

1. Today's Date	2. Full Legal Name of Employer as filed with the NYS Dept. of Labor, Unemployment Insurance Div.	3. Telephone ()
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4. Employer's Address (Street, City, State, Zip Code) Not P.O. Box	5. Fax ()
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6. Name under which Employer's business is conducted if different from the above (D/B/A Name)

7. Billing address (if different from above)	Additional Employers/Locations (Use Reverse Side)
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8. Administrative Contact	9. Nature of Business	10. Industry Code
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11. Form of Organization <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other: _____	12. Coverage is: <input type="checkbox"/> Required <input type="checkbox"/> Voluntary*
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13. Employer's New York Unemployment Insurance Regulation No. (ERNUM#) _____ - _____	*Form DB-135 or 136 must accompany this application if coverage is voluntary
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14. Federal Employer Identification No. _____

15. Employee Classes Covered:

a) All eligible under NY Disability Benefits Law:

b) Only the following class(es):

c) Any Sole Proprietor of Partner who desires to be insured and who is specifically named herein: _____

16. Requested Effective Date	17. Number to be insured (Groups with greater than 50 lives require prior underwriting approval)
	Employees _____ Male _____ Female _____ Total Employees Proprietors/Partners _____ Male _____ Female _____ Approximate Insured <div style="text-align: right;">Monthly Payroll</div>

18. Plan of Insurance	Waiting Period	Maximum Duration	Weekly Benefits	Maximum
	Accident-Sickness		% of Wages	
<input type="checkbox"/> Statutory	7 days - 7 days	26 weeks	50%	<input type="checkbox"/> Statutory
<input type="checkbox"/> Enriched	____ days - ____ days	____ weeks	____%	\$ _____

19. Initial Premium

Employees:	Male	\$ _____ per _____	Female	\$ _____ per _____
Proprietors:	Male	\$ _____ per _____	Female	\$ _____ per _____

20. Billing Annual in advance - Premiums due on the first day of each policy year (Required on plans with 4 or less Employees)

Monthly - Premiums due and payable on the first day of the month.

Quarterly Billing - Premiums due on the last day of each calendar quarter.

21. Previous Carrier's Name	Termination Date	Previous Policy No.
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22. Employee Contributions

None Maximum permitted by law (1/2 of 1% of wages; but not more than 60 cents per week) Other _____

Fort Dearborn Life Insurance Company® of New York
 Home Office
 Pittsford, NY 14534
 (866) 406-3356

ADDITIONAL EMPLOYERS/LOCATIONS

Legal Name of Employer	Location Address (Street, City, State & Zip Code) No P.O. Boxes	Mailing Address	Total Number of Males	Total Number of Females	UI Registration Number	Federal Tax ID No.	To Be Billed Separately (check one)	
							Yes	No

I hereby apply for a New York Disability Benefits Policy on behalf of the Employer named in this Application. I represent that I have read the statements and answers given in this Application; they are true, complete and recorded to the best of my knowledge and belief.

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 _____

_____ by _____
Employer Name Title

_____ Agent/Broker Name (second Agent if applicable)

_____ Street

_____ City State ZIP

_____ % FDLNY Code #

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