NATIONAL BENEFIT LIFE INSURANCE COMPANY
STATE DISABILITY SPECIALISTS

APPLICATION FOR
NEW YORK DISABILITY BENEFITS LAW POLICY

One Court Square
Long Island City, NY 11120
Tel 800 535-2711
Fax 800 584-9370

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.

1. Employer (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)	$1.50 Male	$4.55 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. **Define:**

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. Do you have an NBL General Agent?
☐ **No** ☐**Yes If yes, enter name or Code #.**
Name

Code #

15. Agent or Broker Address

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** _____