TRUSTED 200 YEARS
THE HARTFORD

POLICY APPLICATION FOR NEW YORK STATUTORY DISABILITY BENEFITS

Send completed form via email to your Clarke & Sampson Agent or to bhoward@clarkeandsampson.com
If you have an questions please call us at 703-683-6601

1. EFFECTIVE DATE OF COVERAGE:

2. FULL LEGAL NAME of Employer as filed with the Workers' Compensation Board Disability Benefits Bureau

3. Employers LEGAL Address:

Street: City: State: Zip:

4. Case Contact:

Name: Phone #: E-mail:

5. Employers BILLING/MAILING Address:

Street: City: State: Zip:

6. Billing Contact:

Name: Phone #: E-mail:

7. Employer's Federal Tax ID No. (required):

(9 digits) _____

8. Employer's Unemployment Insurance No.:

(7 digits) _____

9. Employee Contributions: YES ☐ NO ☐

(1/2 of 1% of wages; but not more than 60 cents per week maximum)

10. Nature of Business: _____

Industry Code (SIC): _____

11. Employer Organization: Corporation ☐ Partnership ☐ Proprietorship ☐ LLC ☐ Other ☐ _____

12. Classes of Employees Covered:

☐ a. All full-time & part-time employees working in the state of New York (as defined in the New York Disability Benefits Law)
☐ b. Only the following class or classes of employees: _____
☐ c. Any Sole Proprietor or Co-Partner who desires to be insured and who is specifically named herein:_____

13. Total Number of Male Employees working in New York: _____

Total Number of Female Employees working in New York: _____

Total NY Census : _____

14. ☐ **Annual Billing: 1-7 employees (E-Bill not available with Annual billing)**
Rates (1-7 employees): $2.02 per male/month & $4.70 per female/month ($45 minimum payment)
Rates for employers with 50 employees or more: SEE SALES REPRESENTATIVE

☐ **Quarterly Billing: 8 employees or more**
Rates (8-49 employees): $2.49 per male/month & $5.08 per female/month ($11.25 minimum payment)
Rates for employers with 50 employees or more: SEE SALES REPRESENTATIVE

☐ **Monthly Billing: 500 employees or more**

☐ **Electronic Billing (no paper bills) Enter Email Address here:** _____

15. W2 services requested:

☐ Yes ☐ No

(If W2 services are requested, you must attach the signed tax agreement. To obtain this agreement, call or email us at the contact information listed at the top of this page.)

16. Coverage requested: Statutory Plan (standard) ☐ Enriched Plan (see Enriched Benefits section) ☐

16 Previous Statutory Disability carrier: _____

FOR HOME OFFICE USE ONLY

Regional Office: _____ *Rep:* _____ *Processor:* _____

*POLICY NUMBER: LNY*_____

PRODUCER INFORMATION (REQUIRED)
(IF NO AGENT LIST "NO AGENT")

SECTION A: **Producer to be listed on this policy**	**SECTION B: Agency to be listed on this policy**
Full Legal Name:	Agency Name:
Agent SS#:	TAX ID or SS#:
Producer Code: 42640151	Producer Code:
Address: 228 S Washington St Ste 200	Address:
City: Alexandria State: VA Zip Code: 22341	City: State: Zip Code:
Phone #: 7036836601 E-mail:	Phone #:

ADDITIONAL LOCATIONS IN NEW YORK

LOCATION ADDRESS:
LOCATION ADDRESS:

ADDITIONAL EMPLOYER WITH EMPLOYEES WORKING IN NEW YORK

LEGAL NAME OF EMPLOYER:	**LEGAL ADDRESS:**	**BILLING/MAILING ADDRESS:**
Total # of Male Employees:	Unemployment Insurance No.: (7 digits)	
Total # of Female Employees:	Federal Tax ID No.: (9 digits)	**CONTACT:**
Total Census :	To be billed separately? YES ☐ NO ☐	**EMAIL:**

ADDITIONAL EMPLOYER WITH EMPLOYEES WORKING IN NEW YORK

LEGAL NAME OF EMPLOYER:	**LEGAL ADDRESS:**	**BILLING/MAILING ADDRESS:**
Total # of Male Employees:	Unemployment Insurance No.: (7 digits)	
Total # of Female Employees:	Federal Tax ID No.: (9 digits)	**CONTACT:**
Total Census :	To be billed separately? YES ☐ NO ☐	**EMAIL:**

ENRICHED BENEFITS

For employers with at least 10 employees working in New York
(Please work with your local Hartford Sales Representative for details on coverage options)

Percentage of Weekly Earnings: select	**Benefit Duration:** select	**Maximum Weekly Benefit:**
Monthly Rate per $100 covered salary: $_____ per male, $_____ per female		
Volumes: Male: , Female:		