7 Hanover Square, New York, NY 10004

NY U.I. Number: _____ Guardian Group Policy Number: _____
(Other Guardian Group Coverage(s))

Federal Employer I.D. Number: _____ Previous Carrier: _____

The undersigned employer hereby applies for a policy of group insurance to be effective _____/_____/_____ to provide benefits in accordance with New York State Disability Benefits Law and Paid Family Leave Benefits Law (hereinafter the Law):

☒ Disability Benefits (hereinafter DBL)

☒ Paid Family Leave Benefits (hereinafter PFL)

Type of Organization: ☐ Corporation ☐ Partnership ☐ Proprietorship ☐ LLC/LLP

Note: A member of a limited liability partnership or other self-employed person shall be subject to a waiting period of 2 years before benefits are payable, unless the policy is issued on or before 1/1/18 or within 26 weeks of when the employer first becomes a sole proprietor, limited liability company, limited liability partnership, or other self-employed person.

☐ Yes. ☐ No. Has your company ever filed, or is it now in the process of filing, for bankruptcy (Chapter 7 or 11)?

LEGAL NAME OF EMPLOYER:	LOCATION ADDRESS:	MAILING ADDRESS: (if different)
_____	_____	_____
_____	_____	_____

Nature of Business: _____ SIC CODE: _____

Plan Contact Person: _____ Telephone Number: _____

Email address (required): _____

No. of Employees to be insured for DBL: _____ Males _____ Females _____ Total M/F

No. of Employees to be Insured for PFL: _____ Males _____ Females _____ Total M/F

Please list all additional entities and/or affiliate locations to be covered. Attach additional page(s) if needed.

Employer Legal Name	Employer Location Address, City, State and Zip Code	Tax Identification Number (FEIN #)	Number of DBL Employees		Number of PFL Employees	
			M	F	M	F

DBL Coverage:

Covered Employees: ☐ All eligible employees under the Law

☐ Only the following class(es) _____

☐ All except _____

Coverage: ☐ Required ☐ Voluntary (If Voluntary, attach approval form DB-135 or DB-136)

Benefits: ☐ Statutory (Per NYS Law – **50%** to **$170** weekly maximum benefits)

☐ Enhanced: 50 % to Weekly Max *(choose one)*: ☐ **$200** ☐ **$250** ☐ **$350** ☐ **$450**

☐ **$650** ☐ **Other $**_____

DBL-Employee Contributions: ☐ None ☐ Yes, Maximum ☐ Yes, Other _____

The maximum employee DBL contribution permitted under the Law is ½ of 1% of wages, not to exceed $.60 per week or the equivalent if paid other than weekly.

DBL Rates:

Less than 50 Lives (**P**er **E**mployee **P**er **M**onth): Male $_____ Female $_____ ☒ Statutory ☐ Enhanced

50 or more lives (Monthly): $_____ ☐ Per Capita (**PEPM**) ☐ Per Payroll Rate* ☒ Statutory ☐ Enhanced

*Rate is based on per $100 of monthly payroll, subject to maximum amount per week for each Insured employee.

PFL Coverage:

Covered Employees: ☐ All eligible employees under the Law. Employees outside of New York state are not eligible.

☐ Only the following class(es) _____

☐ All except _____

Benefits: ☐ Statutory (PFL coverage is provided at the benefit amounts and duration required under WCL §204(2))

PFL-Employee Contributions: ☐ 100% ☐ Other, specify Amount _____

The maximum employee PFL contribution will be established annually by the New York's Department of Financial Services (DFS). Current information can be found by visiting www.guardianantytime.com/NY-paid-leave

PFL Rates: Total annual wages for all NY eligible employees: $

Paid Family Leave Rates are established by New York's State Department of Financial Services (DFS) and subject to change annually. DFS will annually publish the rate on or before September 1 of the year prior to the benefit period beginning on the following January 1. The rates may be found at www.guardianantytime.com/NY-paid-leave.

I: BENEFITS: Weekly benefits for each employee eligible under the Law and Insured under the policy shall be those prescribed by New York State Disability Benefits Law and New York State Paid Family Leave Benefits Law**.**

II: PREMIUM:

Mode of Payment: ☐ Quarterly in Arrears ☐ Monthly in Advance ☐ Annually in Advance

Where premiums, as designated herein, are payable to Guardian quarterly in arrears, the first premium is due on the last day of the calendar quarter, commencing with the effective date of the policy, to cover the period of that calendar quarter. Successive premiums are thereafter due on the last day of the calendar quarter for the insurance in force during the calendar quarter.

Where premiums, as designated herein, are payable to Guardian monthly in advance, the first premium is due on the first day of the month, commencing with the effective date of the policy. Successive premiums are thereafter due on the first day of the month.

Where premiums, as designated herein, are payable to Guardian annually in advance, the first premium is due on the first day of the month, commencing with the effective date of the policy. Successive premiums are thereafter due on the first day of the month of each policy anniversary.

III: AGREEMENT:

The undersigned employer, or its duly appointed and authorized agent, hereby understands and agrees:
That in reliance upon the above statements, a New York Disability Benefits Policy and Paid Family Leave benefits bearing the same number as this application, shall be binding upon Guardian as of 12:01 A.M. Eastern Standard Time on the effective date indicated above, provided this application is received by Guardian within 10 days after said date.

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.

THE UNDERSIGNED APPLICANT CERTIFIES THAT, TO THE BEST OF HIS/HER KNOWLEDGE AND BELIEF, ALL OF THE RESPONSES GIVEN ARE TRUE, CORRECT AND COMPLETE. THE APPLICANT UNDERSTANDS THAT A FALSE STATEMENT OR MIS-REPRESENTATION IN THE APPLICATION MAY RESULT IN THE LOSS OF COVERAGE IN THE POLICY, THE RESCISSION OF THE POLICY, OR A REVISION OF THE RATES QUOTED.

By my signature below, I certify that the Employer will extend the protections of WCL§§203-b & 203-c for any additional or enhanced benefits.

Date: _____/_____/_____

Signed at: _____

Employer: _____

Signed By: _____ Title: _____

Broker Name: _____ Guardian Broker Code: _____

Sub-Producer: _____ Sub-Producer Code: _____

Information Form
New York State DBL

To bind coverage for a group we require the following:

Date of Request: _____

Agent / Broker: _____

Exact Legal Name of Insured: _____
(It is imperative that you have the **exact legal name** as registered with the division of labor).

Billing Address: _____
_____
_____

Business Location: (if different than billing address)
_____
_____
_____

Phone Number: _____
Contact Person: _____

Effective Date Requested: _____

Total # of Male Employees to Be Covered: _____
Total # of Female Employees to Be Covered: _____

Nature of Business: _____

Check One: __ Partnership __Proprietorship
__Corporation __Individual

Prior Carrier: _____
or (Is this a new business?)

Unemployment Number: (if available) _____
Federal Tax ID Number: (if available) _____

Contributory: Yes No
Mode: Annual Quarterly

Name & Phone # of person who took order: _____

The above is all that is needed to issue a policy.

Note: Groups of 1 to 6 lives are usually billed annually in advance; otherwise the group is billed quarterly in arrears.

Fax this completed form back to Centurion Agency Ltd. @ fax # 516-825-0953
Questions? Call 516-561-0100 or visit us on the web at www.lifeandhealth.biz