REGENCY INSURANCE
BROKERAGE SERVICES

NY Statutory Disability Benefits Law (DBL) Application

Including Enriched Benefit Options

The undersigned applicant hereby applies for a policy of group insurance to provide disability benefits in accordance with Section 204 of the New York Disability Benefits Law, to be issued in reliance on the statements made in this application. No insurance shall be binding unless and until this application is approved at the Home Office of the Company.

This application becomes part of the policy

Employer Legal Business Name as filed with the NY State Department of Labor						
DBA, T/A or A/K/A name						
Business Address				Mailing/Billing Address (if different)		
City	State	Zip		City	State	Zip
Contact	Phone			Email		

Legal Status Type (Choose One)

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

Nature of Business	SIC Code	NYS UIER#	Employer FEIN

Requested Effective Date	Previous DBL Carrier	NY Workers' Compensation Carrier

Covered Employees (for all New York 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 up to the lessor of a maximum of 60 cents ($0.60) per week or the actual premium per employee if less.
Total Employees		

All employees, pursuant to New York Disability Benefits Law Section 204, are covered: ☒ Yes ☐ No*
*If NO is checked, please list below excluded classes of employees, i.e. Union Local #; Spouse of sole proprietor (form DB-212.5); shareholder officer(s) of One or Two person corporation required to have coverage for its Employees (form DB-212.3).
Exclude:

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

**Voluntary coverage requires form DB-135 or DB-136 to be submitted with application unless form is currently on file with the New York State Workers' Compensation Board.

Other Voluntary Coverage: ☐ Sole ☐ Partners ☐ Member(s)
List Name(s):

☐ Out of State coverage (Not available to employees working in CA, HI, NJ, RI or Puerto Rico):

Name					Employer FEIN	
Address						
# of Employees	Male		Female		States:	

Additional NY Entities/Locations to be covered (as filed with the NY State Department of Labor)				
Name				
Address				
NYS UIER #		Employer FEIN		
# of Employees	Male	Female	Billing Option	☐ Individual Bill ☐ Combined/List Bill

If the number of additional entities exceeds space provided above, attach all additional information required.

Coverage Options - Please select from options below.	
Benefit Level ☒ Statutory Benefit 50% to $170 Other benefit plans are available. Contact Home Office.	Premium Basis for Statutory Benefits LESS THAN 50 EMPLOYEES ☒ Annual in Advance billing (1-49 employees) ☐ Quarterly In Arrears billing (10-49 employees) 50 or MORE EMPLOYEES - requires prior Home Office approval ☐ Quarterly In Arrears billing - $ _____ per employee per month $ _____ per $_____ Weekly Insured Payroll
	For Company Use:

Authorization

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

NOTICE: 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.

Employer Name:	Signature _____	Date _____
Producer Name:	Signature _____	Date: _____
Producer Code:	Address:	
General Agent Name:	General Agent Code: _____	
	Signature _____	Date: _____

Payrolls for each employee –

males –

females –