

P.O. Box 1080, New York, NY 10268 (212) 964-4858 (800) 342-6675

NY U.I. Number \_\_\_\_\_ Guardian Group Policy Number \_\_\_\_\_  
(Excluding Stand Alone Medical)

Federal Employer I.D. Number: \_\_\_\_\_

The undersigned employer hereby applies for a policy of group insurance to provide benefits in accordance with Section 204 of the New York State Disability Law to be effective: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

LEGAL NAME OF EMPLOYER: \_\_\_\_\_ LOCATION ADDRESS: \_\_\_\_\_ BILLING ADDRESS: (if different) \_\_\_\_\_

Additional Insured/Location

The POLICYHOLDER, if other than the EMPLOYER named above, will be:

Previous Carrier: \_\_\_\_\_ Nature of Business: \_\_\_\_\_

Contact Person: \_\_\_\_\_ Telephone Number: (\_\_\_\_) \_\_\_\_\_

Type of Organization:  Corporation  Partnership  Proprietorship  Other: \_\_\_\_\_

No. of Employees to be Insured: \_\_\_\_ Males \_\_\_\_ Females

Include these Partners or Proprietors Name: \_\_\_\_\_

Exclude all Partners or Proprietors Name: \_\_\_\_\_

Covered Employees:  All eligible under Section 204 of N.Y. DBL

Only the following class(es) \_\_\_\_\_

All except \_\_\_\_\_

Coverage:  Required  Voluntary

Benefits:  Statutory  Other \_\_\_\_\_

Employee Contributions:  None  Yes, Maximum  Yes, Other \_\_\_\_\_

Mode of Payment:  Quarterly  Monthly  Annually

Rate: \$ \_\_\_\_\_  Payroll  Per Capita

The undersigned employer hereby understands and agrees:

That in reliance upon the above statements, a New York Disability Benefits Policy bearing the same number as this application, shall be binding upon the Company as of 12:01 A.M. Eastern Standard Time on the effective date indicated above, provided this application is received by the Company within 10 days after said date.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing any 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 \_\_\_\_\_ Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Policyholder: \_\_\_\_\_

By \_\_\_\_\_ Title: \_\_\_\_\_

Soliciting Agent #

General Agent #

**I: BENEFITS:** Weekly benefits for each employee eligible under the Law and Insured under the policy shall be those prescribed by Section 204 of the New York Disability Benefits Law.

**II: PREMIUM:**

GROUP A: When the number of employees to be covered is 50 or more: Based on the data furnished to the Company: the premium rate is shown on Part 1 of this application. The payroll premium rate is calculated per \$100 of monthly payroll, subject to a maximum of \$340.00 per week for each insured employee.

GROUP B: When the number of employees to be covered is less than 50:

|                              | <b>DBL<br/>Coverage<br/>Only</b> | <b>DBL<br/>any other Guardian Coverage<br/>(Excluding Stand Alone Medical)</b> |                             |                            |                                  |
|------------------------------|----------------------------------|--|-----------------------------|----------------------------|----------------------------------|
| <b>Monthly Premium Rates</b> |                                  |  | <b>(payable quarterly)</b>  | <b>Partner/Proprietors</b> | <b>Minimum Quarterly Premium</b> |
| Male Employees               | \$2.60                           | \$2.30   |                             |                            |                                  |
| Female Employees             | \$5.75                           | \$5.00   |                             | \$6.85                     | \$15.00                          |
| <br>                         |                                  |  |                             |                            |                                  |
| <b>Annual Premium Rates</b>  |                                  |  | <b>(payable in advance)</b> | <b>Partner/Proprietors</b> | <b>Minimum Annual Premium</b>    |
| Male Employees               | \$28.21                          | \$24.61  |                             |                            |                                  |
| Female Employees             | \$61.27                          | \$53.48  |                             | \$68.86                    | \$60.00                          |

Where premiums, as designated herein, are payable to the Company quarterly, the first premium is due on the last day of the calendar quarter.

Successive premiums are thereafter due to the last day of the calendar quarter for the insurance in force during the calendar quarter.

The maximum employee contribution permitted under the Law is ½ of 1% of wages, not to exceed \$.60 per week or the equivalent if paid other than weekly.

Insurance coverage for Partners or Proprietorships will be billed separately.