standard security
LIFE INSURANCE COMPANY

www.sslicny.com

488 Madison Avenue, Suite 803, New York, NY 10022-5872

NEW YORK DISABILITY BENEFITS AND PAID FAMILY LEAVE INSURANCE EMPLOYER APPLICATION

The undersigned employer hereby applies for a policy of group insurance to provide benefits in accordance with the New York State Disability and Paid Family Leave 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 by Standard Security Life Insurance Company of New York. Paid Family Leave coverage (PFL) is provided at the benefit amounts and duration required under WCL §204(2). PFL does not cover out of state employees.

Employer Information:

1. Employer (The Insured): ______________________________

2. Business Address: ______________________________ Suite or Floor No.: __________

   City: ______________________ State: __________ Zip Code: __________

3. Billing Address: ______________________________ Suite or Floor No.: __________

   City: ______________________ State: __________ Zip Code: __________

4. Telephone Number: ______________________ Contact Person: ______________________

   Contact Email: ______________________________ 5. SIC Code: __________
   Standard Industrial Classification

6. Form of Organization: ☐ Corporation ☐ Partnership ☐ Sole Proprietor ☐ Other __________

7. NY Employer Registration (UI)#: ______________ 8. Federal Taxpayer ID#: ______________ (required)

9. Requested Effective Date: ______________ (Note: Workers' Compensation Board requires receipt within (30) days).

Billing Information

10. Billing Delivery Mode:

    ☐ Paper Bill via US Mail ☐ Electronic Bill:

    Note: If no selection is made, billing will default to US Mail option.

    Email: ______________________ **(required)**

    Name: ______________________ **(required)**

    Phone: ______________________ **(required)**

11. Billing Mode: ☐ Annually ☐ Quarterly ☐ Monthly

12. No. of Employees to be insured: **DBL** Male: __________ Female __________ **TOTAL DBL:** __________

    PFL Male: __________ Female __________ **TOTAL PFL:** __________

13. DBL Groups of 50 or More Lives (rates require prior approval by underwriter)

    DBL: ☐ Monthly Per Capita Rates: Males $ __________ Female $ __________

    ☐ Payroll Rate Factor $ Per $100 of Covered Payroll (maximum $340 per week)

Covered Employers *(use an extra sheet of paper if necessary)*:

14. Name:	Address:	City/State/Zip Code:	Fed ID:	Billed Separately Yes	/ No
a)				☐	☐

15. Covered Employees: ☐ All eligible under NYS Disability and Paid Family Leave Benefits Law

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

16. Employee DBL Contribution: ☐ Contributory ☐ Non-Contributory

Voluntary Coverages

If voluntary coverage is elected by a sole proprietor, a member of a limited liability company, a member of a limited liability partnership or other self-employed person, Standard Security Life Insurance Company of New York shall subject the applicant to a waiting period of 2 years before benefits are payable, unless the policy is issued on or before 1/1/18 or within 26 weeks of when the employer first becomes a sole proprietor, limited liability company, limited liability partnership, or other self-employed person. A sole proprietor with employees, a member of a limited liability company with employees, a member of a limited liability partnership with employees or other self-employed person with employees, such policyholder shall be covered under the same policy that cover's the policyholder's employees.

17. **Names of Proprietors/Partners to be covered:** Date Employer First Became Proprietor/Partner

a) ______________________ ______________________

b) ______________________ ______________________

☐ Opt In – DBL & PFL

18. **Other Voluntary**

a) ______________________ ☐ Opt In – DBL Only

b) ______________________ ☐ Opt In – DBL & PFL

19. **Optional Enriched DBL Coverage**

A. ☐ In-Hospital Supplement ☐ DOUBLE *(additional 20% of premium)* ☐ TRIPLE *(additional 40% of premium)*

B. Enriched Benefit

The following plans apply to groups with 1-49 lives only. Custom enriched plan for groups with 50+ lives are available with underwriting approval.

Maximum Weekly Benefits							
☐ Plan A	50% to $200		☐ Plan E	50% to $400		☐ Plan I	60% to $250
☐ Plan B	50% to $250		☐ Plan F	50% to $450		☐ Plan J	60% to $300
☐ Plan C	50% to $300		☐ Plan G	50% to $500		☐ Plan K	60% to $350
☐ Plan D	50% to $350		☐ Plan H	60% to $200		☐ Custom	____% to $ ____

20. Workers' Compensation Carrier: ______________________

21. Previous Disability Carrier: ______________________

22. Agent or Broker: ______________________ 23. Sub Agent: ______________________

Address: ______________________ Address: ______________________

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 ______________ 20 ______

Employer: ______________________

By: ______________________ Title: ______________________