NATIONAL BENEFIT LIFE INSURANCE COMPANY

STATE DISABILITY SPECIALISTS

A Citi Company

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)

☐☐–☐☐☐☐☐
N.Y. Employer Registration (UI) No.

Address

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

Location Address
(If different)

2. Nature of Business/SIC#

3. Form of Organization
☐ Profit ☐ Non-Profit

4. Legal Status:
☐ 01 – Individual ☐ 02 – Partnership
☐ 03 – Corporation ☐ 04 – Association
☐ 05 – Limited Partner ☐ 06 – Joint Venture
☐ 10 – LLC ☐ 11 – Trust/Estate
☐ 12 – Executor/Trustee ☐ 13 – LLP
☐ 99 – Other:

5. No. of NY Employees to be Insured

_____ **Males**

_____ **Females**

_____ **TOTAL NUMBER**

See Box 9 to include voluntary coverage for other classes of employees.

6. Premium Basis

LESS THAN 50 EMPLOYEES:

	MONTHLY PER CAPITA RATES	
☐ **Annual in Advance – (1– 49 employees)**	**$1.60 Male**	**$4.75 Female**
☐ **Quarterly in Arrears (10+ employees)**	**$2.90 Male**	**$6.35 Female**
Partner•Sole Proprietor•LLC/LLPMember	**$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 _____