



STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

485 MADISON AVENUE, NEW YORK, NY 10022-5872 TELEPHONE: (212) 355-4141 / FAX: (212) 644-5786

APPLICATION FOR A NEW YORK 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. Business Telephone Number

Contact Person

5. Nature of Business

Form of Organization

Corporation

Partnership

Sole proprietor

Other

6. NY Employer Registration (UI) No.

____ - ____ - ____ - ____ - ____ - ____

7. Federal Taxpayer ID No.

____ - ____ - ____ - ____ - ____ - ____

8. Effective Date of Coverage

9. No. of Employees to be Insured

Male

Female

TOTAL

10. Employee Premium Rate

A. Groups 1-9 (Billed Annually in Advance)

Annual Rates

Male \$37.80

Female \$83.40

B. Groups 1-49 (Billed Quarterly in Arrears)

Monthly Per Capita Rates

Male \$3.15

Female \$6.95

Payroll Rate Factor \$ _____ Per \$100 of Covered Payroll (Maximum \$340 per week)

C. Groups 50 or More (Billed Quarterly in Arrears)

Monthly Per Capita Rates

Male \$

Female \$

Payroll Rate Factor \$ _____ Per \$100 of Covered Payroll (Maximum \$340 per week)

11. Optional Enriched Coverages

AD & D Benefit

100X

200 X

In-Hospital Supplement

DOUBLE

TRIPLE

12. Names of Proprietors or Partners to be Covered

Monthly Rate \$9.36

Annual Rate \$112.32

13. 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 policy

Name	Address	Fed ID#	UI#	To Be Billed Separately	
				YES	NO
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>
				<input type="checkbox"/>	<input type="checkbox"/>

14. Covered Employees All eligible under NY State Disability Law.

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

15. Employee Contribution

Contributory

Non-Contributory

Maximum employee contribution - Shall not exceed 1/2 of 1% of wages subject to a maximum of 60 cents per week.

16. Name of Worker's Compensation Carrier

17. Previous Disability Carrier

Date of Termination

18. Agent or Broker

Address

Suite or Floor No.

City

State

Zip code

"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 _____ 2000

Employer

By

Title