

EMPLOYEE

Group Term Life Enrollment Form

How to apply: An employee (you) must use this form to apply for Group Term life coverage. All new coverage or any increases in coverage will require Evidence of Insurability if plan participation requirements are not met. Any references to coverage being obtained without Evidence of Insurability in the sections below are only applicable if the plan participation requirements are met.

TELL US ABOUT YOURSELF - *Print clearly in dark ink and return as instructed.*

Your Name (<i>last, first, middle</i>)		Date of Birth (<i>month, day, year</i>)		<input type="checkbox"/> Female	Date of Hire
				<input type="checkbox"/> Male	/ /
Annual Salary	Social Security #	Employee I.D. Number	Home Phone ()	Work Phone ()	
Residence Address		City	State	Zip	
Your Beneficiary (<i>last, first, middle</i>)			Relationship		
Beneficiary's Address (<i>street, city, state, zip code</i>)			Beneficiary's Phone Number ()		

AMOUNT OF COVERAGE REQUESTED

If you are currently enrolled for Supplemental Life, you may increase your coverage by 1 times your basic yearly earnings without Evidence of Insurability. Increases of coverage greater than 1 times basic yearly earnings require Evidence of Insurability.

If you are currently **not** enrolled in Supplemental Life then Evidence of Insurability is required to enroll.

Total Supplemental Life coverage of 5 times basic yearly earnings up to a maximum of \$450,000 is available under the plan.

<input type="checkbox"/> I am applying for Supplemental Life coverage for the first time in the amount of: \$ _____ <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 times basic yearly earnings <p style="text-align: center;">OR</p> <input type="checkbox"/> I currently have Supplemental Life coverage of: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 times basic yearly earnings <p style="text-align: center;">AND</p> <input type="checkbox"/> I wish to increase my current Supplemental Life Coverage to a total of: <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 times basic yearly earnings

To the best of my knowledge and belief, the information I've provided on this form is complete and correct. I understand and agree that no coverage shall take effect unless this application is approved by ReliaStar Life Insurance Company of New York. I understand my coverage begins on the "effective date" assigned by ReliaStar Life Insurance Company of New York, provided I am actively at work. I also understand that evidence of good health may be required for coverage to begin. I understand that **receipt of accelerated benefits may affect eligibility for public assistance programs and may be taxable**, and that there is no additional premium, charge, or administrative fee for this benefit. I authorize my employer to deduct from my wages the premium for the above coverage.

Your Signature:	Date Signed:
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