Commercial Travelers Building
70 Genesee Street
Utica, NY 13502-3582

Transferred Business Information

1. Effective date of requested coverage:

2. Name of existing insurance carrier(s) on coverage to be replaced:

NAME OF INSURANCE CARRIER	COVERAGE BEING REPLACED	DATE TO BE CANCELED
A.	❑ Life ❑ AD&D ❑ STD ❑ LTD	
B.	❑ Life ❑ AD&D ❑ STD ❑ LTD	

3. Reason for change:

4. Benefit description (Attach copy of existing certificate or booklet unless previously submitted.)

RATING INFORMATION

Please fill in the existing rates on coverages being replaced.

Life $ /$1,000	Short Term Disability $ /$10.00 of Weekly Benefit
AD&D $ /$1,000	Long Term Disability $ /$100.00 ❑ Weekly Covered Wages ❑ Monthly Benefit

Date of last rate increase:	Old Rate

Is existing insurance carrier(s) requesting a change in the current rates stated above? ❑ Yes ❑ No

If yes, what are the new rates requested by line of coverage?	New Rates

EXPERIENCE INFORMATION

Disability	Names of Disabled Employees	Age at Disability	Date of Disability	Benefit Amount
Open Claims				

PREMIUM AND CLAIM HISTORY FOR LAST TWO POLICY YEARS

Please note: Complete claims incurred for disability if available, otherwise complete claims paid.

Life			Disability		
Policy Year Ending Date	Premiums Paid	Claims Paid	Premiums Paid	Claims Paid	Claims Incurred

Continue on Reverse Side

List all persons who are not currently active at work but are still considered employees, excluding any employees listed on the front of the form in the Open Claims section (e.g. jury duty, leave of absence, waiver of premium).

Name	Date of Birth	Sex	*Amount of Benefit	Line of Coverage	Date Last Worked	Date Expected Back	Reason for Absence

Remarks

*Under the column "Amount of Benefit," please use more than one line for a given person if he or she is covered for more than one benefit being applied for with CT*Group*.

I hereby certify that the information given above is, to the best of my knowledge, an accurate account of our previous insurance program. It is understood that the information furnished hereon may affect the initial rates and other underwriting conditions of any insurance plan we issue to your company.

Name of Employer:	Date:
By:	Official Title: