

The United States Life Insurance Company in the City of New York

Member of American International Group, Inc.

The undersigned employer hereby applies for a policy of group insurance to provide benefits in accordance with Section 204 of the New York Disability Law to be effective: _____, _____.

1. **LEGAL NAME OF EMPLOYER:** _____ **LOCATION ADDRESS:** _____ **BILLING ADDRESS: (If different)** _____

2. **Additional Insured/Location**

Previous Carrier: _____ Nature of Business: _____
 3. Tel. Number: (____) _____ Contact Person: _____

4. NY U.I. NUMBER: _____ 5. Federal Employer I.D. Number: _____ 6. Type of Organization:
 Corporation
 Partnership
 Proprietorship
 Other: _____

7. No. of Employees to be Insured: [____] Males
 {____} Females

8. Include these Partners or Proprietors Name _____
 Exclude all Partners or Proprietors Name _____

9. Covered Employees: All eligible under Section 204 of N.Y. DBL
 Only the following class(es): _____
 All except _____

10. Coverage: Required Voluntary 11. Benefits: Statutory Other

12. Mode of Payment: Quarterly Annually 13. Employee Contributions: None Yes, Maximum Yes, Other _____

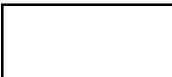
THE UNDERSIGNED EMPLOYER HEREBY UNDERSTANDS AND AGREES:
 That in reliance upon the above statements, a New York Disability Benefits Policy bearing the same number as this application, shall be binding upon the Company as of 12:01 A.M. Eastern Standard Time on the effective date indicated above, provided this application is received by the Company within 10 days after said date.

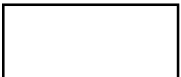
ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME 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 at _____ this _____ day of _____, _____

Policy No. _____ Employer: _____

RATE: \$ _____ By _____ Title: _____
 Per-Capita Payroll

Soliciting Agent 

General Agent 

I: BENEFITS:

Weekly benefits for each employee eligible under the Law and insured under the policy shall be those prescribed by Section 204 of the New York Disability Benefits Law.

II: PREMIUM:

GROUP A: *When the number of employees to be covered is 50 or more:*

Based on the data furnished to the Company, the premium rate is shown on Part 1 of this application. The payroll premium rate is calculated per \$100 of monthly payroll, subject to a maximum of \$340.00 per week for each insured employee.

GROUP B: *When the number of employees to be covered is less than 50:*

Monthly Premium Rates:		(payable quarterly)		
Male Employees		Female Employees	Partner/Proprietors	Minimum Premium
\$3.74		\$7.90	\$9.55	\$15.00
Annual Premium Rates:		(payable in advance)		
Male Employees		Female Employees	Partner/Proprietors	Minimum Premium
\$43.50		\$91.50	\$110.00	\$60.00

Where premiums, as designated herein, are payable to the Company quarterly, 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 the last day of the calendar quarter for the insurance in force during the calendar quarter.

The maximum employee contribution permitted under the Law is 1/2 of 1% of wages, not to exceed \$.60 per week or the equivalent if paid other than weekly.

Insurance coverage for Partners or Proprietorships will be billed separately.