First Rehab Life (The First Rehabilitation Life Insurance Company of America)
600 Northern Boulevard ● Great Neck ● NY 11021
800-365-4999 (516-829-8100) ● Fax 516-829-8211 ● www.firstrehab.com

Master Application

New York State Disability Benefits Law Policy

All statements are true and correct to the best of the Applicant's knowledge and belief.
This application becomes part of the 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 ☐ 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.****

Billing Mode (choose one)	Benefit Level (choose one)	In-Hospital Option (choose one)
☐ **Annual Billing** Minimum Premium is $125.00 annually.	☐ Statutory Benefit ☐ 1.5x Statutory Benefit ☐ 2x Statutory Benefit ☐ 3x Statutory Benefit ☐ 4x Statutory Benefit ☐ 5x Statutory Benefit	☐ In-Hospital Benefit ☐ Not Selected
☐ **Quarterly Billing** (11 or more lives required) Minimum Premium is $35.00 per quarter. *Choose One:* ☐ **Quarterly Premium based on per-capita Rates** ☐ **Quarterly Premium based on covered Payroll (requires breakdown of payroll information)**		**AD&D Option (choose one)** ☐ $ 50,000 AD&D Benefit ☐ $ 25,000 AD&D Benefit ☐ Not Selected

Provide Payroll Breakdown for Quarterly Covered Payroll Option	
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 complete and true.

No one except the Chief Executive Officer, a Vice President or the Secretary of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA may make or modify any contract on behalf of THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA, and no waiver is valid unless it is in writing and signed by one of these officers.

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.***

The final application placed on file with First Rehab Life must be signed.

Applicant: Date _____ Name _____ Signature _____

Producer: Date _____ Name _____ Signature _____

Agency Name _____ Agency # __ __ __ __ - __ __ __ __

Agency Address _____ Phone # _____

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