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: _____

Guardian®

NY STATE MANDATED DBL/PFL
Additional Information Questionaire

(Required Supplement to NY DBL/PFL Master Application)

Employer Name: _____ **GUARDIAN NY DBL Policy #:** _____

Guardian Use Only

BILLING CONTACT INFORMATION:

(For all related billing inquiries and designated recipient of the Guardian premium billing statements.)

Contact Name: _____ **Telephone Number:** _____

Email Address (required)**:** _____

Billing Address: ☐ Same as mailing address listed on Master Application

_____

_____

TAX REPORTING OPTIONS: (Please check one)

☐ **Tax Reports Only**
Quarterly and Yearend Tax Reports will be mailed to Primary Plan Holder Contact. Reports will also be available online via the employer's Guardian Anytime account. Self-Registration required.

☐ **W-2 Printing AND Tax Reports**
Guardian prints W-2. Policyholder files W-2 using Policyholder Fein as provided on the Master Application.

NY REGULATION 194 Requirement: (Applicable for NY situs employers only - Required for all Field Reps and Full Time Agents)

☐ Regulation 194 Form Included ☐ Not Required

Teleguard Claim Service* (Guardian Office Use Only)

☐ Included ☐ Not Eligible

☐ Plan Registered (via PFM Email)

☐ Customized ID Cards Ordered (via Group Forms)

*Eligibility Requirements – Estimated annual disability premium on policy must exceed $15,000. Applies to DBL Claims only. Paid Family Leave Claims will still require completion of PFL Claim form even if Teleguard service is included on the policy.

ADDITIONAL COVERAGE OPTIONS:

☐ **Corporate Officers Coverage Exclusion/NY situs Employer –** (only applicable to Corporations with 2 or less Corporate Officers)

Officers are deemed to be included in coverage for disability and paid family leave under the issued policy as they are considered employees. However, Corporations with 2 or less Corporate Officers may elect to exclude one or both of the Corporate Officers from the statutory coverage. In order to file for exclusion, Form DB212.3 must be submitted with the Master Application. Form may be found on the NY WCB website, http://www.wcb.ny.gov/content/main/forms/db212-3.pdf
Coverage exclusion will be limited to the Officers named on the DB212.3 Form and listed below:

_____ _____

☐ **OUT OF STATE EMPLOYEE COVERAGE** (DBL only – PFL excluded from coverage)

Employers sitused in New York State may elect to cover their employees working in other **Non-Mandated Disability** states with the same DBL benefit provisions, billed under separate division of their DBL policy, at the same billing address as noted on page one of this form. **Coverage is subject to prior UW approval** and limited to Disability coverage only, since under NY State Law, PFL may not be offered to any non-NY covered employees working outside the State of NY. Also, since the Out of State employees would not be considered NY covered employees, they are NOT protected under NY State law.

If elected, list the applicable states where the employees work and number of employees (M/F) per state:

_____ , _____ , _____ , _____ , _____.

In lieu of this option, Guardian would recommend traditional Short-Term Disability coverage.

☐ **PARTNER/PROPRIETOR VOLUNTARY COVERAGE* for Sole Proprietors and Partners (LLC and LLP) with NY Covered Employees**

Under NY Disability Law, sole proprietors and partners of LLC or LLP that have employees, are automatically excluded from disability and PFL coverage. However, they may, voluntarily, elect to be included under the same policy, providing they obtain prior approval from the NY Workers Compensation Board (NY WCB) to be approved for Voluntary Coverage for both disability and paid family leave coverage.

Requirements for Issuance of Coverage under Guardian Policy:

- Submit application for Voluntary Coverage (DB-135 or DB-136) to NY WCB. Forms available on NY WCB website; http://www.wcb.ny.gov/content/main/forms/db135.pdf ; http://www.wcb.ny.gov/content/main/forms/db136.pdf
- Upon receipt of Approval from NY WCB (DB-140), submit copy of DB-140 to Guardian for coverage to be issued as an amendment to policy, effective as of date noted on the DB-140. PP coverage will be issued as separate billed division under the existing DBL/PFL policy. PP coverage subject to separate billing rates as noted below, based on the policy billing mode.
  ☐ DB-140 Form Attached ☐ DB-135/136 submitted to NY WCB, DB-140 Approval Pending
- Partner/Proprietor Rates: Disability (DBL) – $6.85/mo. (Payable Quarterly in Arrears); $68.86/yr. (Payable Annual in Advance); Paid Family Leave (PFL) – same as all other eligible employees. Rates are established by NYS DFS and can be found at, www.guardianantytime.com/NY-paid-leave

*Guardian does not offer Partner/Proprietor Coverage for Sole Proprietors with no employees.

Important Requirement Guidelines Concerning Approved Voluntary Coverage (Per NY State Law):

- Coverage must include both disability and paid family leave. DBL only or PFL only is NOT an option.
- 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.
- Following NY WCB approval, coverage must remain active for at least one (1) year. Request to terminate voluntary coverage, must be submitted directly to NY WCB providing 90-day advance notice of requested termination date.

☐ Check box to acknowledge that you have read and fully understand the requirements of approved Voluntary Coverage as dictated under NY State regulations and noted above.

Employer Signature(required)_____ **Date** _____