Standard Security Life Insurance Company
Independence Holding Group

Strength. Vision. Stability.
485 Madison Avenue, 14th Floor, New York, NY 10022-5872
www.sslicny.com

APPLICATION FOR NEW YORK STATE DISABILITY BENEFITS 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 used 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 Insured):*

2. Business Address: Suite or Floor No.:

City: State: Zip code:

3. Billing Address (If Different Than Above): Suite or Floor No.:

City: State: Zip code:

4. Telephone Number: Contact Person: Contact Email:

5. Nature of Business:

Form of Organization ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other _____

6. NY Employer Registration (UI) #: **7.** Federal Taxpayer ID #: **(required)**

8. Requested Effective Date of Coverage: **Note: Worker's Compensation Board requires receipt within (30) days.**

9. Billing Delivery Mode ☐ Paper Bill via US Mail ☐ Electronic Bill: Email: **(required)**

Name: **(required)**

Note: If no selection is made, billing delivery will default to US Mail option. Phone: **(required)**

10. Billing Mode ☐ Annually ☐ Quarterly ☐ Monthly

11. No. of Employees to be Insured Male Female TOTAL

12. Groups of 50 or More Lives (rates require prior approval by underwriter)

☐ Monthly Per Capita Rates Male $ Female $

☐ Payroll Rate Factor $ Per $100 of Covered Payroll *(Maximum $340 per week)*

13. Names of Proprietors or Partners to be covered:

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

List below those employers with financial interest or control, who are to be included as covered employers under the policy.

Name	Address	Fed ID#	Billed Separately YES / NO
			☐ ☐
			☐ ☐
			☐ ☐
			☐ ☐

15. Covered Employees ☐ All eligible under NY State Disability Law.

☐ All except the following (class or classes to be excluded, unions, etc.)

16. Employee Contribution ☐ Contributory ☐ Non-Contributory

17. Optional Enriched Coverages

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 Benefit	
☐ Plan A	50% to $200
☐ Plan B	50% to $250
☐ Plan C	50% to $300
☐ Plan D	50% to $350
☐ Plan E	50% to $400
☐ Plan F	50% to $450

Maximum Weekly Benefit	
☐ Plan G	50% to $500
☐ Plan H	60% to $200
☐ Plan I	60% to $250
☐ Plan J	60% to $300
☐ Plan K	60% to $350
☐ Custom	____% to $_____

18. Worker's Compensation Carrier:

19. Previous Disability Carrier:

20. Agent or Broker:

21. 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 state value of the claim for each such violation."

Signed at this day of 20

Employer

By Title