Renaissance®

DENTAL · VISION · LIFE · DISABILITY

2 Court St. Suite 102 Binghamton, NY 13901

Renaissance Life & Health
Insurance Company of New York

FOR RENAISSANCE USE ONLY:
Group #: ______________________

NEW YORK DISABILITY BENEFITS LAW (DBL) AND PAID FAMILY LEAVE BENEFITS (PFL) APPLICATION

—This application becomes part of the DBL Policy—

1. Employer Full Legal Name *(As filed with the NY State Department of Labor)*:

Employer Billing Address *(Include Apt#/Suite)*:	City:	State:	ZIP Code:
Employer Location Address *(If different from above)*:	City:	State:	ZIP Code:

2. ADMINISTRATIVE CORRESPONDENT	Name:	Telephone:
	Title:	Email:

3. CLAIMS CORRESPONDENT	Name:	Telephone:
	Title:	Email:

4. Employer Federal Tax ID No. (FEIN):

5. Legal Entity: ☐ Corporation ☐ Partnership ☐ Proprietor ☐ Limited Liability (LLC) ☐ Other: ______________

6. Effective Date *(MM/DD/YY)*:	**7. SIC Code:**	**8. Nature of Business:**	**9. Previous DBL Carrier:**	**10. Termination Date** *(MM/DD/YY)*:

11. DBL—Classes of Employees:

☐ All Eligible Under DBL

☐ All Except: ______________

☐ Only The Following Class(es): ______________

12. DBL—Voluntary Coverage:

☐ Partner/Sole Prop./Member* #: ______________

☐ Teachers #: __________ ☐ Clergy #: __________

☐ Out-of-State* #: ______________

☐ Public Employer: ______________

** List names in Box 20*

13. PFL—Voluntary Coverage:

☐ Partner/Sole Prop./Member* #: ______________

☐ Teachers #: __________ ☐ Clergy #: __________

☐ Public Employer: ______________

(Must be a NY Employee and covered under DBL Policy)

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.

14. DBL—Number of Insured *(all locations, includes voluntary coverages)*:

Males: _______ Females: _______

Total: ______________

15. PFL—Number of Insured *(all locations, includes voluntary coverages)*:

Males: _______ Females: _______

Total: ______________

16. Premium Basis—DBL

☐ Monthly Per Capita	Male	Female
Fewer than 50 employees:	☐ $2.20	☐ $5.00
Partner/Sole Proprietor-LC/LLP member:	☐ $6.20	☐ $6.20

☐ **50+ Employees (EE):**

☐ $_____/EE per month ☐ Other $__________

17. Premium Basis—PFL

☐ .153% of employees average weekly wage, capped at $1,357.11/week

18. COVERAGE & BENEFIT ELECTIONS

Statutory DBL & PFL:

☐ Statutory DBL Benefits 50% to $170/wk

☐ Statutory PFL Benefits 55% to $746.41/wk

Enhanced DBL Benefits:

Up to ☐ 50% ☐ 60% ☐ 70% of wkly wages to a wkly max benefit of: $________

DBL Elimination Period: Injury: ☐ 0 ☐ 7 Sickness: ☐ 0 ☐ 7

☐ 1st Day Hospital Benefit

DBL Extended Benefits: Additional ☐ 13 weeks ☐ 26 weeks

20. ADDITIONAL ENTITIES, EMPLOYERS, PROPRIETORSHIPS, PARTNERS, MEMBERS, OR STATES TO BE INCLUDED. LIST THOSE EMPLOYERS AFFILIATED WITH POLICYHOLDER BY FINANCIAL INTEREST OR CONTROL, WHICH ARE TO BE INCLUDED AS COVERED EMPLOYERS UNDER THE POLICY. (ATTACH ADDITIONAL PAGE IF NEEDED.)

ADDITIONAL ENTITIES TO BE COVERED: ☐ NONE ☐ LISTED BELOW

NAME	STREET ADDRESS	CITY, STATE, ZIP	FEDERAL TAX ID NUMBER

NOTE: Paid Family Leave Coverage issued to a sole proprietor, a member of a limited liability company, a member of a limited liability partnership or other self-employed person is 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 partner or other self-employed person

21. BILLING OPTIONS

-Select One- ☐ Individual Bill for Each Location ☐ Combined Bill for All Locations

-Select One- ☐ Quarterly in Arrears ☐ Annually in Advance *(Required for Groups <10)*

22. DBL—Are Employee Contributions Deducted?

☐ No (100% Taxable Benefit)

☐ Yes: Taxable Percent: _____% if known.

(1/2 of 1% of wages, but not more than $.60/week)

23. PFL—Are Employee Contributions Deducted?

☐ No (100% Taxable Benefit)

☐ Yes: .153% capped at $1,357.11/wk

24. Additional Services

☐ W-2 Preparation

☐ FICA Match

(Service Agreement Required)

25. Electronic Delivery of Documents

☐ Yes, send the administrative kit and other coverage documents electronically. (By checking this box, you are agreeing to receive such materials electronically pursuant to the Terms for Paperless Delivery attached to this application. **You must provide a current email address on the first page of this application**. If the box is not checked, all materials will be sent by hard copy.)

26. Agent OR Broker ☐ No ☐ Yes, if yes complete below:

Printed Name: ______________________________

Signature: ____________________ Date:__________

Agent #: ______________________________

Commission shall be paid only to the above named Soliciting Agent

27. General Agent ☐ No ☐ Yes, if yes complete below:

Printed Name: ______________________________

Signature: ____________________ Date:__________

Agent #: ______________________________

Commission shall be paid only to the above named General Agent

FRAUD WARNING: 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.

Signed By: ______________________________ **Date:** ____________________

Printed Name of Authorized Group Official: ______________________________

Authorized Group Official's Title: ______________________________