

**Application for New York  
Disability Benefits Law Coverage**

To expedite your application, please complete accurately and in full all of the appropriate sections. Please type or print legibly.

1. Legal Name of Employer (as registered in New York) \_\_\_\_\_ TAX ID No. \_\_\_\_\_
2. Current New York Unemployment Insurance Account No.(NYS ERNUM) \_\_\_\_\_
3. Address \_\_\_\_\_
4. Phone No.: (\_\_\_\_\_) \_\_\_\_\_ County \_\_\_\_\_
5. Administrative Contact/Title \_\_\_\_\_
6. Mailing Address (if different from above) \_\_\_\_\_
7. Check one:  Corporation  Partnership  Proprietorship  Other
8. Name and Address of Policyholder (if different from above) \_\_\_\_\_  
\_\_\_\_\_
9. Nature of business \_\_\_\_\_ SIC Code, if known: \_\_\_\_\_
10. Premium Report Forms should be sent to (Check one):  Employer  Policyholder  Individual Subsidiaries
11. Have disability benefits been provided previously?  Yes  No If "yes," by whom \_\_\_\_\_
12. Do employees contribute?  Yes  No
13. The total number of employees as of the last completed payroll period of the Employer who are eligible under the New York Disability Benefits Law, and who are to be covered by this policy, is \_\_\_\_\_, consisting of \_\_\_\_\_ males and \_\_\_\_\_ females.
14. All employees who are eligible under the New York Disability Benefits Law are to be covered by this policy, except \_\_\_\_\_  
\_\_\_\_\_

If employees of subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be insured, list all legal names (as registered in New York) and addresses of such companies, the nature of their business, number of male/female employees at each subsidiary/affiliate location and New York Unemployment Insurance Account No. (NYS ERNUM). Attach separate sheet if necessary.

\_\_\_\_\_  
\_\_\_\_\_

If any exclusions are desired, you must furnish GE Group Life Assurance Company (GEGLAC) a detailed description as to each excluded class before we can consider this application. Indicate as to each such excluded class the provision of benefits being made under the Disability Benefits Law.

**The benefits shall be precisely Statutory as prescribed by Section 204 of the Law, unless otherwise specifically provided below.**

**EXCEPTIONS TO STATUTORY PLAN (DO NOT COMPLETE IF PLAN IS STATUTORY)**

- A. Disability Benefits, instead of beginning with the eighth consecutive day of disability as stated in Section 204.1. of the Disability Benefits Law, shall begin with the \_\_\_\_\_ day if the disability results from accidental bodily injury, and with the \_\_\_\_\_ day if disability results from sickness.
- B. The Maximum number of weeks for which benefits shall be payable shall be \_\_\_\_\_ for each period of disability instead of the maximum benefit period stated in Section 205.1.
- C. The percentage used in determining the weekly benefit shall be \_\_\_\_\_ of the employee's average weekly wage instead of the statutory percentage provided in Section 204.2.

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- D. The maximum weekly benefit shall be \_\_\_\_\_ dollars, after applying the percentage of average weekly wage.  
 E. The minimum weekly benefit shall be \_\_\_\_\_ dollars, or the employee's average weekly wage if less than \_\_\_\_\_ dollars, instead of the statutory minimum.

**New York State law requires the following statement:** A person commits a fraudulent insurance act, which is a crime, if he or she knowingly and with intent to defraud any insurance company or other person, either: (1) Files an application for accident and health insurance or statement of Claim containing any materially false information; or (2) Conceals for the purpose of misleading, information about any fact that is material to a claim. VIOLATIONS ARE SUBJECT TO CRIMINAL PROSECUTION AND MAY ALSO RESULT IN SUBSTANTIAL CIVIL PENALTIES.

Premium payments are due on a monthly/quarterly basis. \$\_\_\_\_\_ accompanies this application as payment toward first premium(s).

Requested Effective Date \_\_\_\_\_

EMPLOYER NAME	DATE SIGNED (MM/DD/YY)	EMPLOYER LOCATION
SIGNED BY (Signature of Authorized Employer Representative)		TITLE
SELLING PRODUCER'S NAME, AGENCY NAME AND ADDRESS		COMMISSION RECEIVING PRODUCER INSURANCE LICENSE (State and Number)
SELLING PRODUCER INSURANCE LICENSE (State and Number)		
By signing this form, the Selling Producer represents that s/he is licensed in the state where the employer is located and has been appropriately appointed by GE Group Life Assurance Company, as required by applicable state law.		
SELLING PRODUCER'S SIGNATURE	SELLING PRODUCER'S PHONE NUMBER	SELLING PRODUCER'S E-MAIL ADDRESS