Lincoln Life & Annuity Company of New York

[Group Insurance Service Office: 8801 Indian Hills Drive
Omaha, Nebraska 68114-4066]

Office Use Only ID# ______

APPLICATION FOR GROUP INSURANCE

is hereby made to LINCOLN LIFE & ANNUITY COMPANY OF NEW YORK (the Company).

A. NAME AND ADDRESS

1. **Applicant's Full Legal Name** (exactly as to be shown in Group Policy): ______

2. **Main Office Address** (physical location and group situs state):

Street ______ City ______ State ______

Zip ______ Phone # ______ FAX # ______ E-Mail Address (if available) ______

B. REQUESTED COVERAGES

The following Group Insurance is applied for as specified in the sold case proposal(s). Complete the requested Effective Date for each coverage.

- ☐ Life & AD&D with Effective Date ______
- ☐ Long Term Disability with Effective Date ______
- ☐ Short Term Disability with Effective Date ______
- ☐ Dental with Effective Date ______
- ☐ Voluntary Life with Effective Date ______
- ☐ Voluntary Life & AD&D with Effective Date ______
- ☐ Voluntary Long Term Disability with Effective Date ______
- ☐ Voluntary Dental with Effective Date ______

C. BUSINESS INFORMATION

1. **Nature of Business** (Please specify): ______

Years in Business ______ Federal Tax ID# ______

2. **Business is Organized As** (select one):

☐ Corporation ☐ Non-Profit Organization
☐ Partnership ☐ Proprietorship ☐ Other ______

3. **Financial Risk** (If Yes to any part, please explain below.)

☐ Yes ☐ No Has Applicant ever filed for bankruptcy?
☐ Yes ☐ No Does Applicant anticipate ceasing or materially reducing active business operations?
☐ Yes ☐ No Has Applicant opted out (or do they anticipate opting out) of Workers' Compensation?

Explanation: ______

4. **Binder** payment submitted: Amount $ ______ (if applicable)

D. REPLACEMENT COVERAGE

☐ Yes ☐ No Will all or part of this coverage **replace** any similar coverage? **If Yes, provide details of the prior plan below and enclose a copy of each inforce contract to be replaced.**

Coverage Type	Prior Carrier Name	Prior Plan Effective Date	Termination Date

E. IMPORTANT NOTICES

ACCIDENT & HEALTH INSURANCE FRAUD. Any person who knowingly and with intent to defraud any insurance company or other person:

(a) files an application for insurance or a statement of claim containing any materially false information; or

(b) conceals, for the purpose of misleading, information concerning any material fact thereto;

commits a fraudulent insurance act, which is a crime. Such person shall also be subject to a civil penalty not to exceed $5000 and the stated value of the claim for each such violation.

ACCELERATED DEATH BENEFIT INFORMATION. This benefit is included with Employee Life insurance, at no additional premium charge. Receipt of Accelerated Death Benefits may affect eligibility for public assistance programs and may be taxable. For this reason, Employees should consult their personal tax advisors before claiming this benefit.

F. AGREEMENT. The Applicant hereby applies for group insurance. The information in this Application is true and correct to the best of the Applicant's knowledge and belief. It forms the basis for this request for group insurance. Omission or misstatement of known information on this Application could affect the validity of any insurance issued and cause the denial of an otherwise valid claim. The Applicant understands that the requested group insurance will:

(a) be issued only if the requested insurance is acceptable to Lincoln Life & Annuity Company of New York (the Company) and is legally permissible;
(b) be issued under a group Policy or Policies in the language customarily used by the Company;
(c) be subject to the Company's usual underwriting requirements (including Evidence of Insurability, if applicable);
(d) be subject to all exclusions, limitations and other provisions of the Policy; and
(e) take effect on the date determined by the Company, in accord with the provisions of the Policy.

The Applicant understands that no agent or broker has the authority to guarantee the acceptability of the requested insurance. The effective date of insurance for which an employee is required to submit satisfactory Evidence of Insurability will be determined in accord with the Policy's terms, and will be subject to the Active Work requirement. The Applicant agrees not to:

(a) collect or pay premiums (other than the Binder Premium, if any) for such insurance, before receiving the Company's notice of approval; or
(b) distribute material describing Policy coverage to persons to be insured, without the Company's prior written consent.

If dental insurance is requested, the Applicant agrees to provide employees and dependents notice of any applicable continuation rights, required by federal COBRA law or any similar state continuation law.

Premium rate quotes were based on data submitted to the Company. Final premium rates will be determined by the actual composition of the group. This application and the Binder payment, if any, constitutes the consideration for any Policy issued. After receipt of the Policy, payment of the premium is deemed acceptance of the Policy's terms. If this Application is approved, it will be made a part of any Policy issued.

Writing Agent
Or Broker's Signature______________________________

Typed or Printed Name______________________________

License Number____________________ State________

Signed by Applicant's Authorized Representative:

Signature______________________________

Typed or Printed Name______________________________

Title______________________________

State Signed______________ Date______________

Must be signed prior to Effective Date