

**APPLICATION TO
PRESIDENTIAL LIFE INSURANCE COMPANY, Nyack, New York
for
GROUP DISABILITY BENEFITS**

Application is hereby made to the Presidential Life Insurance Company ("Company") for Disability Insurance in satisfaction of the New York Disability Law. This Application must be accepted and approved by the Company or its authorized representative prior to any Contract being in existence.

1. Full Legal Name of Applicant:

Address: _____ City _____ State: _____ Zip Code:

2. Billing address if different than above:

Address: _____ City _____ State: _____ Zip Code:

3. Form of organization: Corporation _____ Partnership _____ Proprietorship _____ Other:

Employer Tax Identification Number (FEIN) _____

4. If subsidiary or affiliate companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies on the back of this application.

5. Employers Unemployment Insurance Account Number (ERMIN):

6. Employee classes to be covered: All eligible under NY Disability Benefit Law

Only the following class(es):

Any proprietor or Partnership named herein:

7. Number to be insured: Employees: # of Males _____ # of Females _____

Proprietors / Partners # of Males _____ # of Females _____ Total _____

8. Does employer deduct for DBL: No _____ Yes _____ %

9. Employee contributions: None _____ Maximum permitted by law _____ Other _____ Per _____

10. Prior Carrier Name _____ Termination Date: _____ Policy # _____

11. Billing Mode: Quarterly in arrears _____ Annual in advance _____ Other _____

12. Requested Effective Date: ____/____/____ Rates: _____

GENERAL SCHEDULE OPTIONS: Statutory Benefit Provisions: Yes _____ Other _____
(Note: Benefits must be at least as great as Statutory Benefits in all respects)

13. If other: Elimination Period Accident: _____ Days, Sickness _____ Days,

Maximum Benefit Period _____ Weeks, Maximum Benefit \$ _____ Per _____

In making this Application, the Applicant represents that, to the best of its knowledge and belief, such information accurately reflects the true facts and that the undersigned has authority to bind the Applicant to the proposed Contract. Accordingly, this Application will be a part of the Contract if accepted by the Company or its authorized representative.

Signed at _____ This _____ Day of _____ Year

By: _____ Title _____
Authorized Signature

Licensed Resident Agent:

Address: _____ City: _____ State/Zip: _____ Tax ID # _____

ATTACHMENT TO APPLICATION
Check List Of Additional Information For Policy Set Up

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** Please send to Presidential Life Ins Co- DBL - 500 Helendale Rd. Suite 260 Rochester, NY 14609
Voice 800-272-7901 Fax 585-482-5132

Subsidiary or affiliate companies (companies under common control through stock ownership, contract, or otherwise) to be included per #4 on reverse side of this application:

Name:

Address: Street

City _____ State _____ Zip Code

Federal Tax ID #(FEIN) _____ Unemployment Insurance Account # (ERMIN)

Name:

Address: Street

City _____ State _____ Zip Code

Federal Tax ID #(FEIN) _____ Unemployment Insurance Account # (ERMIN)

Name:

Address: Street

City _____ State _____ Zip Code

Federal Tax ID #(FEIN) _____ Unemployment Insurance Account # (ERMIN)

Name:

Address: Street

City _____ State _____ Zip Code

Federal Tax ID #(FEIN) _____ Unemployment Insurance Account # (ERMIN)