



# Enrollment Application for Group Disability Insurance

Application is hereby made to The Union Central Life Insurance Company for disability Insurance in satisfaction of the New York Disability Benefits Law. This application must be accepted and approved by Union Central or its authorized representative prior to any contract being placed in force.

## PART 1: APPLICANT INFORMATION

Applicant's Full Legal Name \_\_\_\_\_ (First, Middle, Last)

Applicant's Home Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

**Billing Address if different than above:**

Applicant's Home Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

## PART 2: CORPORATION OR COMPANY INFORMATION

Form of organization:  Corporation  Partnership  Proprietorship/LLC  Other \_\_\_\_\_

If subsidiary or affiliated companies (companies under common control through stock ownership, contract, or otherwise) are to be included, list legal name and addresses of such companies.

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address \_\_\_\_\_ City/Town \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Employer's Unemployment Insurance Account Number (ERMIN) \_\_\_\_\_

Employer's Federal Identification Number (FEIN) \_\_\_\_\_

## PART 3: COVERAGE INFORMATION

Employee classes to be covered:

All eligible under NY Disability Benefit Law  Only the following class(es) \_\_\_\_\_

Number of Insureds: Employees \_\_\_\_\_ Males \_\_\_\_\_ Females \_\_\_\_\_ Total \_\_\_\_\_

Does the employer deduct for DBL?  No  Yes If yes, \_\_\_\_\_ Percent

Employee contributions: \_\_\_\_\_ Maximum permitted by law: \_\_\_\_\_ Other \_\_\_\_\_ per \_\_\_\_\_

Prior Carrier Name: \_\_\_\_\_ Termination Date: \_\_\_\_\_

Prior Policy Number: \_\_\_\_\_ Requested Effective Date: \_\_\_\_\_

Billing Mode:  Quarterly in arrears  Annual in advance  Other (specify) \_\_\_\_\_

Statutory Benefit Provisions:  Yes  Other

**NOTE:** All benefit provisions **must be** at least equal in every respect to the minimum statutory requirements of the New York Disability Benefits Law.

If other:

Elimination Period Accident: \_\_\_\_\_ Days Sickness: \_\_\_\_\_ Days Maximum Benefit Period \_\_\_\_\_ Weeks

Maximum Benefit: \$ \_\_\_\_\_ per \_\_\_\_\_

In making this application, the applicant represents that 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 Union Central or its authorized representative.

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 \$5,000.00 and the stated value of the claim for each such violation.

Applicants Signature \_\_\_\_\_ Date \_\_\_\_\_

\_\_\_\_\_ by \_\_\_\_\_  
Employer Name Title

Licensed Resident Agent: \_\_\_\_\_  
(Print or type, please)

Address: \_\_\_\_\_  
Street City State Zip Code

Agent's Social Security or Tax ID Number: \_\_\_\_\_

The Union Central Life Insurance Company, Cincinnati, Ohio