Sun Life Insurance and Annuity Company of New York

Suite 1115, 60 East 42nd Street, New York, NY 10165

Application – New York Disability Benefit Law

1 Employer Information

Name of Employer		
Nature of business	Form of Organization: ☐ Corporation ☐ Partnership ☐ Sole proprietor ☐ Other: ________	
Names of Proprietors or Partners to be covered		
NY Employer Registration No. –	Federal Taxpayer ID No. –	SIC Code

Employer Street Address	Suite or Floor No.	
City	State	Zip code

Billing Address (if different than above)		
City	State	Zip code

Name of Authorized Representative of Employer	Title	
Email address	Phone number	Fax number

List subsidiaries/affiliates in Section 5 of this form.

Will any subsidiaries or affiliates be covered under this policy? ☐ Yes ☐ No

2 Requested Coverage

Please check coverages you are applying for and specify effective date.

☐ **New York Disability Benefits (DBL) – Statutory Benefits**

☐ **Enhanced Disability Benefits**

Effective Date

3 Employee Information

Covered Employees (check one)

☐ All eligible under NY State Disability Law

☐ All except the following (list excluded classes): ____________________

Number of Employees to be Insured: Male: _______ Female: _______ Total: ______

Employee Contribution: ☐ Contributory* ☐ Non-Contributory

* Employee contribution shall not exceed the maximum amount specified in Section 204 of the New York Disability Benefit Law.

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4 Administrative Information

Name of Workers' Compensation Carrier	Employer's Unemployment Insurance Account No.

Previous Disability Carrier	Date of Termination

Name of Agent or Broker	Name of Agency/Broker Firm (if different)

Agent/Broker Street Address	Suite or Floor	Phone number

City	State	Zip Code	Email Address

5 Subsidiaries and Affiliates

Please list all Subsidiaries and Affiliates to be included as covered employers under the policy.

Attach additional pages if necessary.

Name	Address, City, State, Zip	Unemployment Insurance Account No.	Number of employees M	Number of employees F	Billed separately Y	Billed separately N
1.					☐	☐
2.					☐	☐
3.					☐	☐
4.					☐	☐
5.					☐	☐
6.					☐	☐

6 Certification and Signature

The undersigned employer hereby applies for a policy of group insurance to provide benefits in accordance with Section 204 of the New York Disability Benefits Law, to be used in reliance on the statements made in this application.

Any person who knowingly and with intent to defraud any insurance company or other person files an accident and health 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.

No insurance shall be binding unless and until this application is approved by Sun Life Insurance and Annuity Company of New York.

Name of Authorized Representative of Plan Sponsor	Title

Signature of Authorized Representative	Today's date
X	

Signature of Agent/Broker	Amount paid with this application
X	$
Countersigned by licensed resident agent (when required by law)	
X	

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