

A Vision Care Proposal

through



Why vision care?

Two thirds of employees say they would trade a vacation day for eye care benefits.¹

72 percent of employees joined their current employer because of workplace benefits. 83 percent stay for the benefits.²

Vision problems are the second most prevalent health problem in the country, affecting more than 120 million people.³

Nearly 90 percent of those who use a computer at least three hours a day suffer vision problems associated with computer eyestrain.³

Eyestrain is the number one office-related complaint.³

Uncorrected vision can decrease employee performance by as much as 20 percent.³

Vision disorders account for over \$8 billion annually in sick days, lost productivity and medical bills.³

Employers gain as much as \$7 for every \$1 they spend on vision coverage.³

Why Davis Vision?

Value for the member... *you'll see it in their eyes*

Our plans are designed to reduce or eliminate out-of-pocket cost. With complete freedom to choose any frame they desire, over 75% of our members still choose a Davis Vision Collection frame.

Value for the client... *healthy eyes = healthy lives*

Our rates are among the most competitive industry-wide for total flexibility in plan design, funding options and network composition. No wonder more than 97% of our clients renew their plan with us.

Service for all... *100% satisfaction!*

We do what we say we're going to do... guaranteed! Our goal is 100% satisfaction for clients and for members.

Quality you can see... *caring you can feel*

We promise quality: in our work, materials, service and network. We have managed vision care's only ISO 9001:2008 certified laboratories with COLTS prescription and FDA conformance certifications, as well as NCQA certification for our provider credentialing process.

Community service... *more than just a vision plan*

We serve our communities with dedication and care, providing vision services, food, clothing, toys and emergency provisions when needed most.

¹ Source: Best's Review, 2006

² 2007 MetLife Survey, Source: MCOm, Issue 1, 2008, page 4

³ Vision Council of America, Source: Vision in Business 2007

Proposed Benefits through Lifetime Benefit Solutions, Inc.

IN-NETWORK BENEFITS	PLAN DESIGN OPTIONS								
	Low Plan		Medium Plans				High Plan		
Frequency – Once Every:	Option I: Fashion Value		Option II: Designer		Option III: Designer Gold		Option IV:		
Eye Health Examination inclusive of Dilation <i>(when professionally indicated)</i>	12 Mo.	24 Mo.	12 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.
Spectacle Lenses	12 Mo.	24 Mo.	12 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.
Frame	24 Mo.	24 Mo.	12 Mo.	24 Mo.	24 Mo.	24 Mo.	24 Mo.	24 Mo.	24 Mo.
Contact Lens Evaluation, Fitting & Follow-Up Care	12 Mo.	24 Mo.	12 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.
Contact Lenses (in lieu of eyeglasses)	12 Mo.	24 Mo.	12 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.	12 Mo.	24 Mo.
Copayments									
Eye Health Examination	\$10		\$10		\$10		\$10		
Eyeglasses (Frame and/or Spectacle Lenses)	\$25		\$25		\$25		\$25		
Contact Lens Evaluation, Fitting & Follow-Up Care	N/A		\$25 ^{1/}		\$25		\$25		
Eyeglasses - Frame Benefit									
Non-Collection Frame Allowance (Retail):	Up to \$100		Up to \$130		Up to \$130		Up to \$150		
Davis Vision Frame Collection^{2/} (in lieu of Allowance):									
Fashion level	Included		Included		Included		Included		
Designer level	\$15 copayment		Included		Included		Included		
Premier level	\$40 copayment		\$25 copayment		\$25 copayment		Included		
Eyeglasses - Spectacle Lenses Benefit									
Member Charges									
All ranges of prescriptions and sizes	Included		Included		Included		Included		
Choice of glass or plastic lenses	Included		Included		Included		Included		
Oversize Lenses	Included		Included		Included		Included		
Fashion and gradient tinting of plastic lenses	\$15		Included		Included		Included		
Scratch-Resistant Coating	Included		Included		Included		Included		
Polycarbonate Lenses (Children ^{3/} / Adults)	\$0 or \$35		\$0 or \$30		Included		Included		
Ultraviolet Coating	\$15		\$12		Included		Included		
Anti-Reflective Coating (Standard/Premium/Ultra)	\$40/\$55/\$69		\$35/\$48/\$60		\$35/\$48/\$60		\$35/\$48/\$60		
Progressive Lenses (Standard/Premium/Ultra)	\$65/\$105/\$140		\$50/\$90/\$140		Included/\$40/\$90		Included/\$40/\$90		
Intermediate-Vision Lenses	\$30		\$30		Included		Included		
Blended-Segment Lenses	\$20		\$20		Included		Included		
High-Index Lenses	\$60		\$55		\$55		\$55		
Polarized Lenses	\$75		\$75		\$75		\$75		
Photochromic Glass Lenses	\$20		\$20		Included		Included		
Plastic Photosensitive Lenses	\$70		\$65		\$65		\$65		
Scratch Protection Plan: Single Vision Lenses Multifocal	\$20 \$40		\$20 \$40		\$20 \$40		\$20 \$40		
Contact Lens Benefit (in lieu of eyeglasses)									
Non-Collection Contact Lenses: Materials Allowance	Up to \$100		Up to \$130		Up to \$130		Up to \$150		
- Evaluation, Fitting & Follow-Up Care – Standard	15% Discount		15% Discount		Included		Included		
- Evaluation, Fitting & Follow-Up Care – Specialty Lens Types	15% Discount		15% Discount		Up to \$60 allowance Plus a 15% discount on any overage		Up to \$60 allowance Plus a 15% discount on any overage		
Collection Contact Lenses^{2/} (in lieu of Allowance): - Materials, Evaluation, Fitting & Follow-up Care	N/A		up to 4 boxes		up to 8 boxes		up to 8 boxes		
Medically Necessary Contact Lenses (with prior approval) - Materials, Evaluation, Fitting & Follow-Up Care	Included		Included		Included		Included		

OUT-OF-NETWORK REIMBURSEMENT SCHEDULE

Eye Examination: up to \$30	Single Vision Lenses: up to \$25	Trifocal Lenses: up to \$45	Elective Contact Lenses: up to \$75
Frame: up to \$30	Bifocal Lenses: up to \$35	Lenticular Lenses: up to \$60	Medically Necessary CL: up to \$225

^{1/} Copayment applies to Collection Contact Lenses only.

^{2/} Collection is available at most participating independent provider offices. Collection is subject to change.

^{3/} Polycarbonate lenses are covered in full for dependent children, monocular patients and patients with prescriptions +/- 6.00 diopters or greater.

One-year eyeglass breakage warranty included

Davis Vision Extras

In-Network: The choice is yours

Using the Davis Vision program couldn't be easier. Just select the network provider of your choice, identify yourself as a Davis Vision member, make an appointment, and leave the rest up to us.

Eye Health Examination

Members receive a comprehensive eye health examination, including dilation, when professionally indicated. After the copayment, the eye health examination is covered in full.

Frames

Davis Vision offers limitless choice:

- **Retail Allowance:** All frames are covered in full up to the plan-specified allowance, plus members receive a 20% discount off any overage that may apply.
- **Davis Vision Frame Collection:** In lieu of the frame allowance, members can select any frame from Davis Vision's exclusive Collection! The Collection features three levels of frames: Fashion, Designer and Premier, with retail values of \$125 - \$225. By selecting a Collection frame, member eyewear is often completely covered. In fact, approximately 7 out of 10 members take advantage of the tremendous savings by selecting a Davis Vision Collection frame.¹
 - **Option I:** All of the **Fashion** frames are fully covered! Any **Designer** level frame is only \$15 and any **Premier** level frame is \$40.
 - **Options II & III:** All of the **Fashion** and **Designer** frames are fully covered! Any **Premier** level frame is only \$25.
 - **Option IV:** All of the **Fashion**, **Designer** and **Premier** frames are fully covered!

Spectacle Lenses

Standard lenses are covered in full and many extras are included at no cost to our members. Plus, Davis Vision members can select many of the most popular lens options at greatly discounted prices, reflecting savings of up to 40% - 60% off as compared to average retail pricing.

Contact Lenses

Members who select contact lenses in lieu of eyeglasses are offered the same great choice:

Options I & II:

Elective Contact Lens Allowance: All contact lenses are covered in full up to the plan-specified allowance, plus members receive a 15% discount off any overage that may apply.

Options III & IV:

Contact Lens Evaluation, Fitting & Follow-Up Care Allowance: For Standard contact lenses, evaluation and fitting fees are covered in full. For Specialty contact lenses (including, but not limited to, toric, multifocal and gas permeable lenses), members receive \$60 toward their contact lens evaluation and fitting, plus a 15% discount off the balance over \$60.

Options II, III & IV:

Davis Vision Contact Lens Collection: In lieu of the allowance, members may be fit with contact lenses from our Collection, all of which are covered in full up to the plan-specified amount below and include evaluation, fitting and follow-up care.

<i>Disposable:</i>	Option II: Four boxes/multi-packs Options III & IV: Eight boxes/multi-packs
<i>Planned Replacement:</i>	Two boxes/multi-packs

Out-of-Network

Members may visit any provider of their choice. If an out-of-network provider is selected, the member pays the provider fees for services and materials at the point of service and then is reimbursed according to the plan schedule outlined in the "Proposed Benefits" table.

¹ Participating retail providers typically do not display the Collection, but are contractually required to maintain a comparable selection (in both quantity and quality) of frames that would be covered in full, with no additional member out-of-pocket expense.

Davis Vision Extras

The Davis Vision program goes over and above to offer many value-added features at no extra cost!

One-Year Breakage Warranty

All eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery. The one-year breakage warranty applies to all plan covered eyeglasses (i.e. all spectacle lenses, Davis Vision Collection frames and national retailer frames, where our exclusive Frame Collection is not displayed).

Scratch-Protection Plan

Standard scratch-resistant coating is available for plastic lenses free of charge. Members may also purchase an optional scratch-protection plan which will replace scratched lenses with new lenses of the same material, style and prescription, at no charge (for a period of one-year from the original date of dispensing).

Medically Necessary Contact Lenses Covered in Full Upon Prior Approval

When "medically necessary" contact lenses are prescribed and approved to correct a member's eyesight, Davis Vision will cover the cost in full. Contact lenses may be determined as medically necessary in the treatment of the following conditions: Keratoconus, Anisometropia, Corneal Disorders, Pathological Myopia, Aniseikonia, Post-traumatic Disorders, Aphakia, Aniridia and Irregular Astigmatism. In general, medically necessary contact lenses may be prescribed in lieu of eyeglasses, when it will result in significantly better visual acuity and/or improved binocular function, including avoidance of diplopia or suppression.

Replacement Contact Lens Program

Davis Vision's proprietary LENS123® mail order program offers the guaranteed lowest prices on contact lens replacements. Members simply call 1-800-LENS 123 or visit www.lens123.com with their current prescription.

Ancillary Product Discount

At most participating network offices, members will receive a 20% courtesy discount on items not covered by the benefit, e.g., second pairs, sunglasses, etc. Disposable contact lenses are available at a 10% discount.

Laser Vision Correction Discounts

Davis Vision members are entitled to savings of up to 25% off the provider's usual and customary fees, or a 5% discount on any advertised special through our network of physicians and refractive surgery centers (some centers provide a flat fee equating to these discount levels).

Low Vision

With prior approval by Davis Vision, members who require low-vision services and optical devices are entitled to the following coverages. Both in- and out-of-network services are eligible for:

- One comprehensive Low-Vision evaluation every five years, with a maximum charge of \$300. This examination, sometimes called a functional vision assessment, can determine distance and clarity of vision, the size of readable print, the existence of blind spots or tunnel vision, depth perception, eye-hand coordination, problems perceiving contrast and lighting requirements for optimum vision.
- Maximum Low-Vision Aid allowance of \$600 with a lifetime maximum of \$1,200 for items such as high power spectacles, magnifiers and telescopes. These devices are utilized to maximize use of available vision, reduce problems of glare or increase contrast perception, based on the individual's visual goals and lifestyle needs.
- Follow-up care: four visits in any five-year period, with a maximum charge of \$100 for each visit.



SEE LIFE

Underwritten by

HM Life Insurance Company of New York

EBS RMSCO Inc.

New Business Vision Transmittal Form

PRIMARY CONTACT INFORMATION			
Name (Last, First, M.I.)		Telephone Number	Fax Number
E-mail Address		Company Name	
Address		City	State Zip Code
Number of Eligible Employees	Number of Enrolled Employees	Is this coverage included in a Flex/Cafeteria Plan? <input type="checkbox"/> Yes <input type="checkbox"/> No	

BENEFIT DATA (Refer to Benefits and Costs page in Proposal. Use REMARKS section for additional comments.)		
Plan Funding	Benefit Plan	Frequency (Exam/Lenses/Frame)
Rate Guarantee	Rate Region	Effective Date

BILLING ADMINISTRATION			
Main Contact Name (Last, First, M.I.)		Telephone Number	Fax Number
E-mail Address		Company Name	
Address		City	State Zip Code

PRODUCER INFORMATION			
License Number	Commission Payable to: <input type="checkbox"/> Agency (Agency TIN Number: _____) <input type="checkbox"/> Producer Social Security Number _____		
Agency Name			
Producer Name			
Address		City	State Zip Code
E-mail Address			
Telephone Number		Fax Number	
Split with another producer:	<input type="checkbox"/> No <input type="checkbox"/> Yes (If Yes, please note in remarks section)		
If an Agency is receiving commissions, the individual producer signing the group application must also be appointed in the state of sale. Attach a copy of your producer license from the state of sale, if not previously appointed by us.			

VISION ELIGIBILITY REQUIREMENTS			
Main Contact Name (Last, First, M.I.)		Telephone Number	Fax Number
E-mail Address		Company Name	
Address		City	State Zip Code
<input type="checkbox"/> All active employees working 30 hours or more per week			
Retirees Eligible:	<input type="checkbox"/> Yes	<input type="checkbox"/> No	

Spouse Eligible:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Minor Dependents Eligible:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	(to age 19) or _____
Domestic Partners Eligible:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Student Dependents Eligible:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	(to age 23) or _____
Eligibility Waiting Period for Current and Future Employees:	<input type="checkbox"/>	No Waiting Period	<input type="checkbox"/>	Other	_____
Benefit ending upon termination: <input type="checkbox"/> Immediately <input type="checkbox"/> End of the month					
Continuation due to layoff, Leave of Absence, or Disability: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "yes" and other than 3 months for layoff, 6 months for Leave of Absence or 12 months for Disability, please describe: _____					
Enrollment limitation for late enrollees applies: <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other _____					
If "yes," <input type="checkbox"/> First day of the following month <input type="checkbox"/> 90 Days <input type="checkbox"/> Other (please describe): _____					
Open enrollment applies: <input type="checkbox"/> Yes <input type="checkbox"/> No					
If "yes," Dates of open enrollment period: _____ Date benefits become effective following open enrollment: _____					

REMARKS

REQUIREMENTS

- Groups must have a minimum of 2 enrolled employees.
- Employer-funded rates require a minimum of 75% employer contribution; all other plans are voluntary.
- Enrollment Forms should be forwarded to: EBS RMSCO
- New hire mailings will be facilitated directly to member homes including a Personalized Provider List, ID Card and Summary Benefit Brochure.
- Groups will be responsible for the accuracy of their eligibility and the files submitted and any COBRA lives will be included in active population.

FOR HOME OFFICE USE ONLY

Commissions: 10% level	Other:				
Special Client Agreement:	<input type="checkbox"/>	Yes	<input type="checkbox"/>	No	
Policy Number _____ (assigned by home office)					
Rates & Tier Type:					
Two Tier	Three Tier			Four Tier	
Employee Only	Employee Only			Employee Only	
Employee + Family	Employee + One			Employee + Spouse	
	Employee + Family			Employee + Child(ren)	
				Employee + Family	



Vision Care Proposal Signature Page

Acceptance of our Vision Care Proposal through Davis Vision requires completion and return of this Signature Page by an authorized representative of the Plan and includes the following:

- 1) Group Name:
2) Billing Address:
3) Tax ID #:
4) Main Contact:
5) Telephone Fax
6) Email:
7) Vision Plan Effective Date: NOTE: Davis Vision offers a defined benefit plan with the plan year beginning on the effective date for the duration of the benefit period selected...
8) Option(s) Selected: Plan Name

Circle one: Fashion Value Designer Designer Gold Premier Platinum

Circle one: 12/12/24 12/12/12 24/24/24

Circle one: Fully insured ASO(Fee for Service)/Self-Funded

Circle one: Employer Funded Voluntary

Circle one: Two Tier Three Tier Four Tier

Indicate rates selected: Two Tier \$ Three Tier \$ Four Tier \$

- 9) Eligibility data format (please circle): Paper Applications Electronic File

Note: Minimum of 2 participants required Number of Eligible Employees

- 10) Eligible Employees - circle all that apply: Active Retiree Disabled COBRA

- 11) Plan Participation (when do benefits begin)

- 12) Benefits Cease (when do benefits end)

- 13) Broker Name:

- 14) Broker Phone Number:

- 15) Sales Representative:

- 16) Sales Representative Phone Number:

Please forward all completed materials to:

Patricia Pritchard
Implementation Specialist
Lifetime Benefit Solutions
115 Continuum Drive
Liverpool, NY 13088
Email: Patricia.Pritchard@lifetimebenefitsolutions.com

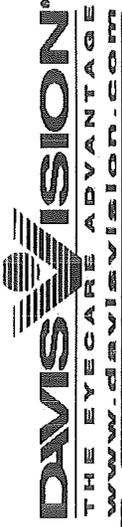
Authorized Representative's Signature:

Date Signed: Title:

Please be advised that EBS-RMSCO, Inc. may be compensated for the services provided to you, our customer, in the form of commission. EBS-RMSCO has agreements with certain carriers whereby we receive a commission and/or a "contingency payment", which rewards EBS-RMSCO for achieving pre-set benchmarks such as profitability goals, volume levels, and/or growth targets. It is important to note that these arrangements in no way influence our analysis of carriers in providing you with the best coverage option(s) available to you. We represent you, our customer. Additional information as to participating carriers may be provided upon request.

Davis Vision Enrollment Application

Employee (Member) Information (Please Print)



Employer/Group Name _____

Reason for Application:
 Addition
 Change
 Reinstatement
 COBRA
 Termination

Employee (Member) First Name/Middle Initial/Last Name _____

Mailing Address _____ City _____ State _____ Zip Code _____

Employee (Member) Identification Number _____

Effective Date: Month _____ Day _____ Year _____

Employee Status:
 Active
 Hourly
 Salary
 Retired (Date) _____

Employee Hire Date: Month _____ Day _____ Year _____

Employee Phone Number _____

To be completed by Account Administrator or Human Resources representative only:
 Group Number _____
 Payroll Code _____
 Branch Code _____

Check Type of Coverage:
 Employee Only
 Employee and Spouse or Domestic Partner
 Family
 Employee and Child
 Employee and Children

Please indicate the change(s) that you need to make to your record:

Change of Name
 Change of Address
 Change of Phone
 Change Birthdate
 Change Effective Date
 Change Report Code
 Change Enrollment Status to:
 Employee and Spouse/Domestic Partner
 Employee Only
 Employee and Child
 Employee/Children

Complete (if applicable)	First Name/Middle Initial/Last Name	Social Security Number	Change	Effective Date of Change			Sex	Check if			Birth Date*	
				MM	DD	YY		F/M	Student Over 19	Disabled	MM	DD
<input type="checkbox"/> Self			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Spouse <input type="checkbox"/> Dom. Part.			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			
<input type="checkbox"/> Child <input type="checkbox"/> Other			<input type="checkbox"/> Add <input type="checkbox"/> Term					<input type="checkbox"/>	<input type="checkbox"/>			

"I certify that this enrollment information is true and correct."
 * Required for all members/dependents

_____ Date _____
 _____ Type Name Of Member/Employee Completing Form

**HM LIFE INSURANCE COMPANY OF NEW YORK
APPLICATION FOR GROUP INSURANCE
REQUIREMENTS FOR NEW YORK**

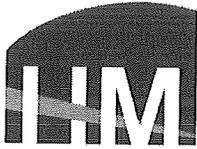
HM Life Insurance Company of New York's (HM) (formerly known as Highmark Life Insurance Company of New York) group insurance application policy requires all groups to **complete and forward the following documents** in order to receive the applicable insurance coverage through HM within their state of domicile.

_____ **HM APPLICATION FOR INSURANCE FORM** (sign and return with original signature of an authorized representative, witness and resident agent, where required).

_____ A copy of the collective bargaining agreement if union members are to be covered by the group insurance requested.

* **Please Note:** Do not attach a check for the premium deposit of an estimated 1st month's premium. It is not a requirement of either HM or Davis Vision, Inc.

**Please return the completed application and necessary attachments
AT LEAST 30 DAYS PRIOR TO EFFECTIVE DATE
in order to ensure timely policy generation.**



LIFE INSURANCE
COMPANY OF
NEW YORK

Administrative Offices*
[P.O. Box 535061
Pittsburgh, PA 15253-5061]
Home Office
[420 Fifth Avenue, Third Floor
New York, NY 10018]
1-800-833-1115
www.hminsurancegroup.com
* Note – please direct all correspondence to
the Administrative Office

APPLICATION FOR GROUP INSURANCE

INSTRUCTIONS

This application must be accompanied by the Coverage Transmittal form, Disclosure Statement and the proposal for coverage requested. Every entry on this form should be completed to avoid delay in processing your request. If an informational block does not apply or information is not available, please indicate "none" in the space provided. If a form is incomplete, it may be returned. Please read the Fraud Notice, which only applies to health and accident insurance, and when finished, sign and date the form, make a copy for your records and send the original to HM Life Insurance Company of New York. **Please print in blue or black ink.**

APPLICANT INFORMATION

Full Legal Name of Group (to appear on Policy)

Tax ID Number

Telephone Number

Fax Number

Address

City

State

Zip Code

Delivery Address (if different than above)

City

State

Zip Code

Nature of Business

SIC Code

Corporation

Partnership

Government

Other:

Affiliates to be insured? Yes* No "If "yes," complete the table below, attaching additional sheets if necessary.

AFFILIATE #1

Full Legal Name

Nature of Business

Address

City

State

Zip Code

AFFILIATE #2

Full Legal Name

Nature of Business

Address

City

State

Zip Code

AFFILIATE #3

Full Legal Name

Nature of Business

Address

City

State

Zip Code

COVERAGE REQUESTED

Life and AD&D

Dependents Life

Additional Life and AD&D

Life Only

Dependents Life

Additional Life

Short Term Disability

Long Term Disability

Vision

Stop Loss

Aggregate

Specific

Other: _____

Voluntary Products

Life and AD&D

Spouse Life and AD&D

Child Life

Life Only

Spouse Life

Short Term Disability

Spouse Life

Child Life

Requested Effective Date

Number of Eligible Employees

Will the requested insurance replace existing insurance? Yes No

Premium Deposit of \$ _____ included. Estimated 1st month's premium must be attached to this application, except for Voluntary and Small Business Plan products. The Premium Deposit will be applied to the first premium when due. Make check payable to **HM Life Insurance Company of New York**. Do not make the check payable to the agent or leave the "Payee" blank. If a policy is not issued, the premium deposit will be refunded in full.

Administrative Office: [P.O. Box 535061, Suite P6518 • Pittsburgh, PA 15253-5061] • (800) 833-1115

Active Work Requirement (N/A for Stop Loss)

No employee will become insured unless the employee satisfies an Active Work Requirement on the scheduled Effective Date.

Will any employees be Disabled on the last day before the scheduled Effective Date? Yes* No

*If "yes," list the following information on a separate piece of paper and attach to this application:

- (1) Provide the information about each employee who is expected to be disabled on the last day before the scheduled Effective Date: Name; Sex; Date of Birth; Salary; Amount of Coverage; Diagnosis; Prognosis; Date Last Worked; Expected Date of Return.
- (2) List all employees who will not be actively at work on the scheduled Effective Date (other than Disabled employees listed based on above.)

Are there any Union Members being covered? Yes* No

*If "yes," a copy of the collective bargaining agreement is required with the submission of the application.

Remarks:

AGREEMENT

The insurance coverage requested and requested effective date must be approved by **HM Life Insurance Company of New York** under its current rules and practices, including Active Work, Evidence of Insurability and Pre-Existing Condition provisions. All options and special requests are subject to Underwriting approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage. All materials describing this coverage must be approved in writing by **HM Life Insurance Company of New York** prior to distribution. Note: Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until notified.

Premium rates and quotes were based on the data submitted to **HM Life Insurance Company of New York**. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

Applicants applying for accident and health insurance (please note: this Fraud Notice does not apply to application for life insurance):

Any person who knowingly and with intent to defraud or deceive any insurance company submits an insurance application or statement of claim containing any false, incomplete or misleading information may be subject to civil or criminal penalties, depending on state law.

I am aware that this form is to be attached to, and made a part of, the insurance policy.

I am also aware that, if my insurance coverage includes a Living Benefit, the receipt of accelerated death benefits may affect eligibility for public assistance programs and may be taxable.

I represent that the statements contained in this application are true and complete to the best of my knowledge and belief, and I understand that they form the basis for **HM Life Insurance Company of New York's** approval of the coverage requested.

Printed Name of Applicant's Authorized Representative

Signature of Applicant's Authorized Representative

Date

Title

Signature of Witness and/or Agent

Location (City, State)

Signature of Resident Agent, where required

Agent License Number

Printed Name of Resident Agent