



POLICY INFORMATION TRANSMITTAL FOR NEW YORK STATUTORY DISABILITY BENEFITS

SEND COMPLETED TRANSMITTAL TO: (FAX) 860-392-3250 (EMAIL) statutory.disability@thehartford.com
QUESTIONS? CALL: 1-800-454-7020

1. EFFECTIVE DATE OF COVERAGE:	
2. FULL LEGAL NAME of Employer as filed with the Workers' Compensation Board Disability Benefits Bureau	
3. Employer's LEGAL Address: Street: _____ City: _____ State: _____ Zip: _____	
4. Case Contact: Name: _____ Phone #: _____	
5. Employer's BILLING/MAILING Address: Street: _____ City: _____ State: _____ Zip: _____	
6. Billing Contact: Name: _____ Phone #: _____ E-mail: _____	
7. Electronic Consent: <input type="checkbox"/> I, the policyholder, wish to receive communications electronically from The Hartford and third parties administering my policy/ies on The Hartford's behalf. Policyholder Email Address: _____ Producer Email Address: _____	
8. Employer's Federal Tax ID No. (required): (9 digits) _____	9. Employer's Unemployment Insurance No.: (7 digits) _____
10. Employee Contributions: YES <input type="checkbox"/> NO <input type="checkbox"/> (1/2 of 1% of wages; but not more than 60 cents per week maximum)	11. Nature of Business: _____ Industry Code (SIC): _____
12. Employer Organization: Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> LLC <input type="checkbox"/> Other <input type="checkbox"/> _____	
13. Classes of Employees Covered: <input type="checkbox"/> a. All full-time & part-time employees working in the state of New York (as defined in the New York Disability Benefits Law) <input type="checkbox"/> b. Only the following class or classes of employees: _____ <input type="checkbox"/> c. Any Sole Proprietor or Co-Partner who desires to be insured and who is specifically named herein: _____	
14. Total Number of Male Employees working in New York: _____ Total NY Census : _____ Total Number of Female Employees working in New York: _____	
15. <input type="checkbox"/> Annual Billing: 1-7 employees (E-Bill not available with Annual billing) Rates (1-7 employees): \$1.78 per male/month & \$4.14 per female/month (\$45 minimum payment) Rates for employers with 50 employees or more: SEE SALES REPRESENTATIVE <input type="checkbox"/> Quarterly Billing: 8 employees or more Rates (8-49 employees): \$2.19 per male/month & \$4.47 per female/month (\$11.25 minimum payment) Rates for employers with 50 employees or more: SEE SALES REPRESENTATIVE <input type="checkbox"/> Monthly Billing: 500 employees or more <input type="checkbox"/> Electronic Billing (no paper bills) Enter Email Address here: _____	16. W2 services requested: <input type="checkbox"/> Yes <input type="checkbox"/> 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.)
17. Coverage requested: Statutory Plan (standard) <input type="checkbox"/> Enriched Plan (see Enriched Benefits section) <input type="checkbox"/>	
18. Previous Statutory Disability carrier: _____	

AGENTS PLEASE NOTE: All agencies & producers must be properly licensed and appointed with The Hartford before they can be listed on the policy and receive commissions.

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

<p>SECTION A: Producer to be listed on this policy</p> <p>Full Legal Name:</p> <p>Agent SS#:</p> <p>Producer Code:</p> <p>Address:</p> <p>City: State: Zip Code:</p> <p>Phone #:</p>	<p>SECTION B: Agency to be listed on this policy</p> <p>Agency Name:</p> <p>TAX ID or SS#:</p> <p>Producer Code:</p> <p>Address:</p> <p>City: State: Zip Code:</p> <p>Phone #:</p>
Commission Rate: _____	

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)	CONTACT:
Total # of Female Employees:	Federal Tax ID No.: (9 digits)	
Total Census :	To be billed separately? YES <input type="checkbox"/> NO <input type="checkbox"/>	

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)	CONTACT:
Total # of Female Employees:	Federal Tax ID No.: (9 digits)	
Total Census :	To be billed separately? YES <input type="checkbox"/> NO <input type="checkbox"/>	

ENRICHED BENEFITS

For employers with at least 10 employees working in New York
(Please contact our service team by phone at 1-800-454-7020 to request additional 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: _____		

Please see the next page for important information on disclosure

The Hartford compensates both internal and external producers for the sale and service of our products. In most cases, producers are paid a commission, which is fixed or based on a percentage of the premium. In addition, producers may be eligible for various forms of incentive compensation, including contingent commission and other non-cash awards. Incentive compensation is based upon a variety of factors that may include the level of premium written, retention and growth of premium, overall profitability, or other performance measures. Some of our producers elect not to accept some or all forms of compensation from The Hartford. Please direct specific questions regarding your insurance producer's compensation directly to your insurance producer. For specific questions on The Hartford's internal producers, please contact our Customer Service 800 number (800-523-2233).

The Hartford® is The Hartford Financial Services Group, Inc. and its subsidiaries