Disability Operations: P.O. Box 9102, Plainview, NY 11803-9002
(631)845-2200, (800)887-9111, FAX(631)845-2392

New York
Disability Benefits Law

Zurich American Insurance Company

(Please type or print legibly.)
Check one of the following: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ Other:

Name of owner or partners:
Name must appear exactly as filed with N.Y. State Division of Unemployment

Street address:
City, State, Zip Code:

Name under which employer's business is conducted, if different from above:

Mailing address, if different from above:
City, State, Zip Code:

Business of employer:
SIC Code, if known:

Tax Identification number:

Is this business seasonal? ☐ Yes ☐ No
If "Yes," specify months in full-time operation and estimate monthly covered payroll:

Is voluntary coverage desired for any of the following classes of employees:
☐ Partners ☐ Proprietor ☐ Clergy ☐ Teachers ☐Part-time domestics ☐ Other:
If "Yes," complete *Voluntary Disability Benefits for Proprietor or Partner* application for each person or DB-135 or DB-136 for all other classes.

See reverse side for eligibility requirements.

If union employees are to be excluded, give name and local number.
Name/Local number:
Name/Local number:

What is employer's Unemployment insurance account number? -

Total number of employees to be insured: Number of males: Number of females:

50% or more employees part-time? ☐ Yes ☐ No

Will employees contribute to this insurance? ☐ Yes ☐ No
If "Yes," is the contribution the maximum permitted by law? ☐ Yes ☐ No Amount: $ per

If your employees make a contribution toward the cost of this insurance, please specify the percentage, based on three year average, of the **total cost** assumed by the employer: %.

Employer currently is: ☐ Insured for statutory DBL ☐ Insured for benefits in excess of statutory ☐ Self-Insured
☐ New venture, not previously insured

Name of previous carrier, if applicable:

When and why was previous coverage terminated?

Will subsidiaries or affiliates be covered? ? ☐ Yes ☐ No
If "Yes," please complete the reverse side of this form. **(additional locations must be listed on reverse side.)**

Requested effective date:

Workers' Compensation Board requires receipt within 30 days.

Agent or Broker:
Date:
Address:
City, State, Zip Code:

Please list all subsidiaries or affiliates. Attach additional pages(s), if needed.

NAME	ADDRESS, CITY, STATE AND ZIP CODE	Unemployment Insurance Account Number	Number of Employees		Subsidiary To Be Billed Separately	
			M	F	M	F

Eligibility Requirement Summary

Employees are eligible if they are working or have recently worked for a "covered" employer for at least four consecutive weeks. Part-time employees become eligible on the 25th day of employment. There are however, some exceptions. The law EXCLUDES certain categories of employees as follows:

- Spouse or minor child of the employer;
- Government, railroad, maritime or farm workers;
- Ministers, priests, rabbis, members of religious orders, sections, Christian Science readers;
- Corporate offices and persons engaged in a professional or teaching capacity in or for a religious, charitable or educational institution of a "non profit" character, and persons receiving rehabilitation services in a sheltered workshop operated by such institutions under a certificate issued by the U.S. Department of Labor;
- Persons receiving aid from a religious or charitable institutions, who perform work in return for such aid;
- One or two corporate officers who either singly or jointly own all of the stock and hold all of the offices of a corporation which employs no other employees;
- Golf caddies; and
- Daytime students in elementary or secondary school, who work part-time during the school year or their regular vacation period.