ShelterPoint Life Insurance Company
600 Northern Boulevard, Ste. 310 | Great Neck, NY 11021
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
www.shelterpoint.com | Phone: 800.365.4999 (516.829.8100)

# NYS Statutory Disability Benefits Law (DBL) Application

## Including Optional Benefits

*This application becomes part of the DBL policy.*

| Full Legal Business Name (as filed with the NY State Department of Labor) | | | | | |
|---|---|---|---|---|---|
| | | | | | |
| **Business Address** | | | **Mailing Address (if not the same)** | | |
| | | | | | |
| **City** | **State** | **Zip** | **City** | **State** | **Zip** |
| | | | | | |
| **Applicant E-mail** | **Applicant Phone** | | **Attention/Care of** | | |
| | | | | | |
| **Applicant Website Address** | | | | | |
| | | | | | |

**Legal Entity Type (Choose one)**

☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Association ☐ Limited Partner (LP) ☐ Joint Venture (JV)
☐ Limited Liability Co. (LLC) ☐ Trust or Estate ☐ Executor or Trustee ☐ Limited Liability Partnership (LLP or LLLP) ☐ Other

| Nature of Business | SIC Code | Federal ID # | Unemployment Insurance # |
|---|---|---|---|
| | | | |

| Requested Effective Date | Current Workers' Compensation Carrier | Current DBL Carrier |
|---|---|---|
| | | |

| Covered Employees (for all Locations) | | Employee Contribution |
|---|---|---|
| Number of Covered Males | | ☐ Noncontributory ☐ Contributory |
| Number of Covered Females | | An employee's contribution for statutory DBL coverage shall not exceed ½ of 1% of wages received on or after the effective date of this policy, up to the lower of a maximum of 60 cents ($0.60) per week or the actual premium per employee. |
| ***Total Employees*** | | |

All employees, pursuant to New York Disability Benefits Law Section 204, are covered: ☐ Yes ☐ No
If NO is checked, please list excluded classes of employees.

| Type of Organization | Coverage Includes | Voluntary Coverage: List additional Class(es) of Employees to be included. |
|---|---|---|
| ☐ Profit | ☐ Teachers | |
| ☐ Non-Profit | ☐ Clergy | |

*Voluntary coverage requires form DB135 or DB136 to be submitted with application unless form is currently on file with the New York State Workers' Compensation Board*

**Proprietors: If Business Entity is a Proprietorship, list Names of Proprietors below.**

| | | | |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

| Additional Entities/Locations to be covered (as filed with the NY State Department of Labor) | | | |
|---|---|---|---|
| Name | | | |
| Address | | | |
| Federal ID # | | Unemployment Insurance # | |
| | | | |
| Name | | | |
| Address | | | |
| Federal ID # | | Unemployment Insurance # | |
| Name | | | |
| Address | | | |
| Federal ID # | | Unemployment Insurance # | |

**** If the number of additional entities exceeds space provided above, attach all additional information required on a separate piece of paper.****

| **DBL Benefits** – Please select ONE from options below. | | **Optional Riders** – Please select from options below. | |
|---|---|---|---|
| **Statutory DBL Benefit Only**<br>☐ Statutory Benefit | **Enhanced DBL Benefits**<br>☐ 1.5x Statutory Benefit<br>☐ 2x Statutory Benefit<br>☐ 3x Statutory Benefit<br>☐ 4x Statutory Benefit<br>☐ 5x Statutory Benefit | **In-Hospital Rider**<br>☐ Selected | **AD&D Benefit Rider**<br>☐ $ 50,000<br>☐ $ 100,000 |

| **Optional BaseLine Benefits–** Please select from policy options below. | | **Optional Non-Insurance Benefits** |
|---|---|---|
| **Term Life**<br>☐ $ 15,000 Benefit | **Hospital Cash**<br>☐ $100/day | **Employer & Employee Assistance Program**<br>☐ Selected<br>**Nurse Helpline**<br>☐ Selected |

**Billing Options** – Make one selection from the options below.

| | | |
|---|---|---|
| ☐ **Annual Billing**<br>Minimum DBL Premium is $125.00 annually. | ☐ **Quarterly Billing – DBL based on covered payroll** (11 or more lives required )<br>Minimum DBL Premium is $35.00 per quarter | |
| ☐ **Quarterly Billing** (11 or more lives required )<br>Minimum DBL Premium is $35.00 per quarter | Monthly Covered Payroll applicable to Females | $ |
| | Monthly Covered Payroll applicable to Males | $ |
| | Total Monthly Covered Payroll | $ |

**Authorization**

**The applicant declares that, to the best of his knowledge and belief, the statements and answers to the questions in this application are correct and true.**

No one except the Chief Executive Officer, a Vice President or the Secretary of SHELTERPOINT LIFE INSURANCE COMPANY may make or modify any contract on behalf of SHELTERPOINT LIFE INSURANCE COMPANY. Any change or amendment to the policy shall be signed by ShelterPoint Life and the policyholder.

***NOTICE (Does not apply to life insurance):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 and the stated value of the claim for each such violation.***

**Applicant:** Date _____ Name _____ Signature _____

**Producer:** Date _____ Name _____ Signature _____

Agency Name **CENTURY BENEFITS GROUP INC** Agency # **0000-4523**

Agency Address **400 WHITE SPRUCE BLVD SUITE C** **ROCHESTER** **NY** **14623** Phone # **585-224-8138**

| Policy #: | Effective: | Male Rate: | Female Rate: | Payroll Rate: |
|---|---|---|---|---|