STANDARD SECURITY
LIFE INSURANCE COMPANY OF NEW YORK

Strength. Vision. Stability.

APPLICATION FOR NEW JERSEY TEMPORARY DISABILITY BENEFITS POLICY

APPLICATION IS HEREBY MADE FOR A POLICY OF GROUP INSURANCE TO PROVIDE DISABILITY BENEFITS IN ACCORDANCE WITH NEW JERSEY TEMPORARY DISABILITY LAW.

1. EMPLOYER:_____

   STREET ADDRESS:

   _____

   CITY:_____STATE: NJ ZIP:_____

   TELEPHONE NUMBER: _____

EMPLOYER IDENTIFICATION NUMBER (EIN)
POLICY NUMBER
REQUESTED EFFECTIVE DATE

2. AUTHORIZED REPRESENTATIVE:_____

   TITLE:_____TELEPHONE NUMBER:

   _____

   (ADDRESS OF REPRESENTATIVE IF DIFFERENT FROM ABOVE)

   ADDRESS:_____

   CITY_____STATE:_____ZIP_____

3. NATURE OF BUSINESS _____

4. NUMBER OF EMPLOYEES TO BE COVERED: MALES:_____ FEMALES:_____

5. CLASSES OF EMPLOYEES TO BE COVERED ALL employees of the employer are ELIGIBLE for this coverage except for those in the following class(es):*

CLASS	STATE PLAN OR PRIVATE PLAN	NO. OF EMPLOYEES

* No class of employee can be excluded based on age, race, sex, national origin or wages paid, which will result in adverse selection

6. EMPLOYEE CONTRIBUTIONS:**
   ( ) CONTRIBUTORY
   ( ) NON-CONTRIBUTORY (**Employer pays 100% of coverage**)

   **Please note an employee consent election is required for private plans covering bargaining unit employees although the election may be waived by an authorized union representative.

7. SCHEDULE OF BENEFITS:
( ) STATUTORY ( ) NON-STATUTORY STATUTORY (**If benefits are better than statutory, please define below)**

WEEKLY BENEFIT	WAITING PERIOD	MAXIMUM DURATION	PREMIUM BASIS
[85]% of Average Weekly Wages to a Maximum of $[881] per week.]	[7] days	X [26]weeks	Per Capita_____Payroll _____

8. NAME OF BROKER_____ GENERAL AGENT: _____

ADDRESS:_____ADDRESS: _____

BROKER#:_____ GENERAL AGENT#: _____

*** Broker must have a New Jersey's broker or life and health license.

9. ADDITIONAL EMPLOYERS TO BE INCLUDED. List below those employers affiliated with policyholder by financial interest or control, whose employees are to be covered under this policy:

NAME	ADDRESS	TAX ID#

Please attach additional sheet if more space needed

WARNING: Any person who includes any false or misleading information on any application for insurance is subject to criminal and civil penalties.

Statement of Certification: By signing below, you certify that all statements made in this application are true and complete to the best of your knowledge and belief.

_____

Signature Title

_____

Telephone Number Date

Home Office: 485 Madison Avenue. New York, New York 10022. 212-355-4141