Enrollment/Change Form

Basic Life and Basic AD&D Insurance, Supplemental Life and Supplemental AD&D Insurance,
Short Term Disability Insurance, and Long Term Disability Insurance provided by:

UNIMERICA LIFE INSURANCE COMPANY OF NEW YORK
One Penn Plaza - 8th Floor
New York, NY 10119-0899

NEW YORK STATE FRAUD WARNING NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

TO BE COMPLETED BY EMPLOYER

Employer Name:		Policy Number:
Employer Authorization:	Date of Hire: ___/___/___	Class:
	Plan Variation/Reporting Code:	Plan:
Requested Effective Date of Coverage / Date of Change: ___/___/___		☐ Enroll ☐ Cancel ☐ Change

Reason: (Check the Appropriate Boxes)	☐ New Group Plan	☐ New Hire	☐ Annual Open Enrollment	☐ Address Change
	☐ Name Change	☐ Employee Terminated	☐ Marriage	☐ Birth
	☐ Divorce	☐ Court Ordered Dependent	☐ Death	☐ Other:
	☐ Adoption/Legal Custody	☐ Cobra/State Continuation	Start Date ___/___/___	End Date ___/___/___

EMPLOYEE INFORMATION

SS# ____________-________-________________	Employer Assigned ID# ___________		Date of Birth: _____/_____/___________
Last Name:	First Name:		Middle Initial:
Address:	City:	State:	Zip Code:
Home Phone:	Work Phone:	Email Address:	Annual Salary: $
Sex: ☐ Male ☐ Female	Marital Status: ☐ Single ☐ Married ☐ Domestic Partner *		
Number of hours worked per week: _______________			
Employee Type (Check all that apply): ☐ Active ☐ Hourly ☐ Salary ☐ Union ☐ Non-union ☐ Retired ☐ Other			

FAMILY INFORMATION

Dependents to be enrolled, cancelled, changed: (Attach additional sheet if necessary)

Check Appropriate Box	First Name MI Last Name (if different) / Dependent Social Security Number or Assigned ID	Date of Birth	Sex	Relationship**	Incapacitated***
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	☐ Spouse ☐ Domestic Partner*	Not Applicable
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No
☐ Enroll ☐ Change ☐ Cancel	SS# ___ ___ ___ - ___ ___ - ___ ___ ___ ___	____/____/_____	☐ M ☐ F	Dependent	☐Yes ☐No

*Domestic Partner coverage is determined by state law or as determined by your employer. Please contact your employer for confirmation.

**For court ordered Dependent(s), legal documentation must be attached. Please see an Employer representative for more information about the qualifications for full-time student status. If Dependent(s) does not reside with enrollee, please provide address on separate sheet.

*** Dependent is unmarried, financially dependent upon subscriber/covered person and incapable of earning a living because of mental illness, developmental disability, or mental retardation. If answered "Yes" for Incapacitated, please attach medical certification of disability.

BENEFIT ELECTIONS				
Person	Basic Life	Basic AD&D	Supplemental Life	Supplemental AD&D
Employee Spouse (or Domestic Partner) Dependent	☐ $_____ ☐ $_____ ☐ $_____ ☐ Waive (if applicable)	☐ $_____ ☐ Waive (if applicable)	☐$_____ ☐$_____ ☐$_____ ☐ Waive Have you used tobacco of any kind in the past 12 months? Employee? ☐Yes ☐No Spouse? ☐Yes ☐No	☐ $_____ ☐ $_____ ☐ $_____ ☐ Waive
Person	Short Term Disability		Long Term Disability	
Employee Spouse (or Domestic Partner) Dependent	☐_____ ☐ Buy-up ☐ Waive (if applicable)		☐_____ ☐ Buy-up ☐ Waive (if applicable)	

BENEFICIARY(IES)*	Beneficiary(ies) to be designated at time of Enrollment.							
Product	Full Name		%	Address	City	State	Zip Code	Relationship
Life & AD&D	Primary							
	Secondary/ Contingent							

* Do not use to change a previously designated Beneficiary. For changes, use the Beneficiary Designation form available from the Employer.

AUTHORIZATION AND ACKNOWLEDGEMENT	Form must be signed

I hereby declare that all the statements made above are, to the best of my knowledge and belief, true and complete and that they are the basis on which insurance requested by me may be issued.

All statements made by me are: representations; and, not warranties. No statement made by me will be used to: contest the insurance provided by the Policy, unless, it is contained in a written statement signed by me; and, a copy of the statement is furnished to me or my beneficiary.

I understand that by signing this form I am authorizing the necessary premium deductions from my salary or wages for the coverage(s) I have selected. I acknowledge that I have read the applicable Fraud Warning Notices provided below.

NEW YORK STATE FRAUD WARNING NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Employee/Enrollee Signature:	Date: