EVIDENCE OF INSURABILITY STATEMENT

Plan Sponsor Name/Address:
The Business Council of New York State, Inc. Insurance Fund
12 Corporate Woods Blvd. – Suite 17, Albany, NY 12211
Phn: 1-800-692-5483 X 313 Fax: 518-432-7033 Lynn.Smith@bcnys.org

Employer: _____Group #_____

Please note a Medical Information Packet will be sent directly to the applicant from Aetna

Employee Member: _____ SS#:_____
Address: _____
_____ Date of Hire: _____
_____
Phone: _____ Annual Salary: _____
Email: _____ Date of Birth:_____

Coverage(s) applied for:

LIFE:

◯ Employee Basic Life ◯ Employee Supplemental, Optional, Voluntary Life
◯ Spouse ◯ Child

	Employee Basic Life	Employee Supplemental, Optional/Voluntary	Spouse Date of Birth _____	Child
Current Amount:	$_____	$_____	$_____	$_____
Additional Amount:	$_____	$_____	$_____	$_____
Total Life Amount:	$_____	$_____	$_____	$_____
Guarantee Issue Amt:	$_____	$_____	$_____	$_____

Reason for Requested Coverage:

◯ Salary Increase ◯ Change in Multiple ◯ Late Applicant ◯ Change in Increments
◯ Life Event/Status Change ◯ Amount above the Guarantee Issue Limit ◯ Other

DISABILITY: (EMPLOYEE ONLY)

◯ SHORT TERM DISABILITY: CURRENT PERCENTAGE: _____% REQUESTED PERCENTAGE: _____%

◯ LONG TERM DISABILITY: CURRENT PERCENTAGE: _____% REQUESTED PERCENTAGE: _____%

Applicant Signature: _____ Date: _____

Employer Signature: _____ Date: _____

Updated 7/17