SECURITY MUTUAL LIFE
INSURANCE COMPANY OF NEW YORK
[SECURITY MUTUAL BUILDING • 100 COURT ST.
P.O. BOX 1625 • BINGHAMTON, NY 13902-1625
888-722-8645 • www.smlny.com]

❑ New Business
❑ Contract Change: Policy No. _____

Application for Individual TERM LIFE INSURANCE

SECTION I – Proposed Insured/Applicant/Owner

(Home Office Use)

_____
First Name, Middle Initial, Last Name

_____
Home Address (Street, Apt. No.)

_____
City, State, Zip Code

Social Security Number _____ Gender ❑ Male ❑ Female

U.S. Citizen or Permanent Resident of U.S.? ❑ Yes ❑ No

State and Country of Birth _____ Date of Birth _____

Current Occupation _____ Annual Income from Employment $_____

Email _____

Home Phone Number _____ Cell Phone Number _____ Work Phone Number _____

Do you have a U.S. Driver's License? ❑ Yes ❑ No If "Yes", License Number _____ State of Issue _____

SECTION II – Questions for Proposed Insured

1. Current Height _____ft. _____ inches Current Weight _____lbs.

		Yes	No
2a.	Does the Proposed Insured have any existing life insurance policies or annuity contracts in force with any insurer?		
2b.	Is the insurance now being applied for intended to replace or change existing life insurance or annuities in any company? (If "Yes," attach required replacement forms.)		

Name of Company	Policy Number	Amount
		$
		$
		$

		Yes	No
3.	Have you applied for or are you receiving disability benefits from any source?		
4.	Do you require assistance or supervision or use any type of medical equipment to perform any activities of daily living? (Activities of daily living are defined as bathing, continence, dressing, eating, toileting and transferring.)		
5.	Currently or within the **past 12 months** have you		
	a. Used any tobacco, nicotine or marijuana containing product or delivery method, or been prescribed any tobacco or nicotine cessation treatment?		
	b. Used marijuana more than 2 times per week?		
	c. Used heroin, morphine, other narcotics, barbiturates, amphetamines or hallucinogenic drugs other than as prescribed by a licensed member of the medical profession?		
	d. Been or are you currently a resident or inpatient of a hospital (excluding maternity), nursing, assisted living, drug or alcohol treatment facility?		
	e. Participated in non-commercial flights as a pilot or crew member, hang gliding, sky diving, more than one instance of scuba diving, motorized vehicle racing or mountain climbing?		

SECTION II – Questions for Proposed Insured *(continued)*		Yes	No
6.	Currently or within the **past 5 years**, have you been diagnosed as having or received treatment from a licensed member of the medical profession for any of the following?		
	a. Cancer (other than basal cell and squamous cell skin cancer)		
	b. Heart attack, aneurysm, peripheral arterial disease, or other heart condition		
	c. Stroke or mini-stroke		
	d. Multiple Sclerosis, Muscular Dystrophy, Parkinson's, ALS (Amyotrophic Lateral Sclerosis)		
	e. COPD (Chronic Obstructive Pulmonary Disease), pulmonary fibrosis, emphysema		
	f. Kidney failure		
	g. Hepatitis (other than hepatitis A), cirrhosis or other liver disorder or disease		
	h. Diabetes requiring insulin		
	i. AIDS (Acquired Immune Deficiency Syndrome)		
	j. HIV (Human Immune Deficiency Virus)		
	k. Alcohol abuse, drug abuse, or dependency on prescription pain medications		
	l. Depression requiring hospitalization or emergency treatment		
	m. Major organ transplant		
7.	Within the **past 5 years**, have you had an application for life or health insurance declined for medical reasons?		
8.	Within the **past 5 years**, have you been convicted of reckless driving or driving under the influence of alcohol or drugs?		
9.	Name of your personal health care professional/clinic: ❑ None		
	Street Address:		
	City, State, Zip:		

SECTION III – Term Plan Selection

[❑ 15 Year Level] [❑ 20 Year Level] [❑ 30 Year Level]

Premium Frequency: ❑ Annually ❑ Semi-Annually ❑ Quarterly ❑ Monthly **Modal Premium**

(There is an additional charge for the convenience of paying more frequently than annually.)

Face Amount $ _____ $ _____

Dividend Option ❑ Paid in Cash ❑ Reduce Premiums

Riders, if eligible:

❑ **Waiver of Premium Benefit in Event of Total Disability** $ _____

❑ **Terminal Illness Options Accelerated Benefit** $ No Charge

There is no separate premium charge to add this rider to this policy. The portion of the death benefit that is accelerated will be discounted and an administrative expense charge of up to $250 may be deducted from the accelerated death benefit. Receipt of accelerated benefits may affect eligibility for public assistance programs and may be taxable.

❑ **Dependent Children's Insurance Benefit**

Face Amount (Maximum $10,000) $ _____ $ _____

If application is for a Dependent Child under age 15, please indicate the total life insurance in force and applied for with all companies on Applicant $_____ **and complete the following chart:**

Child's Name (First, Middle Initial, Last)	Sex	Date of Birth	Social Security Number	Home Address & Primary Phone Number (Street, Apt. No., City, State, Zip Code)	Relationship to Insured	Total Life Insurance Now In Force and Applied For

Total Initial Premium Amount $ _____

SECTION IV – Beneficiary Information

Beneficiary's Name (First, Middle Initial , Last)	Sex	Date of Birth	Social Security Number	Home Address & Primary Phone Number (Street, Apt. No., City, State, Zip Code)	Relationship to Insured	% of Proceeds	Type
							❑ Primary ❑ Contingent
							❑ Primary ❑ Contingent
							❑ Primary ❑ Contingent
							❑ Primary ❑ Contingent

SECTION V – Protection Against Unintended Termination

Do you wish to designate another person to receive copies of any premium or lapse notices sent to you? ❑ Yes ❑ No

If "Yes," please provide the following:

Designee's Name (First, Middle Initial, Last)	Home Address (Street, Apt. No., City, State, Zip Code)

SECTION VI – Acknowledgement

I REPRESENT that all statements and answers given on this Application are full, complete and true to the best of my knowledge and belief. I agree that the answers given in this Application will be the basis of any insurance policy issued on this Application (the 'Policy') and will be attached to and made part of the Policy.

I represent that I have read or had read to me the Application. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed at _____ Date _____
(City, State, Zip)

_____
Signature of Proposed Insured/Applicant/Owner

SECTION VII– Licensed Agent Certification

I certify that I personally solicited this application and that each question was asked exactly as written and that the statements and answers provided in this Individual Term Life Insurance Application have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief.

To the best of your knowledge does this insurance replace any existing insurance or annuities in any company? ❑ Yes ❑ No

The replacement notice (if applicable) was provided to the Proposed Insured/Applicant/Owner.

_____ _____
Licensed Agent's Signature Print Agent's Name

Licensed Agent Code Number: _____ Date: _____