

**APPLICATION FOR
NEW YORK DISABILITY BENEFITS LAW POLICY**

The undersigned employer hereby applies for a policy of group insurance to provide Benefits in accordance with Section 204 of the New York Disability Benefits Law, to be issued in reliance on the statements made in this application. No insurance shall be binding unless and until this application is approved at the home office of the Company.

333 West 34th Street
New York, NY 10001-2402
Tel 800 535 2711
Fax 212 615 7395

1. Employer's Legal Name (The Policyholder)

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N.Y. Employer Registration (UI) No.

Address

* □□-□□□□□□□□

FEIN Employer Federal Tax ID No. (* REQUIRED FIELD)

Location Address
(If different)

2. Nature of Business/SIC#	4. Legal Status: <input type="checkbox"/> 01 - Individual <input type="checkbox"/> 03 - Corporation <input type="checkbox"/> 05 - Limited Partner <input type="checkbox"/> 10 - LLC <input type="checkbox"/> 12 - Executor/Trustee <input type="checkbox"/> 99 - Other:	<input type="checkbox"/> 02 - Partnership <input type="checkbox"/> 04 - Association <input type="checkbox"/> 06 - Joint Venture <input type="checkbox"/> 11 - Trust/Estate <input type="checkbox"/> 13 - LLP
3. Form of Organization <input type="checkbox"/> Profit <input type="checkbox"/> Non-Profit		

5. No. of NY Employees to be Insured

_____ Males

_____ Females

_____ TOTAL NUMBER

6. Premium Basis

LESS THAN 50 EMPLOYEES:

<input type="checkbox"/> Annual in Advance - (1- 49 employees)	MONTHLY PER CAPITA RATES
<input type="checkbox"/> Quarterly in Arrears (10+ employees)	\$1.60 Male \$4.75 Female
Partner•Sole Proprietor•LLC/LLPMember	\$2.90 Male \$6.35 Female
	\$9.50 Male \$9.50 Female

50 or MORE EMPLOYEES:

Quarterly in Arrears \$ _____ per employee per month

Other: \$ _____ per \$ _____ Weekly Insured Payroll

7. Billing Options

Individual bill for each entity

Combined/list bill for entities

8. Is business seasonal?

No Yes

9. Class(es) of Employees to be Insured

All Eligible under D.B. Law All except: _____

Only the following class(es): _____

Voluntary Coverage - Additional Class(es) of Employees to be Included (not included in box 5):

Partner/Sole Proprietor/Member # _____ [List name(s) in box 16] Teachers # _____ Clergy # _____

Out of State # _____ [List state(s) in Box 16]

10. Coverage/Benefits

Statutory DBL Benefits - 50% to \$170/wk

Enriched Benefits (requires Home Office approval. Plan Design:

11. Previous Carrier—Date of Termination

12. Are employee contributions deducted?

No (100% Taxable) Yes - Taxable Percent _____ % If known (1/2 of 1% of wages; but not more than \$.60 per week)

13. Effective Date of Coverage

14. General Agent

GA Code # _____

15. Agent or Broker Address

NBL Code # _____

Contact:

Phone:

Fax:

16. Additional entities, employers, partner/sole proprietor/member or states to be included. List below those employers affiliated with policyholder by financial interest or control, which are to be included as covered employers under the policy.

Name	Address	Employer UI No.	Federal Tax ID No. (REQUIRED)

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.

Signed at _____ this _____ day of _____, 20____

Employer/Agent _____ By _____ Title _____