



COMMERCIAL TRAVELERS  
MUTUAL INSURANCE COMPANY  
MONITOR LIFE INSURANCE  
COMPANY OF NEW YORK  
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.

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 <input type="checkbox"/> Sole Proprietorship <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation (profit) <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
8. DO THE EMPLOYEES OF THE EMPLOYER HAVE WORKERS' COMPENSATION COVERAGE? <input type="checkbox"/> YES <input type="checkbox"/> 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? <input type="checkbox"/> YES <input type="checkbox"/> NO
9. TOTAL NUMBER OF FULL-TIME EMPLOYEES ON PAYROLL OF EMPLOYER _____ ARE ALL FULL-TIME EMPLOYEES ON THE PAYROLL OF THE EMPLOYER ELIGIBLE FOR INSURANCE? <input type="checkbox"/> YES <input type="checkbox"/> NO. IF "NO," STATE HERE THE CLASS OR CLASSES EXCLUDED, AND THE NUMBER OF EMPLOYEES IN EACH SUCH EXCLUDED CLASS. (Employees working less than 30 hours per week for the Employer cannot be insured.)	
10. DEFINITION OF ELIGIBLE EMPLOYEES	
11. NEW EMPLOYEES MUST BE IN CONTINUOUS SERVICE _____ <input type="checkbox"/> DAYS <input type="checkbox"/> MONTHS BEFORE THEY BECOME ELIGIBLE FOR INSURANCE. DOES THIS PROBATIONARY PERIOD APPLY TO EMPLOYEES IN SERVICE ON THE EFFECTIVE DATE OF THE CONTRACT? <input type="checkbox"/> YES <input type="checkbox"/> NO	
12. DOES THE EMPLOYER CURRENTLY HAVE, OR WITHIN THE LAST 2 YEARS HAD, SIMILAR GROUP INSURANCE ON THEIR EMPLOYEES? <input type="checkbox"/> YES <input type="checkbox"/> 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 <input type="checkbox"/> Life Insurance <input type="checkbox"/> AD&D <input type="checkbox"/> Disability <input type="checkbox"/> With Maternity <input type="checkbox"/> 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 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 monthly 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? <input type="checkbox"/> YES <input type="checkbox"/> NO	
DATED AT	NAME OF EMPLOYER
This _____ day of _____ 20____	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: \_\_\_\_\_ Plan Administrator Name & Address \_\_\_\_\_

Billing Mode:  Quarterly  Monthly

IRS Employer Identification No. \_\_\_\_\_ (IRS assigned) \_\_\_\_\_

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

Policyholder Phone No. \_\_\_\_\_ - \_\_\_\_\_

**BROKER DATA**

FULL NAME (Please Print) \_\_\_\_\_ SS # \_\_\_\_\_

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

ADDRESS \_\_\_\_\_

BUSINESS PHONE \_\_\_\_\_ AREA CODE \_\_\_\_\_  
 ( ) \_\_\_\_\_

Are you currently 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
_____	_____
_____	_____
_____	_____