

NEW YORK DISABILITY BENEFITS AND PAID FAMILY LEAVE INSURANCE EMPLOYER APPLICATION

The undersigned employer hereby applies for a policy of group insurance to provide benefits in accordance with the New York State Disability and Paid Family Leave Benefits Law, to be used in reliance on the statements made in this application. No insurance shall be binding unless and until this application is approved by Standard Security Life Insurance Company of New York. Paid Family Leave coverage (PFL) is provided at the benefit amounts and duration required under WCL §204(2). PFL does not cover out of state employees.

Employer Information:

1. Employer (The Insured): _____

2. Business Address: _____ Suite or Floor No.: _____
City: _____ State: _____ Zip Code: _____

3. Billing Address: _____ Suite or Floor No.: _____
City: _____ State: _____ Zip Code: _____

4. Telephone Number: _____ Contact Person: _____
Contact Email: _____ 5. SIC Code: _____
Standard Industrial Classification

6. Form of Organization: Corporation Partnership Sole Proprietor Other _____

7. NY Employer Registration (UI)#: _____ 8. Federal Taxpayer ID#: _____
(required)

9. Requested Effective Date: _____ (Note: Workers' Compensation Board requires receipt within (30) days).

Billing Information

10. Billing Delivery Mode: _____ Email: _____ (required)
 Paper Bill via US Mail Electronic Bill: _____ Name: _____ (required)
Note: If no selection is made, billing will default to US Mail option. Phone: _____ (required)

11. Billing Mode: Annually Quarterly Monthly

12. No. of Employees to be insured: **DBL** Male: _____ Female _____ **TOTAL DBL:** _____
PFL Male: _____ Female _____ **TOTAL PFL:** _____

13. DBL Groups of 50 or More Lives (rates require prior approval by underwriter)
DBL: Monthly Per Capita Rates: Males \$ _____ Female \$ _____
 Payroll Rate Factor \$ _____ Per \$100 of Covered Payroll (maximum \$340 per week)

Covered Employers (use an extra sheet of paper if necessary):

14. Name:	Address:	City/State/Zip Code:	Fed ID:	Billed Separately Yes / No	
a)				<input type="checkbox"/>	<input type="checkbox"/>

15. Covered Employees: All eligible under NYS Disability and Paid Family Leave Benefits Law
 All except the following (class or classes to be excluded, union, etc.)

16. Employee DBL Contribution: Contributory Non-Contributory

Voluntary Coverages

If voluntary coverage is elected by a sole proprietor, a member of a limited liability company, a member of a limited liability partnership or other self-employed person, Standard Security Life Insurance Company of New York shall subject the applicant to a waiting period of 2 years before benefits are payable, unless the policy is issued on or before 1/1/18 or within 26 weeks of when the employer first becomes a sole proprietor, limited liability company, limited liability partnership, or other self-employed person. A sole proprietor with employees, a member of a limited liability company with employees, a member of a limited liability partnership with employees or other self-employed person with employees, such policyholder shall be covered under the same policy that cover's the policyholder's employees.

17. **Names of Proprietors/Partners to be covered:** _____ Date Employer First Became Proprietor/Partner _____
a) _____
b) _____

Opt In – DBL & PFL

18. **Other Voluntary**

- a) _____ Opt In – DBL Only
b) _____ Opt In – DBL & PFL

19. **Optional Enriched DBL Coverage**

- A. In-Hospital Supplement DOUBLE (additional 20% of premium) TRIPLE (additional 40% of premium)
B. Enriched Benefit

The following plans apply to groups with 1-49 lives only. Custom enriched plan for groups with 50+ lives are available with underwriting approval.

Maximum Weekly Benefits						
<input type="checkbox"/> Plan A	50% to \$200		<input type="checkbox"/> Plan E	50% to \$400	<input type="checkbox"/> Plan I	60% to \$200
<input type="checkbox"/> Plan B	50% to \$250		<input type="checkbox"/> Plan F	50% to \$450	<input type="checkbox"/> Plan J	60% to \$250
<input type="checkbox"/> Plan C	50% to \$300		<input type="checkbox"/> Plan G	50% to \$500	<input type="checkbox"/> Plan K	60% to \$350
<input type="checkbox"/> Plan D	50% to \$350		<input type="checkbox"/> Plan H	60% to \$200	<input type="checkbox"/> Custom	___% to \$ ___

20. Workers' Compensation Carrier: _____
21. Previous Disability Carrier: _____
22. Agent or Broker: _____ 23. Sub Agent: _____
Address: _____ Address: _____

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: _____
By: _____ Title: _____