

Continental Assurance Company



CNA Plaza
Chicago, Illinois 60685

A Stock Company

APPLICATION FOR NEW YORK DISABILITY BENEFITS POLICY

Application is hereby made to the Continental Casualty Company for a policy of group insurance to provide disability benefits in accordance with Section 204 of the New York Disability Benefits Law:

Check One: Corporation Ownership
 Partnership Other

1. Employer: _____

Address: _____ Phone No. _____
street city state zip code

2. Name of business if different from above: _____

3. Name and address of policyholder if different from above:
Name: _____

Address: _____
street city state zip code

4. Nature of business: _____

5. New York Unemployment Insurance No. _____

6. Federal Employer's Identification Number (FEIN) _____

7. If Disability Benefits were previously provided, please state name of prior insurer _____

8. Plan of Insurance: The weekly benefits for each insured employee under the policy shall be those prescribed by Section 204 of the New York State Disability Benefits Law.

9. Effective Date: The Policy Period begins on _____, 20____, at 12:01 A.M. Standard Time at the above address of the Employer (or policyholder, if different than the Employer.)

10. (a) Classes of Eligible Employees: All employees defined by Section 201 of the New York Disability Benefits Law who are eligible for benefits under Section 204 of the Law by virtue of Section 203 of the Law except: _____

(b) Ownerships and Partnerships: The following owners or partners are also covered under the policy: _____

11. What other New York Disability Law policy is the owner or partner(s) named in 10(b) above now carrying or have an application or reinstatement pending for?

Owner/Partner	Insurer	Weekly Benefit Amount	Elim. Period Acc./Sick	Maximum Duration
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12. Number of eligible employees: Male Female Total

13. Premium: Based on the information furnished to Us, premium for the benefits stated under item 8 shall be:

Premiums, as stated in this Application, are payable to Us when billed. A grace period of 31 days is allowed for the payment of each premium. We reserve the right to cancel this insurance at any time for non-payment of premium. We also reserve the right to change the premium rate as set forth in this Application.

14. Employee Contribution:

Yes, 1/2 of 1% of wages, not to exceed \$60/week or the equivalent if paid other than weekly No

This Application shall become part of the policy, when issued, in accordance with the provisions of the policy.

The undersigned Employer hereby understands and agrees that this Application cancels and replaces any other Application to Us for a New York Disability Benefits policy.

I know it is a crime to complete this Application with information I know is false or to omit any facts I know are important.

Employer Signature _____ Employer (Print Name & Title) _____ Date _____

Sub-Agent/Broker Signature _____ CAC/DBL Agent Signature _____

Send to : **Continental Assurance Company**
State Plans Dept. P.O. Box 257
Parsippany, NJ 07054

E-mail to: **dbl.app@cna.com**

Fax to: **(973) 541-3512**

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