HM LIFE INSURANCE COMPANY
HM INSURANCE GROUP

HM Life Insurance Company
P.O. Box 535050
Pittsburgh, PA 15230
Tel: 888-529-8983
Fax: 800-749-9826
hmig.com

Group Supplemental Insurance Application for Group Insurance

Please Type or Print – Must be completed in full. Indicate "N/A" or "none" if item does not apply.

Applicant

Full Legal Name of Group (to appear on Policy)			Tax ID Number
Key Contact Person	Business Telephone		Fax Number
E-mail	Internet Address		
Address	City	State	ZIP
Delivery Address (if different from above)	City	State	ZIP
Nature of Business			SIC Code

Type of Organization: ☐ Corporation ☐ Government ☐ Partner ☐ Franchise ☐ Association ☐ Other

List Classes of Employees to Be Covered:	Eligibility Waiting Period (new hires only):		
Are there any affiliates to be insured? ☐ Yes ☐ No If yes, list below; if additional space is needed, please attach a separate sheet.			
Full Legal Name of Affiliate	Nature of Business		
Address of Affiliate	City	State	ZIP

Coverage Requested

Coverage Type (Check all that apply)

☐ Critical Illness	☐ Employee	☐ Spouse*	☐ Child(ren)
☐ Hospital Indemnity	☐ Employee	☐ Spouse*	☐ Child(ren)
☐ Accident	☐ Employee	☐ Spouse*	☐ Child(ren)
☐ Term Life/AD&D	☐ Employee	☐ Spouse*	☐ Child(ren)
☐ Disability Income	☐ Employee		

Requested Effective Date: | Number of Eligible Employees:

Will the requested insurance replace existing insurance? ☐ Yes ☐ No

If "Yes," please check all that apply: ☐ Critical Illness ☐ Hospital Indemnity ☐ Accident ☐ Term Life/AD&D ☐ Disability Income

Is this a Section 125 plan? ☐ Yes ☐ No

Do you have employees in California, Hawaii, New Jersey, New York, Puerto Rico or Rhode Island? ☐ Yes ☐ No

If "Yes," please check all that apply: ☐ California ☐ Hawaii ☐ New Jersey ☐ New York ☐ Puerto Rico ☐ Rhode Island

** Spouse may include domestic partner*

Applicant Agrees That

The insurance coverage requested and requested effective date must be approved by HM Life Insurance Company under its current rules and practices including Active Service, Evidence of Insurability and Pre-existing Condition provisions. 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. All materials describing this coverage must be approved in writing by HM Life 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 quoted were based on the data submitted to HM Life. Final premium rates will be determined on the basis of the actual composition of the group of persons who become insured.

I understand at least 10 employees must be enrolled to issue the policy and once issued to keep the requested insurance coverage in force.

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's approval of the coverage requested.

Signature of Applicant's Authorized Representative

Date

Title

Print Name of Applicant's Authorized Representative

Signature of Witness and/or Agent

Location, City/State

Print Name of Witness and/or Agent

Agent License Number

This application must be accompanied by the Coverage Transmittal form and the proposal for the coverage requested.

Fraud Notice (*Please read carefully*)

For your protection **Arizona** law requires the following statement to appear on this form: "Any person who knowingly presents a false or fraudulent claim for payment of a loss is subject to criminal or civil penalties." Any person who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.