

# Application for New York Voluntary Disability Benefits



For Proprietor(s), Partner(s), Member(s), Owner(s) LLC/LLP  
Zurich American Insurance Company  
P.O. Box 9102, Plainview, NY 11803-9002  
Telephone: (631) 845-2200, (800) 887-9111  
Fax: (631) 845-2392

This coverage is not available to any Proprietor(s), Partner(s), Member(s), Owner(s), aged 60 or over, or not actively engaged in the duties of business.

Policy Number

Name of Firm

Name of Proprietor, Partner, Member, Owner

Date of Birth

Age

If partnership, list names and ages of other partners      Age


Have they applied for insurance?

- Yes    No   (each partner must  
 Yes    No   complete separate  
 Yes    No   application)

- |                                      |   |  |   |  |
|--------------------------------------|---|--|---|--|
| Have you ever had Life Insurance     | Declined?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Cancelled?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Rated up?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | Renewal refused?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |
| Have you ever had Health Insurance   | <input type="checkbox"/> Yes <input type="checkbox"/> No              | <input type="checkbox"/> Yes <input type="checkbox"/> No               | <input type="checkbox"/> Yes <input type="checkbox"/> No              | <input type="checkbox"/> Yes <input type="checkbox"/> No                     |
| Have you ever had Accident Insurance | <input type="checkbox"/> Yes <input type="checkbox"/> No              | <input type="checkbox"/> Yes <input type="checkbox"/> No               | <input type="checkbox"/> Yes <input type="checkbox"/> No              | <input type="checkbox"/> Yes <input type="checkbox"/> No                     |

If "Yes", explain

To the best of your knowledge and belief, have you within the past five years had medical or surgical advice or treatment or any departures from good health?       Yes    No

If "Yes", explain

Have you ever had or been advised to have an operation?       Yes    No

If "Yes", explain

To the best of your knowledge and belief have you ever had:

- Rheumatism                       Epilepsy                       Diabetes                      Disease of the:
- Mental Disorder                       Syphillis                       Hernia                       Brain                       Heart                       Vessels
- Ulcer of stomach/duodenum                       Tuberculosis                       Vertigo                       Nervous System                       Blood                       Kidneys

Any physical impairment, deformity or disease other than those listed.

If "Yes", explain

If application is approved by the Company, coverage will commence on approval date or on receipt by the Company of premium due, whichever date is later.

COVERAGE APPLIED FOR THIS \_\_\_\_\_ DAY OF \_\_\_\_\_ 20\_\_\_\_

Signature of Applicant

Signature of Agent or Broker

Agency or Brokerage Name

Street Address

City

State

Zip Code

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 FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.