HM LIFE INSURANCE COMPANY OF NEW YORK
HM INSURANCE GROUP

P.O. Box 535057
Pittsburgh, PA 15253-5057
Tel: 800-328-5433
Fax: 412-544-1246
hmig.com

HM Stop Loss
Application for Insurance

Please Type or Print – Must be completed in full.

APPLICANT INFORMATION

Full Legal Name of Group (*to appear on Policy*)		Key Contact Person		
Tax ID Number	Business Telephone Number		Fax Number	
Email		Internet		
Address	City	State	Zip Code + 4	County
Delivery Address (*if different than above*)		City	State	Zip Code + 4
Nature of Business	SIC Code **N/A**	☐ Corporation ☐ Partnership ☐ Government ☐ Other*: _____		

*If an Association, Trust or Charitable Organization, a copy of the bylaws and/or trust is required with the submission of the application. If a union, or if union employees are covered, a copy of the collective bargaining agreement is required with the submission of the application.

Affiliates to be insured? ☐ Yes* ☐ No *If "yes," complete the table below. Attach 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

THIRD PARTY ADMINISTRATOR *(Complete the table below for each administrator. Attach additional sheets if necessary.)*

Full Legal Name of Third Party Administrator (TPA)			
Tax ID Number	Business Telephone Number	Fax Number	
Address	City	State	Zip Code + 4
Delivery Address (*if different than above*)	City	State	Zip Code + 4
Key Contact Person	Email	Internet	

Applicant's Initials: _____

Are there prior TPAs? ☐ Yes* ☐ No *If "yes," insert the TPA name below. Attach additional sheets if necessary.	
Prior TPA	will be responsible for the payment of all run-in claims on the specific and aggregate (if applicable)
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PRODUCER (*Agent/Broker*)

Name			License Number(s) – *Please attach a copy, if not on file.*		
Tax ID Number	Business Telephone Number	Fax Number	Email	Internet	
Address		City	State	Zip Code + 4	
Requested Effective Date					
Estimated Initial Enrollment	Single:	Family:	Total:		

Premium Deposit of $_____ included. Estimated 1st month's premium must be attached to this application. 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.

FRAUD NOTICE *(Please read carefully)*

Applicants applying for accident and health insurance: 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.

APPLICANT UNDERSTANDS AND AGREES THAT

The stop loss insurance requested and requested effective date must be approved by **HM Life Insurance Company of New York** as under our current rules and practices. All options and special requests are subject to Home Office approval. No insurance agent or broker has authority to guarantee acceptability of requested insurance coverage.

Our approval is subject to receipt of Disclosure, if required, the first month's premium, final census, Claim Information, and any other information requested in connection with this application. Failure to do so will result in approval being denied or delayed until a later date.

Receipt of a premium and its deposit in connection with the Application shall not constitute an acceptance of liability. In the event that **HM Life Insurance Company of New York**, or our authorized agent, disapproves this Application, its sole obligation shall be to refund such sum to the Applicant.

Coverage will not be in effect until notified in writing by the Home Office. Do not cancel prior coverage until so notified.

Final premium rates will be determined on the basis of Disclosure, if required, Claim Information and the actual composition of persons covered by the underlying employee benefit plan on the requested effective date. Should subsequent information become known which, if known as of the date specified by **HM Life Insurance Company of New York**, or our authorized agent, would have affected the rates, deductibles, terms or conditions for coverage, we will have the right to revise the rates, deductibles, terms or conditions, by providing written notice to the Applicant. The Policy, if issued, may be void, if whether before or after a claim or loss, any material fact or circumstance was concealed or misrepresented on behalf of the Applicant, or if the Applicant or its Agent, committed fraud.

A signed and dated summary plan document describing the underlying employee medical plan must be submitted within [**60**] days of the Requested Effective Date. If the description of the benefits or plan provisions differs from what was initially utilized to underwrite the risk, the premium rates and aggregate retention factors may be subject to re-rating, retro-active to the requested effective date.

The stop loss insurance which is the subject of this Application is a reimbursement contract, and the Applicant must first pay claims and make funds available to pay claims as they become payable before submitting them for reimbursement. Oral statements not expressly incorporated herein are not part of this Application.

Issuance of the Policy is in reliance of the data, including Disclosure, census and Claim Information, submitted to us, and payment of the first month's premium; subsequent premiums are due no later than the first day of each calendar month during the Plan Year.

Applicant's Initials: _____

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 requested stop loss insurance.

PLEASE SAVE, PRINT, SIGN AND RETURN THE APPLICATION VIA MAIL, EMAIL OR FAX.

Printed Name of Applicant's Authorized Representative

Signature of Applicant's Authorized Representative | Date | Title

Signature of Witness (Licensed Producer) | Printed Name of Witness

Applicant's Initials: _____