APPLICATION FOR DISABILITY BENEFITS INSURANCE

New York State Insurance Fund. NYSIF

15 Computer Drive West, Albany, NY 12205

Policy Reference No.

We (I) hereby apply to the New York State Insurance Fund, NYSIF, for a policy under the NEW YORK DISABILITY BENEFITS LAW, assuring the payment of BENEFITS to employees HEREINAFTER described. The Owners of a Sole Proprietorship, Partnership or Members of an LLC will not be covered by NYSIF. However, ALL Employees of these organizations, other than employees considered exempt from coverage, are required by New York State Law to be provided Disability Benefits Insurance.

(1) INSURANCE DATE desired to take effect at 12:01 A.M. Eastern Standard Time Mo/Da/Year: _____ Policies cannot be backdated. It is mutually understood and agreed that no liability shall be attached to the New York State Insurance Fund under this application and that insurance will not be effective until accepted by the New York 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 or $60.00 CHECK is received with this APPLICATION. Please make check payable to: NYSIF Disability Benefits**

(2) NAME OF EMPLOYER _____
Printed or Typewritten

(2a) TRADE NAME(S), If any, _____
DBA, T/A, Other (specify)

(3) MAILING ADDRESS _____
Number / Street / Suite | City or Town | State or Prov. | Zip, Postal Code | Country

(4) PRIMARY CONTACT: _____
Name | Title | Telephone Number | Fax Number | E-Mail

(5) NEW YORK STATE LOCATION: If PO Box is used in line (3) or the Applicants headquarters is outside New York State, Applicant must list a physical New York address.

_____
Address: Number / Street / Suite (PO BOX is not acceptable) | City or Town | State | Zip

(6) FEDERAL TAX I.D. NO. _____ if no Federal Tax I.D., SOCIAL SECURITY NO. _____

(7) ORGANIZATION TYPE indicate if Sole Proprietor, Partnership, Corporation, LLC, PLLC, Political Subdivision, NFP Corp. or Other (specify): _____

(8) NATURE OF BUSINESS (describe activity) _____

(9) ADDITIONAL ENTITY(S) _____
(attach separate sheet if needed) Entity Name | Address | City | State | Zip | Organization Type | Entity Federal Tax I.D. No.

(10) If applicable, applicants may apply to the NYS Workers' Compensation Board Disability Benefits Bureau for Exclusion of: Corporation EXECUTIVE OFFICERS (limit 2), SPOUSE or TRADE UNIONS that provide disability benefits insurance to its Members. If your company would like to exclude any of the following classes please indicate:

( ) Executive Officer(s) Exclusion limited to Corporations with only 1 or 2 Corporate Officers (DB-212.3 must be submitted with this Application).
( ) Spouse Exclusion for Sole Proprietors and Partnerships only (DB-212.5 must be filed with the NYS Workers' Compensation Board Disability Bureau).
( ) Trade Unions or Other Classes of employees excluded.

Trade Union Name | Trade Union Number

(11) WORKERS' COMPENSATION POLICY: _____
Provider Name | Policy Number

(12) LIST YOUR CURRENT DISABILITY BENEFITS INSURANCE PROVIDER (if applicable):

(Current Disability Insurance Provider Name)	(Policy No.)	No. of Claims	(Claims $)	(Annual Premium $)	(Period of Insurance: Mo/Yr to Mo/Yr)
			$	$	

(13) TOTAL NUMBER of EMPLOYEES & LIMITED ANNUAL WAGES of ALL EMPLOYEES to be covered by the NEW YORK STATE INSURANCE FUND, NYSIF.
Wages must include every form of earnings including: tips, bonuses, commissions, room, board, etc. Total Limited Annual Wages is $17,680 per person for each employee earning $17,680 or more annually. For employees earning less than $17,680 annually, include their cumulative actual annual wages in this total. For Corporations only, list the number of NYS Corporate Officers and include their Total Limited Wages with Employee Wages. Owners, Officers, and Members of other business types are excluded.

New York State Employees	Total Number of Employees	Total Number Corp. Officers	Total Limited Annual Wages
Male			$
Female			$

(14) NAME(S) and ADDRESS(S) of all OWNERS, PARTNERS, MEMBERS of an LLC or OFFICERS (REQUIRED even if individuals work outside of New York State).

Name	Title	Address	City	State	Zip

(15) INSURANCE BROKER: _____
(Optional) Name | Address | City | State | Zip | Telephone | E-Mail

(16) ACCOUNTANT: _____
(Optional) Name | Address | City | State | Zip | Telephone | E-Mail

We (I) understand that the renewal date on the New York State Insurance Fund Disability Benefits policy will be the annual anniversary date of the policy inception. We (I) also understand that We (I) will be required to submit Payroll Reports for policy period(s) on a prescribed form for all reportable wages under the terms of our (my) New York State Insurance Fund Disability Benefits Insurance policy no later than thirty days after the end of such period. Failure to report payroll will result in a payroll estimate which may increase the Premium required for the policy 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 purposes of misleading, information concerning any fact material thereto, commits a fraudulent act which is a crime and shall be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each violation. Policy cancellations require 30 days advanced written notice to NYSIF.

(17) SIGNATURE (Required): _____
Must be: OWNER, PARTNER, MEMBER or OFFICER from No. (14) | Print Name | Date

THE INFORMATION YOU PROVIDED 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 New York State Insurance Fund in processing your insurance coverage with the New York 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, New York State Insurance Fund, 199 Church Street, New York, NY 10007.

Complete this APPLICATION, attach your MINIMUM DEPOSIT PREMIUM or $60.00 CHECK payable to "NYSIF DISABILITY BENEFITS" and MAIL TO:

NYSIF Disability Benefits, 15 Computer Drive West, Albany, NY 12205

For assistance go to our website www.nysif.com and contact us, or telephone nysif customer service at 1(866)697-4332

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 the policy renewal or 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.

NYSIF New York State Insurance Fund

DISABILITY BENEFITS INSURANCE INFORMATION

New York State Law requires employers who have in employment one or more employees full-time or part-time (except High School students and other specified categories) on at least 30 days in a calendar year, to be an employer requiring approved disability benefits insurance coverage. Employers of personal or domestic employees in a private home require coverage only if they employ one or more employees working 40 or more hours per week.

Effective January 1, 2010, the NYSIF Statutory Disability Benefits premium rates for Standard Risks are $.14 for male employees and $.14 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. Employers with annual claims exceeding the annual premium may be subject to a NYSIF premium differential until annual claims decrease below the annual premium.

To obtain coverage, a completed Application and Premium Deposit must be submitted together.

The Premium Deposit equals:
100% of the estimated annual premium for policies $499 or less.
50% of the estimated annual premium for policy premium of $500 to $999, with 9 equal monthly installments to follow.
25% of the estimated annual premium for policy premium of $1,000 or more, with 9 equal monthly installments to follow.
A $10 monthly installment fee is added to the monthly premium for policyholders who choose to pay monthly installments.

To secure an accurate rate of coverage and premium quotation for disability benefits insurance, NYSIF requires the past three years claims history to be submitted to NYSIF if your organization employs more than 15 employees in New York State. If claims history is not submitted prior to the policy inception date, NYSIF will assume that prior claims history is greater than the estimated premium and NYSIF may apply a premium differential until loss history becomes favorable.

If policy approval is granted, disability benefits insurance coverage in the New York State Insurance Fund, NYSIF, becomes effective the day following the postmark on the envelope in which the completed application and required premium deposit are received, or any subsequent date requested on the application. A policy cannot be backdated.

All NYSIF Disability Benefits policies are automatically renewed on their anniversary date.

In the event that the NYSIF Disability Benefits insurance policy is no longer required, **the policyholder must provide written notice with reason for cancellation**, signed only by an Officer of the organization, to express the intention to cancel coverage from NYSIF **not less than 30 days before the effective date of such cancellation or policy renewal.**

NOTICE TO CORPORATIONS:
If a corporation has three or more executive officers, disability benefits coverage is required for all officers and employees.

Corporations with 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 the officers only and these officers(s) have the option to include or exclude themselves from coverage. Officers are automatically included unless an Election to Exclude DB-212.3 form is completed and submitted with the Application. If there are **NO OTHER EMPLOYEES** besides the above described one or two corporate officers, then a disability benefits policy is not mandatory; however, these officers may apply for Voluntary Coverage by submitting a DB-135 form to the NYS Workers' Compensation Board Disability Benefits Bureau.

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 Workers' Compensation Board Disability Benefits Bureau. If there are NO OTHER EMPLOYEES besides the above described spouse, coverage remains mandatory for your spouse and a policy is required unless form DB-212.5 is filed with the New York State Workers' Compensation Board Disability Benefits Bureau.

For additional information about NYSIF Workers' Compensation or Disability Benefits insurance visit **nysif.com** and for **q**uestions regarding coverage please contact the NYS Workers Compensation Board by telephoning 1-800-353-3092

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NYSIF Disability Benefits
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