NEW YORK DISABILITY BENEFITS and PAID FAMILY LEAVE INSURANCE EMPLOYER APPLICATION

Mutual of Omaha Insurance Company
3300 Mutual of Omaha Plaza
Omaha, NE 68175-0001

Mutual of Omaha Insurance Company ("Company"), Mutual of Omaha Plaza, Omaha NE 68175. Application is hereby made for a New York Disability Benefits Policy and Paid Family Leave Rider to be effective _____, 20_____ as of 12:01 AM Eastern Standard Time.

Employer Name _____ Phone (_____) _____-_____

Employer Address_____

City_____ State _____ Zip _____ Tax ID# _____

NY UI # _____ Nature of Business (or SIC Code)_____

Employer Primary Contact _____ Title _____

Email _____ Primary Contact Phone (_____) _____-_____

Billing Contact _____ Email _____

Billing Contact Phone (_____) _____-_____ Are employees currently on DBL or PFL leave? ☐ Yes ☐ No

Billing Address (if different) _____

City _____ State _____ Zip _____ Prior Carrier _____

Prior Carrier Policy #_____

DBL Covered Employees	M: _____	F: _____	PFL Covered Employees	M: _____	F: _____
DBL Monthly Covered Payroll (if applicable)	M: $_____	F: $_____	PFL Monthly Covered Payroll	M: $_____	F: $_____

Business is a: ☐ Proprietorship ☐ Partnership ☐ Corporation ☐ Other _____
☐ LLC ☐ LLP ☐ Nonprofit

Non-Statutory Coverage Includes: ☐ Teachers ☐ Clergy ☐ Other_____

Coverage Excludes: _____

Additional Entities/Location to be covered:	
Employer Name	_____
Address	_____ City _____ State_____ Zip_____
Tax ID #	_____ NY UI #_____
Primary Contact	_____ Email_____
Billing Contact	_____ Email_____
Billing Contact Phone	(_____) _____-_____
Employer Name	_____
Address	_____ City _____ State_____ Zip_____
Tax ID #	_____ NY UI #_____
Primary Contact	_____ Email _____
Billing Contact	_____ Email _____
Billing Contact Phone	(_____) _____-_____
Separate Billing by Locations?	☐ Yes ☐ No

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

Group Size (select one)	
☐ 1-49 Complete Section A	☐ 50+ Complete Section B

SECTION A

Disability Benefits Law (DBL) Options for Groups with 1-49 Lives:

New York Statutory DBL Benefit

Employee Contribution: ☐ None ☐ $0.60 per week maximum ☐ Other _____

Paid Family Leave (PFL) Benefit Options for Groups with 1-49 Lives:

New York Statutory PFL Benefit

Employee Contribution: ☐ 100% Employee Paid ☐ 100% Employer Paid ☐ Other _____

SECTION B

Disability Benefits Law (DBL) Options for Groups with 50+ Lives:

Weekly Benefits		Elimination Period	
% of Wages	Maximum Amount	Accidents – Sickness	Maximum Duration
☐ Statutory Benefit (50%)	($170)	(7 days – 7 days)	(26 weeks)
☐ 50% ☐ 60% ☐ 66- 2/3% ☐ _____ (Must be greater than current statutory benefit)	☐ $_____ (Must be greater than current statutory benefit)	☐ 7 days – 7 days ☐ None – 7 days ☐ 3 days – 3 days ☐ None – 3 days	☐ 26 weeks ☐ 52 weeks

Employee Contribution ☐ None ☐ $0.60 per week maximum ☐ Other _____ (must be less than $.60)

Paid Family Leave (PFL) Benefit Options for Groups with 50+ Lives:

Weekly Benefits		
% of Wages	Maximum Amount	Maximum Duration
☐ NY Statutory PFL Benefit (67%) OR ☐ Enhanced: _____% (Must be greater than current statutory benefit but not to exceed 100% of the employees wage)	☐ NY Statutory PFL Benefit OR ☐ Enhanced: _____% SAWW OR ☐ Enhanced: $_____ (Must be greater than 67% SAWW but not to exceed 100% of the employees wage) SAWW= State Average Weekly Wage	☐ NY Statutory PFL Benefit (12 weeks) OR ☐ Enhanced: _____ (Must be greater than current statutory benefit)

Employee Contribution ☐ 100% Employer Paid ☐ 100% Employee Paid ☐ Other_____

BILLING OPTIONS

☐ Quarterly in Arrears (Minimum Quarterly Premium in Arrears is $15.00) ☐ Monthly in Advance

DBL PREMIUM RATE

☐ PEPM (1-49 lives)	Male: $1.95	Female: $5.10
☐ PEPM (50+ lives)	Male: $_____	Female: $_____
☐ Per $100 Monthly Covered Payroll (50+ lives)	Male: $_____	Female: $_____
☐ Sole Proprietor/Partner	Male: $9.25	Female: $9.25

If Business Entity is a Proprietorship/Partnership and elects to receive coverage, list Names of Proprietors/Partners below:

Name _____ Name _____

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

Date entity was established if less than 5 years old _____

PFL PREMIUM RATE	*The state of New York determines the rate for Statutory Plans

Per Percent of Annualized Weekly Wages Male: _____% Female: _____%

Weekly benefit for each employee eligible under the Disability Benefits Law and Paid Family Leave Benefits Law insured under the policy shall be those prescribed by Section 204 of the Disability Benefits Law and Paid Family Leave Benefits Law based on the total number of employees set forth above. Premium shall be calculated at the appropriate rate shown within the Premium Rate table above.

THE UNDERSIGNED EMPLOYER HEREBY UNDERSTANDS AND AGREES

That, in accordance with the Disability Benefits Law and Paid Family Leave Benefits Law, insured employees may not contribute more than ½ of 1% of wages paid on and after the effective date of policy, with a maximum of $.60 per week, to the premium cost hereof. If enhanced benefits are not selected above, the Family Leave benefits coverage is provided at the benefit amounts and duration required under Workers' Compensation Disability Benefits Law and Paid Family Leave Benefits Law section 204(2).

All statements in this New York Disability Benefits and Paid Family Leave Insurance Employer Application and any claims experience data provided to Mutual of Omaha Insurance Company are true and complete and will be relied upon by Mutual of Omaha Insurance Company to determine whether to issue a policy. Such statements and claims experience data, along with the group insurance proposal from Mutual of Omaha Insurance Company are the basis for any policy issued by Mutual of Omaha. If there is any material misrepresentation in this New York Disability Benefits and Paid Family Leave Insurance Employer Application or the claims experience data, Mutual of Omaha Insurance Company has the right to contest any issued policy during the first two years after the effective date of such policy. All statements shall be deemed representation and not warranties.

The insurance evidenced by this certificate provides disability income insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Department of Financial Services.

If additional or enhanced benefits beyond those specified in WCL §204(2) are selected above, the undersigned hereby agrees to extend the protections of WCL§203-b & §203-c for the additional or enhanced benefits

For issuers that opt to issue coverage to a sole proprietor, a member of a limited liability company, a member of a limited liability partnership or other self-employed person, the issuer shall subject the applicant 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. See Checklist under Sole Proprietor Opt-In and Section 363.6(j).

New York Paid Family Leave only covers New York State employees.

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 $5,000 and the stated value of the claim for each such violation.

Name of Authorized Representative: _____ Title: _____

Signature of Authorized Representative: _____ Date: _____

TO BE COMPLETED BY MUTUAL OF OMAHA INSURANCE COMPANY SALES OFFICE

Employer Name _____ Phone (_____) _____-_____

Employer Address_____

City _____ State _____ Zip _____

Other Lines of Coverage with Mutual of Omaha: (check applicable)

☐ LTD ☐ STD ☐ VLTD ☐ VSTD ☐ FMLA

Inforce Policy Number: G000_____

Broker/Sales Information

Broker Name _____

Firm Name _____

Address _____ City _____ State _____ Zip _____

Phone (_____) _____-_____ Email _____

Firm - Tax ID # _____ Firm - Mutual of Omaha Producer # _____

Broker SSN # _____ Broker - Mutual of Omaha Producer # _____

Mutual of Omaha Sales Rep _____

Mutual of Omaha Sales Trainee _____

Renewal Executive _____

Mutual of Omaha Group Office_____

Completed by _____ Date _____

Year	Weeks Available	Max % of Employee Salary	Cap % of State Average Weekly Wage
01/01/2023	12	67%	67%

PFL 2023 Maximum Wage Base = $87,785.88 (equivalent to $1,688.19 on a weekly basis)
PFL 2023 Max Weekly Benefit= $1,131.09
PFL 2023 Rate = .455%

Make checks payable to “Mutual of Omaha Insurance Company”

Mail premium to:
Mutual of Omaha Insurance Company
Maxon Administrators, Inc.
76 North Broadway
Irvington, NY 10533