APPLICATION FOR DISABILITY BENEFITS INSURANCE
THE STANDARD LIFE INSURANCE COMPANY OF NEW YORK
360 Hamilton Avenue
White Plains, New York 10601

The Policyholder hereby applies to The Standard Life Insurance Company of New York for a Policy under the New York Disability Benefits Law, assuring the payment of benefits to employees hereinafter described.

1. Name of Policyholder : ____(the "Policyholder")

2. Mailing Address: ____

   New York Location: ____

3. Nature of Business: __________________________________ Federal Tax ID # (TIN):______________________________

   Telephone Number: ________________________ (Unemployment Insurance Account No): ________________________

   Type of Entity: [ ] Individual [ ] Partnership [ ]Corporation [ ] Other (specify): ______________________________________

4. This Policy will take effect at 12:01 A.M. Eastern Standard Time on ________ and will continue in force until canceled in accordance with the provisions of the Policy.

5. (a) All employees as defined in and subject to the New York Disability Benefits Law are to be insured, except the following (if none, so state):

   ____

   [ ] Executive Officer(s) Exclusion (Form DB-212.3 must be filed.)
   [ ] Spouse(s) Exclusion (Form DB-212.5 must be filed.)

   Union employees excluded [ ] yes [ ] no (If yes, please provide local name and local number): ________________________________

6. Name, Address, Unemployment Insurance Account No. and Federal Taxpayer ID No. of other Employers to be covered by the Policy:

   ____
   (if none, state "none")

7. (a) Name of Policyholder's Workers' Compensation Insurance Carrier: ________________________________

(b) Previous DBL Carrier(s):	Policy No.:	Total Annual Premium:	Periods of Insurance:	No. Of Claims:	Cost of Claims:	Reason for Cancellation:
1.______________________	____________	$___________	____________	____________	$___________	____________
2.______________________	____________	$___________	____________	____________	$___________	____________
3.______________________	____________	$___________	____________	____________	$___________	____________

8. Policyholder's projected payroll for the full year of ALL employees covered by the Policy.

	A	B	C	DO NOT WRITE IN THESE BOXES		
	No. Of Employees:	No. Of Officers, if any, included:	Annual Payroll of A + B:	RATE:	MOD%:	PREMIUM:
MALES						$
FEMALES						$
				Annual Est. Premium:		$
				Deposit Premium:		$

The Policy is issued on a [ ] Contributory [ ] Non-contributory basis.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance 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 will also be subject to a civil penalty not to exceed five thousand dollars ($5,000) and the stated value of the claim for each such violation.

We understand that the renewal date for this Policy is __________. We understand that we will be required to submit reports for each period on a prescribed form of all reportable wages under the terms of the Policy not later than thirty (30) days after the end of that period, and that each report must be accompanied by our premium payment for the period. Such reports are subject to minimum charges as stated in the Policy.

SIGNED:____ DATE: _________________________________
(Signature of Owner, Partner or Officer)

Name, address and phone of INSURANCE BROKER, if any: ____
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