COMMERCIAL TRAVELERS
MUTUAL INSURANCE COMPANY
COMMERCIAL TRAVELERS BUILDING
UTICA, NEW YORK 13502

Group Insurance Application

An application for Group Insurance Plan covering the eligible employees (as defined below) of the Employer named below.

FIDELITY SECURITY LIFE
INSURANCE COMPANY
POLICYHOLDER SERVICE
70 GENESEE STREET, UTICA, NY 13502

Check the Company(s) you are applying to ❑ **Commercial Travelers** ❑ **Fidelity Security Life Insurance Company**

1. LEGAL NAME OF EMPLOYER *(This name will appear on all documents of insurance.)*

2. MAIN ADDRESS OF EMPLOYER *(Monthly premium statements will be sent to this address)*

3. NAME AND ADDRESS OF ANY SUBSIDIARY OR AFFILIATED COMPANY OF THE EMPLOYER INCLUDED IN THIS APPLICATION

4. LOCATIONS OF ANY EMPLOYEES IF OTHER THAN THOSE STATED IN ITEMS 2 OR 3

5. NATURE OF EMPLOYER'S BUSINESS *(If more than one business, state all.)*

6. KIND OF ORGANIZATION
❑ Sole Proprietorship ❑ Partnership ❑ Corporation (profit) ❑ Other (Indicate kind)

7. IF SOLE PROPRIETORSHIP OR PARTNERSHIP:
(a) Give name of proprietor or of each partner:

(b) Do the proprietor or partners have Workers' Compensation Coverage? ❑ YES ❑ NO

8. DO THE EMPLOYEES OF THE EMPLOYER HAVE WORKERS' COMPENSATION COVERAGE?
❑ YES ❑ NO

24-HOUR HEALTH AND ACCIDENT COVERAGE MAY BE ELECTED FOR ALL EMPLOYEES (INCLUDING A PROPRIETOR OR PARTNER) SUBJECT TO AN EXTRA PREMIUM 24-Hour Coverage? ❑ YES ❑ NO

9. TOTAL NUMBER OF EMPLOYEES ON PAYROLL OF EMPLOYER _____ FULL-TIME _____ PART-TIME _____
ARE ALL EMPLOYEES ON THE PAYROLL OF THE EMPLOYER ELIGIBLE FOR INSURANCE? ❑ YES ❑ NO. IF "NO," STATE HERE THE CLASS OR CLASSES EXCLUDED, AND THE NUMBER OF EMPLOYEES IN EACH SUCH CLASS.

10. DEFINITION OF ELIGIBLE EMPLOYEES

11. NEW EMPLOYEES MUST BE IN CONTINUOUS SERVICE _____ ❑ DAYS ❑ MONTHS BEFORE THEY BECOME ELIGIBLE FOR INSURANCE. DOES THIS PROBATIONARY PERIOD APPLY TO EMPLOYEES IN SERVICE ON THE EFFECTIVE DATE OF THE CONTRACT? ❑ YES ❑ NO

12. DOES THE EMPLOYER CURRENTLY HAVE, OR WITHIN THE LAST 2 YEARS HAD, SIMILAR GROUP INSURANCE ON THEIR EMPLOYEES? ❑ YES ❑ NO IF "YES," SUBMIT FORM 50031 "TRANSFERRED BUSINESS INFORMATION," A COPY OF THE CONTRACT OR CERTIFICATE AND A COPY OF THE PREMIUM STATEMENT OF THE PRIOR CARRIER FOR THE MONTH IMMEDIATELY PRECEDING THE EFFECTIVE DATE OF THE PLAN.

13. REPRESENTATIVE OF EMPLOYER WITH WHOM CORRESPONDENCE IS TO BE CONDUCTED

Name Title

14. AMOUNT OF DEPOSIT *(Approximately 1 month's premium)*
$

15. EFFECTIVE DATE *(May not be earlier than date on which at least 75% of eligible employees are enrolled.)* / /

16. CHECK BENEFITS APPLIED FOR HERE. DESCRIBE IN DETAIL ON REVERSE SIDE
❑ LIFE INSURANCE ❑ AD&D ❑ STD ❑ With Maternity
❑ IDI ❑ LTD ❑ Without Maternity

The specifications on the back of this application are, by reference, made part of this application,

17. The employer agrees to give all eligible employees an opportunity to enroll in the plan as they become eligible and to report to the Company all employees who enroll. The Employer further agrees to pay the required premiums to the Company and to deduct the required employee's contributions, if any, from the employee's salaries or wages. It is understood that no insurance will be effective until (1) this application has been approved and accepted by the Company at its Home Office, (2) an approximate initial premium has been paid to the Company by the Employer and (3) at least 75% of the eligible employees have elected the insurance.

18. DOES THE EMPLOYER PAY THE ENTIRE PREMIUM? ❑ YES ❑ NO

Any person who, includes any false or misleading information on an application for an insurance policy is subject to criminal or civil penalties.

I certify, on behalf of the named employer that all statements made above are true and complete to the best of my knowledge and belief.

DATED AT	NAME OF EMPLOYER
This day of in the year	SIGNATURE OF EMPLOYER
AGENCY	OFFICIAL TITLE
SIGNATURE OF LICENSED RESIDENT AGENT	AGENT'S ADDRESS
PRINT NAME OF LICENSED RESIDENT AGENT	

Specify Benefits Sold Proposal No. _____

1. Class Descriptions: A _____ C _____

B _____ D _____

2.

Benefits	Class	Life	AD&D	Short Term Disability	Intermediate/Long Term Disability
	____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____
	____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____
	____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____
	____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	% of Earnings ____ Benefit Max. $ ____ Flat Amt. $ ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____	Benefit % ____ Benefit Max. $ ____ Flat Amt. $ ____ Elim. Period ____ Benefit Period ____
Rate		$ ____	$ ____	$ ____	$ ____

3. Miscellaneous:

Billing Mode: ❑ Quarterly ❑ Monthly

IRS Employer Identification No. _____ (IRS Assigned)

IRS Welfare Plan No. _____ (Employer assigned: required by IRS)

Policyholder Phone No. _____ - _____

Plan Administrator Name & Address

_____

_____

_____

_____

BROKER DATA

FULL NAME (Please Print)

NAME OF BROKERAGE FIRM, AGENCY OR INSURANCE CO. YOU WORK FOR

ADDRESS

BUSINESS PHONE AREA CODE

( )

Are you licensed with us as a Broker? ❑ Yes ❑ No

If yes, what is your license #? _____

Indicate to whom commissions should be paid and any commissions split if applicable:

Name of Individual(s) or Firm (Please Print)	% Split