SHELTERPOINT
Master Application

ShelterPoint Life Insurance Company
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NYS Disability Benefits (DBL) and Paid Family Leave Benefits (PFL) Application Including Optional Benefits

This application becomes part of the DBL 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 Co. (LLC) ☐ Trust or Estate ☐ Executor or Trustee ☐ Limited Liability Partnership (LLP or LLLP) ☐ Other

A sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person who elects PFL coverage under Article 9 of the WCL shall be subject to a waiting period of 2 years before PFL benefits are payable if coverage is initially elected after January 1, 2018 or, if later, more than 26 weeks after the employer first becomes a sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person.

If Business Entity is a Proprietorship, Limited Liability Company or Limited Liability Partnership, provide the date the Business Entity was established:_____

Nature of Business	**SIC Code**	**Public Employer**	**Federal ID #**	**Unemployment Insurance #**
		☐ Yes ☐ No		

Requested Effective Date	**Current Workers' Compensation Carrier**	**Current DBL Carrier**

COVERED EMPLOYEES

Do you wish to cover out-of-state employees for DBL? ☐ Yes ☐ No
PFL coverage is not available for employees in states/territories other than New York State.

If Yes, list states:

Coverage not available for employees in states/territories with mandated Temporary Disability Insurance (New Jersey, Rhode Island, California, Hawaii and Puerto Rico).

All employees, pursuant to New York Disability and Paid Family Leave Benefits Law, Article 9, Section 204, are covered:
☐ Yes ☐ No If NO is checked, please list excluded classes of employees

EMPLOYEE CONTRIBUTION			
DBL ☐ Noncontributory ☐ Contributory		Number of Covered Males	
		Number of Covered Females	
		Total 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 , PFL-135 or PFL-136 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 #	

**** If the number of additional entities exceeds space provided above, attach all additional information required on a separate piece of paper.****

DBL and PFL Benefits – Please select ONE from options below.		**Optional Riders -** Please select from options below.	
Statutory DBL with PFL Benefits ☐ 1x Statutory DBL Benefit	**Enhanced DBL Benefits** ☐ 1.5x Enriched DBL Benefit ☐ 2x Enriched DBL Benefit ☐ 3x Enriched DBL Benefit ☐ 4x Enriched DBL Benefit ☐ 5x Enriched DBL Benefit	**In-Hospital Rider** ☐ Selected	**AD&D Benefit Rider** ☐ $50,000 ☐ $100,000
All DBL benefit options include statutory PFL benefits			

Optional BaseLine Benefits – Please select from policy options below.			**Optional Non-Insurance Benefits**
Term Life ☐ $ 15,000 Benefit		**Hospital Cash** ☐ $165/day	☐ **Employer & Employee Assistance Program** ☐ **Nurse Helpline**

Billing Options – Make one selection from the options below.	
☐ **Annual Billing** Minimum DBL Premium is $125.00 annually.	Minimum DBL Premium is $35.00 per quarter. A quarterly installment fee may apply to quarterly billed cases. 11 or more lives required ☐ **Quarterly Billing** ☐ **Quarterly Billing – DBL based on covered payroll** 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/her knowledge and belief, the statements and answers to the questions in this application are correct and true.

No one except the Chief Executive Officer, a Vice President or the Secretary of SHELTERPOINT LIFE INSURANCE COMPANY may make or modify any contract on behalf of SHELTERPOINT LIFE INSURANCE COMPANY. Any change or amendment to the policy shall be signed by ShelterPoint Life and the policyholder.

NOTICE (Does not apply to life insurance): 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.

Applicant: Date _____ Name _____ Signature _____

Producer: Date _____ Name _____ Signature _____

Agency Name _____ Agency # _____

Agency Address _____ Phone # _____

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