standardsecurity
LIFE INSURANCE COMPANY

☐ DBL Only (requires Home Office approval)
☐ PFL Only
☐ Group Life

STANDARD SECURITY LIFE INSURANCE COMPANY OF NEW YORK

NEW YORK DISABILITY BENEFITS, PAID FAMILY LEAVE INSURANCE, & GROUP LIFE APPLICATION

The undersigned employer hereby applies for a policy of group insurance. No insurance shall be binding unless and until this application is approved by Standard Security Life Insurance Company of New York (SSL). 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. **Full Legal Name of Employer:** _____ (required)

   Doing Business as Name: (if applicable) _____

2. **Physical Address:** _____ (required) **Suite or Floor No.:** _____

   City: _____ (required) **State:** _____ (required) **Zip Code:** _____ (required)

3. **Mailing Address:** _____ **Suite or Floor No.:** _____

   City: _____ **State:** _____ **Zip Code:** _____

4. **Telephone Number:** _____ **Contact Person:** _____

   Contact Email: _____ 5. **Type of Business:** _____ (required)
   Nature of Business or SIC Code

6. **Form of Organization:** ☐ Corporation ☐ LLC ☐ Partnership ☐ Sole Proprietor ☐ Other _____

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

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

Billing Information

10. **Billing Delivery Mode:**

    ☐ Email Copy of Bill ☐ Paper Copy of Bill
    Note: Please consider email option, as it allows delivery to multiple copies.

    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: Male $ _____ Female $ _____

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

Additional Covered Legal Name/FEIN or Location *(use an extra sheet of paper if necessary):*

14. **Name**	**Physical Address** (if any)	**City/State/Zip Code**	**Additional Federal Taxpayer ID#** (if any)	**Separate Billing Yes / No**
				☐ / ☐
				☐ / ☐

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

☐ All except the following (*class or classes to be excluded*) _____

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

Voluntary Coverages

If voluntary coverage is elected by a sole proprietor (SP), a member of a limited liability company (LLC), a member of a limited liability partnership (LLP) or other self-employed person (SEP), SSL shall subject the applicant to a waiting period of 2 years before benefits are payable, unless the policy is issued within 26 weeks of when the employer first becomes a sole proprietor (SP), LLC, LLP, or other SEP. An SP with employees, a member of an LLC with employees, a member of an LLP with employees or other SEP with employees, 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 Note - Please mark this option if you desire to have the above-mentioned name(s) covered for DBL & PFL.

18. Other Voluntary Classes (*requires prior approval by the NYS WCB Plans Acceptance Unit through employer submission of form DB-135 / DB-136*)

a) _____

b) _____ ☐ Opt In – DBL & PFL

19. Optional Coverages for DBL

A. DBL In-Hospital Supplement ☐ DOUBLE *(additional 10% of premium)* ☐ TRIPLE *(additional 25% of premium)*

B. DBL 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 Benefit							
☐ Plan A	50% to $200	☐ Plan D	50% to $350	☐ Plan G	50% to $500	☐ Plan J	60% to $300
☐ Plan B	50% to $250	☐ Plan E	50% to $400	☐ Plan H	60% to $200	☐ Plan K	60% to $350
☐ Plan C	50% to $300	☐ Plan F	50% to $450	☐ Plan I	60% to $250	☐ Plan L	Custom_____

20. Optional Benefit: Guaranteed Issue Group Term Life Insurance - NY Employees Only (*choose one option only*):

☐ Benefit Amount: $15,000

Cost: $3.00 per employee, per month

21. Workers' Compensation Carrier: _____

22. Previous Disability Carrier: _____

23. Agent or Broker: _____ Code # _____ **23. Sub Agent:** _____ Code # _____

Address: _____ Address: _____

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 claims for each such violation. (PLEASE NOTE - This is not applicable to the life insurance coverage.)

Signed at: _____ _____ day of _____ 20 _____

Employer: _____

By: _____ Title: _____