

APPLICATION FOR DISABILITY BENEFITS INSURANCE

NEW YORK STATE INSURANCE FUND

15 COMPUTER DRIVE WEST
ALBANY, NY 12205
Telephone (866) 697-4332

DO NOT WRITE IN THIS SPACE	
NIF FILE	POLICY NO. DBL

We (I) hereby apply to THE STATE INSURANCE FUND for a policy under the NEW YORK DISABILITY BENEFITS LAW, assuring the payment of BENEFITS to employees HEREINAFTER described.

(1) **INSURANCE IS DESIRED TO TAKE EFFECT AT 12:01 A.M. EASTERN STANDARD TIME ON _____** It is mutually understood and agreed that no liability shall attach to The State Insurance Fund under this application and that insurance will not be effective until accepted by The State Insurance Fund as evidenced by the inception date indicated in a policy or on a written binder. **NO COVERAGE WILL BE EFFECTED UNLESS THE REQUIRED MINIMUM DEPOSIT PREMIUM OF \$100.00 IS RECEIVED ALONG WITH THIS APPLICATION.**

(2) **NAME OF EMPLOYER _____**
(Name should be printed or typewritten)

(2a) **TRADE NAME(S), If any _____**

(2b) **ADDITIONAL ENTITY(S), If any _____**

(3) **MAILING ADDRESS _____**
(Number) (Street) (City or Town) (State) (Zip Code) (County)

(4) **TELEPHONE NUMBER (____) _____** N.Y. UNEMPLOYMENT INSURANCE NO: _____

(5) **N.Y. STATE LOCATION(S) _____**

(6) **NATURE OF BUSINESS _____** Out of state Corp. **must list N.Y. location** **FED. TAX ID.# _____**

(7) **Check type of entity** INDIVIDUAL PARTNERSHIP CORPORATION OTHER-Specify _____

(8) **We (I) desire ALL our (my) employees (as defined in and subject to the N.Y. Disability Benefits Law), including officers, if any, covered under The State Insurance Fund Disability Benefits Policy _____** If answer is No, check appropriate box:
(yes or no)

- Executive Officer(s) Exclusion (DB-212.3 must be filed. See Notice to Corporations on form UDB-36A for details.)
- Spouse(s) Exclusion (DB-212.5 must be filed. See Notice to Sole-Proprietorships or Partnerships on form UDB-36A for details.)
- Other classes of employees to be excluded-describe (if Union employees excluded, give local # and the name of the union.)

(9) **WORKERS' COMPENSATION POLICY# _____** State Fund Other: Name _____

List Previous Disab. Ben. Ins. Co's. (If State Fund, provide Pol# only)	Policy No's	Total Annual Premium	Periods of Insurance	No. of Claims	Cost of Claims	Reason for Cancellation
_____	_____	\$ _____	_____	_____	\$ _____	_____
_____	_____	\$ _____	_____	_____	\$ _____	_____
_____	_____	\$ _____	_____	_____	\$ _____	_____

(11) The following constitutes our (my) projected estimated payroll for the full year of ALL employees who are to be covered by THE STATE INSURANCE FUND.

(12) See Form UDB-36A for details on rates and payroll limitations.

A		B		C		Do Not Write In These Boxes		
NO. OF EMPLOYEES (Not including officers)	+	NO. OF OFFICERS, IF ANY, INCLUDED IN COVERAGE	+	ANNUAL PAYROLL OF A + B	RATE	MOD %	PREMIUM	
MALES	+			\$ _____			\$ _____	
FEMALES	+			\$ _____			\$ _____	
							ANNUAL EST. PREM.	\$ _____
							DEPOSIT PREMIUM	\$ _____

(12) Number of employees for whom D.B. deductions are made _____

(13) **LIST THE NAME AND ADDRESS OF ALL OFFICERS, PARTNERS (OR GEN. PARTNERS) OR INDIVIDUAL OWNER. (Attach an additional sheet if necessary.)**

Name (Please Print)	Home Address (Number, Street, City, State, Zip Code)	Title
_____	_____	_____
_____	_____	_____
_____	_____	_____

(14) **Insurance Broker, if any _____** Tel. No. (____) _____

Address _____ **Zip Code _____**

(15) **Name of Accountant, if any _____** Tel. No. (____) _____

We (I) understand that the renewal date on State Insurance Fund Disability Benefits policies is July 1 and we (I) understand that we (I) will be required to submit reports for each period on a prescribed form of all reportable wages under the terms of our (my) State Insurance Fund Disability Benefits Policy not later than thirty days after the end of such period; and that each report will be accompanied by our (my) premium payment for the period. Such reports are subject to minimum charges for each period or any part thereof as stipulated in the policy contract.

Any person who knowingly and with the intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent 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.

(16) **SIGN HERE _____** **DATE _____**
(Signature of OWNER, PARTNER OR OFFICER) (PRINT NAME)

THE INFORMATION YOU PROVIDE IS PROTECTED BY THE PERSONAL PRIVACY PROTECTION LAW: The authority to obtain the personal information requested herein is found in Section 83 of the Workers' Compensation Law as supplemented by Section 450.1, 450.3 and 450.5 of Chapter VI of Title 12(C) of the Official Compilation of Codes, Rules and Regulations of the State of New York. The principal purpose for which the information is sought is to assist the State Insurance Fund in processing your insurance coverage with the State Insurance Fund and its release is governed by the limitations of the Personal Privacy Protection Law. This information will be maintained by the Director of Underwriting, The State Insurance Fund, 199 Church Street, New York, New York 10007.

Please complete this Application (Sign and Date), include your initial Deposit Payment Check and mail to:

NYSIF Disability Benefits
15 COMPUTER DRIVE WEST
ALBANY, NY 12205

SPECIMEN DISABILITY BENEFITS POLICY OF INSURANCE

In consideration of the payment of the premium and in reliance upon the statements in the declarations and subject to the conditions and other terms of this policy, The State Insurance Fund agrees with the Policyholder and/or Employer named in the declarations to the following:

INSURING AGREEMENTS

- (a) The State Insurance Fund agrees to pay the disability benefits which any eligible employee, because of employment within any class stated in the declarations while such class is covered under this policy, is entitled to receive under Section 204 of Article 9 of the New York State Workers' Compensation Law, hereinafter referred to as the Disability Benefits Law, and for which the Employer would be liable during the term of his coverage under this policy.
- (b) The Policyholder agrees to act for and on behalf of any and all Employers of eligible employees in all matters pertaining to this policy, and every act done by, agreement made with, or notice (other than a notice of cancellation) given to the Policyholder shall be binding on all such Employers.
- (c) All dates stated in the declarations, endorsements, notices of cancellation and notices of reinstatement, if any, shall apply as of 12:01 a.m. Eastern Standard Time of the date given.

CONDITIONS

1. **Premiums** The premium bases and rates at the inception of the policy shall be as stated in the declarations; however, the premium bases and rates are each subject to change by The State Insurance Fund as of either each July 1 or as of the effective date of any amendment to the Disability Benefits Law which affects The State Insurance Fund's obligations under this policy, or as of both such dates.
2. **Records, Examination and Audit** The Policyholder and/or Employer shall furnish The State Insurance Fund with all information that it may reasonably require with regard to any matters pertaining to the insurance afforded by this policy. All documents, books and records which may have a bearing on the insurance or premiums under this policy shall be open for examination and audit by The State Insurance Fund at all reasonable times during the continuance of this policy and within three years after the final termination thereof.
3. **Claim Notices by Policyholder or Employer** Upon receipt by the Policyholder or the Employer of notice of disability on which claim may be based, written notice shall be given by or on behalf of the Policyholder or the Employer to The State Insurance Fund as soon as practicable. The Policyholder or the Employer shall give immediate notice to The State Insurance Fund with full particulars of any claim made on account of disability. If any suit or other proceeding is instituted against the Employer, every summons, notice or other process shall be immediately forwarded to The State Insurance Fund. Nothing elsewhere contained in this policy shall relieve the Employer of his obligations to The State Insurance Fund with respect to notice herein imposed upon him.
4. **Provisions Required by Statute** As between the eligible employee and The State Insurance Fund, notice to or knowledge of the occurrence of an injury or sickness suffered by such employee on the part of the Employer of such employee shall be deemed notice or knowledge, as the case may be, on the part of The State Insurance Fund; jurisdiction of the Employer of such employee shall, for the purpose of the Disability Benefits Law, be jurisdiction of The State Insurance Fund and The State Insurance Fund shall in all things be bound by and subject to the orders, findings or decisions rendered in connection with the payment of benefits under the provisions of said Law.

The Chairperson of the Workers' Compensation Board of the State of New York shall have the right to enforce in the name of the people of the State of New York for the benefit of the eligible employee, either by filing a separate application or by making The State Insurance Fund a party to the original application, the liability of The State Insurance Fund in whole or in part for the payment of the benefits afforded hereunder, provided, however that payment in whole or in part of such benefits by either the Policyholder or the Employer of such employee or The State Insurance Fund shall to the extent thereof be a bar to the recovery against the other of the amount so paid.

Bankruptcy or insolvency of the Policyholder or the Employer of the eligible employee shall not relieve The State Insurance Fund of any of its obligations under this policy.

All of the provisions of the Disability Benefits Law shall be and remain a part of this policy as fully and completely as if written herein, so far as they apply to disability benefits provided by this policy. Notwithstanding any other provision of this policy, or any endorsement made a part thereof, benefits payable under this policy or any such endorsement in accordance with the provision of benefits made under the Disability Benefits Law by the Employer of the eligible employee shall be payable at least to the extent and in the manner and subject to the conditions required by the terms of such provision of benefits, which provision is evidenced by this policy.

5. **Renewal and Cancellation**
 - (a) The insurance under this policy shall automatically renew and continue in full force and the Policyholder shall be liable for the premium for each succeeding period unless, in compliance with the provisions of Section 94 of the Workers' Compensation Law, the Policyholder with respect to the entire policy or unless either the Policyholder or an Employer named in the declarations on behalf of such Employer, shall give The State Insurance Fund written notice of his intention to withdraw not less than thirty days before the effective date of such cancellation.
 - (b) This policy may be canceled by the State Insurance Fund as provided in Section 226, Subdivision 5 of the Workers' Compensation Law by furnishing written notice to the Policyholder and Employer at least ten days before cancellation is to take effect.
 - (c) If an Employer or Employers of eligible employees fail to pay his or their share of the premium for this policy to the Policyholder, then upon written request of the Policyholder that this policy be canceled with respect to the employees of such Employer or Employers, The State Insurance Fund shall cancel the insurance afforded under this policy to said Employer or Employers and this policy shall remain in full force and effect with respect to the employees of those Employers who continue to contribute the required premium. In such case, the Policyholder shall be responsible for the delinquent Employer's or Employers' share of the premium due to the date of such partial cancellation.
6. **Declaration** The Policyholder agrees that the statements in the declarations are his agreements, and are representations and not warranties, and that this policy, together with such declarations, embodies all agreements existing between the Policyholder and The State Insurance Fund relating to this insurance and that no changes to these agreements are valid except those made by endorsement issued by The State Insurance Fund.
7. **Assessments** The State Insurance Fund, with regard to assessments, agrees:
 - (a) To levy no assessment against the Policyholder and Employer insured under this policy.
 - (b) To pay the assessments levied on the total payrolls of employees covered under this policy pursuant to Sections 214-2, 214-3 and 228 of the Disability Benefits Law.
8. **Special Provisions Relating to Employee Contributions** In accordance with the requirements of the Disability Benefits Law, any excess of the aggregate contributions of employees applied to the cost of insurance provided hereunder over the premiums paid by the Policyholder (less any amounts returnable under this policy) shall, under the rules of the Chairperson of the New York State Workers' Compensation Board, be paid to the Policyholder and distributed or applied for the sole benefit of employees or otherwise be applied or disposed of as prescribed in Section 216 of said Law.
9. **Distribution of Excess Earnings** The State Insurance Fund agrees that if and whenever The State Insurance Fund, in its discretion, shall determine to distribute excess earnings, the Policyholder shall participate therein only to the extent and upon the conditions fixed and determined by The State Insurance Fund subject to the requirements of the "Special Provision Relating to Employee Contributions."
10. **Assignment by Policyholder** Assignment of the Policyholder's interest under this policy shall not bind The State Insurance Fund until its consent is endorsed thereon.

In Witness Whereof, THE STATE INSURANCE FUND has caused this policy to be signed by its Underwriting Director.

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ALBANY, NY 12205

TEL. (866) 697-4332

DISABILITY BENEFITS UNDERWRITING

Enclosed is the requested application for Disability Benefits insurance.

To make a definite rate and deposit premium quotation for statutory disability benefits coverage, we request the past three years experience with your previous carrier (see item #10 of the enclosed application).

If no previous disability benefits insurance was carried, insert the word "none" on line 10 of the application.

IF THIS INFORMATION IS NOT SUBMITTED, WE WILL HAVE NO CHOICE BUT TO ASSUME THAT YOUR PRIOR EXPERIENCE WAS SUBSTANDARD AND INCREASED RATES WILL APPLY.

The Disability Benefits Law provides that an employer who has in employment one or more employees (except students in an elementary or secondary school and other specified categories) on each of at least 30 days in a calendar year, shall be a covered employer. Employers of personal or domestic employees in a private home require coverage if they employ one or more employees working 40 or more hours per week.

Effective January 1, 2007, the Disability Benefits premium rates for standard risks are \$.16 for male employees and \$.32 for female employees, applicable to each \$100 of covered payroll limited to a maximum of \$340 per week, per employee, and shall include reasonable value of tips, board, rent, housing, lodging or similar advantage received under the contract of hire.

To effect coverage, a complete application and an initial deposit must be submitted. The deposit required is 100% of the estimated annual premium for those policies \$499 or less, and 50% for policies with a premium range of \$500 to \$999 with 9 installments. For those policies above \$1,000 a 25% deposit is required with 9 installments. In no event can initial deposit be less than \$100.

Reporting plans may be annual, semi-annual or quarterly. Estimated premium range will determine your policy reporting plan.

All New York State Insurance Fund Disability Benefits policies are automatically renewed on their anniversary dates.

Coverage in the New York State Insurance Fund becomes effective the day following the postmark on the envelope in which the completed application and required initial deposit are received, or any subsequent date requested. In the event that your policy is no longer required, you must provide written notice of your intention to withdraw not less than 30 days before the effective date of such cancellation.

NOTICE TO CORPORATIONS: If your corporation is comprised of ONLY one or two executive officers who individually or between them own 100% of the outstanding stock, with each one owning at least one share, and there are OTHER EMPLOYEES, coverage is not mandatory for these officers; you have the option to elect to exclude these officers from coverage by filing form DB-212.3 with the New York State Insurance Fund.

If there are NO OTHER EMPLOYEES besides the above described one or two officers, then a disability benefits policy is not mandatory.

NOTICE TO SOLE PROPRIETORSHIPS OR PARTNERSHIPS who employ their spouse(s): If your spouse is your employee and you have OTHER EMPLOYEES, disability benefits coverage is mandatory for such spouse unless you elect to exclude your spousal employee from coverage on your Disability Benefits policy by filing form DB-212.5 with the New York State Insurance Fund.

If there are NO OTHER EMPLOYEES besides the above described spouse, coverage remains mandatory and a policy is required unless form DB-212.5 is filed with the Disability Benefits Bureau of the WORKERS' COMPENSATION BOARD.

Enclosures

UB-36A (Rev. 12/06)