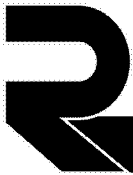

600 Northern Boulevard, Great Neck, New York 11021

The First Rehabilitation Life Insurance Company of America

NEW YORK STATE DISABILITY BENEFITS LAW POLICY APPLICATION

POLICY NUMBER ______________________ **EFFECTIVE DATE:** 12:01 AM EST, __________

All statements are true and correct to the best of the Applicant's knowledge and belief.
This application becomes part of the policy.

1. Employer (Policyholder/Insured): ______________________________

2. Business Address: ______________________________
   City / State / Zip: ______________________________
   Telephone Number: ______________ Contact Person: ______________
3. Mailing Address, if different: ______________________________
   City / State / Zip: ______________________________
4. Nature of business: ______________________________
   Form of organization: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other __________
5. Unemployment Insurance Number (UIN): __________ Federal Taxpayer Identification Number (TIN) __________
6. Covered subsidiaries or affiliated companies:

Name	Address	UIN	TIN

7. All employees, pursuant to New York Disability Benefits Law Section 203, are covered: ☐ Yes ☐ No
   If NO is checked, please list excluded classes of employees:
   ____
   ____
8. Total number of employees to be insured, including Corporate Officers: Male _____ Female _____ Voluntary _____
   Proprietors (list) ______________________________
   ____
   ____
   ____
9. Employer is currently:
   ☐ Insured for statutory DBL ☐ Insured for benefits in excess of statutory
   ☐ Self-insured ☐ New business, not previously insured
   Name of prior carrier, if applicable ______________________
   Reason for termination: ______________________
10. Workers' compensation insurance carrier ______________________ policy number: ______________
11. Employee Contribution ☐ Non -Contributory ☐ Contributory _______ % of premium contributed by employer.

An employee's conbtribution for statutrory DBL coverage shall not exceed the lesser of 1/2 of 1% of wages received on or after the effective date of this policy, up to a maximum of 60 cents ($0.60) per week or the actual premium per employee.

12. Billing options:
   - ☐ Groups of **1 to 10 employees** (billed **annually in advance**)
   - ☐ Groups of **11 to 49 employees**
     - ☐ Billed quarterly in arrears
     - ☐ Billed annually in advance
   - ☐ Groups of **50 or more employees** (billed **quarterly in arrears**)
     Monthly Rate based on covered payroll (maximum covered payroll of $340.00 per week per employee)
     Monthly per capita rates: Male _____ ; Female_____
     Payroll Rate Factor $ _________

13. Additional benefit options:
   - ☐ Enriched Benefits
     - ☐ 1.5 x Statutory Benefit
     - ☐ 2.0 x Statutory Benefit
     - ☐ 3.0 x Statutory Benefit
   - ☐ In-Hospital Benefits
   - ☐ Accidental Death & Dismemberment (AD&D) Benefits

No one except the President, a Vice President or the Secretary of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA may make or modify any contract on behalf of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA. No waiver is valid unless it is in writing and signed by one of these officers.

NOTICE: 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.

Dated ____________________ Signature of Employer ______________________________

Name ____

Title ____

Dated ____________________ Signature of Agent ______________________________

Agency Name ____

____

Agent's Address____

____

Policy Number:__________________ Broker Number: ____________ Rep Number:_________