contingent — Full Name	Address	SSN *if known*	Relationship	% of Benefit*	DOB	Phone No.

*Total must equal 100%

For Accident Insurance:
The coverage applied for provides limited benefits health insurance only. This coverage does not meet the minimum requirements for Medicare supplement, long term care insurance, nursing home insurance only, home care insurance only, or nursing home and home care insurance in the state of New York. Purchase of this coverage may be unnecessary if you already have or intend to purchase Medicare supplement insurance or long term care insurance.

For Accident Insurance (my signature below attests to the following): I understand this is Accident-only insurance. The Accident-only insurance does not provide coverage for sickness. This is a supplement to health insurance and is not a substitute for major medical coverage. Lack of major medical coverage (or other essential coverage) may result in an additional payment with your taxes. I acknowledge that I have comprehensive hospital, surgical and medical health insurance (minimum essential coverage).
☐ Yes ☐ No If the answer to the question is no, the coverage will not be issued.

Your Full Name

Signature

I wish to make the choices indicated on this form. If electing coverage, I authorize deductions from my wages to cover my contribution, if required, toward the cost of insurance. I understand that my deduction amount will change if my coverage or costs change. I represent that the statements contained herein, including, if applicable, those made in response to the Evidence Of Insurability questions, are true and complete to the best of my knowledge and belief, and I understand that they form the basis of any coverage under the Group Policy(ies) and Certificate(s). I understand that any misstatements which are material to the issuance of coverage may be used as a basis for contesting the validity of my insurance and/or denial of payment of a claim. I agree to notify The Standard Life Insurance Company of New York (The Standard) of any change in my medical condition while my enrollment application is pending. I acknowledge that I have read the Fraud Notice. I agree that if my application is approved by The Standard, the effective date of any coverage will be determined in accordance with the terms of the Group Policy(ies) and Certificate(s), including any applicable Active Work requirement and my coverage will be subject to all terms and conditions of the Group Policy(ies) and Certificate(s).

FRAUD NOTICE (Only applies to Accident and Health Insurance)

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim 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 a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Signature of Applicant (Member/Employee)	Date

Beneficiary Information

- Your designation revokes all prior designations.
- Benefits are only payable to a contingent Beneficiary if you are not survived by one or more primary Beneficiary(ies).
- If you name two or more Beneficiaries in a class:
  1. Two or more surviving Beneficiaries will share equally, unless you provide for unequal shares.
  2. If you provide for unequal shares in a class, and two or more Beneficiaries in that class survive, we will pay each surviving Beneficiary his or her designated share. Unless you provide otherwise, we will then pay the share(s) otherwise due to any deceased Beneficiary(ies) to the surviving Beneficiaries pro rata based on the relationship that the designated percentage or fractional share of each surviving Beneficiary bears to the total shares of all surviving Beneficiaries.
  3. If only one Beneficiary in a class survives, we will pay the total death benefits to that Beneficiary.
- If a minor (a person not of legal age), or your estate, is the Beneficiary, it may be necessary to have a guardian or a legal representative appointed by the court before any death benefit can be paid. If the Beneficiary is a trust or trustee, the written trust must be identified in the Beneficiary designation. For example, "Dorothy Q. Smith, Trustee under the trust agreement dated _____."
- A power of attorney must grant specific authority, by the terms of the document or applicable law, to make or change a Beneficiary designation. If you have questions, consult your legal advisor.
- Dependents Insurance, if any, is payable to you, if living, or as provided under your Employer's coverage under the Group Policy.

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