

State Disability Policy Change Request

Date _____

Policy No _____ Policyholder Name _____

Please indicate any changes or corrections to your NY DBL or NJ TDB policy and return promptly to NBL.

Effective date of change _____

Address _____

Legal name of business _____

New FEIN # _____

Add new entity/named insured

Employer Name _____

Address _____

Contact Name _____ Contact E-Mail _____

Telephone Number _____

Total No. of additional employees: _____ ; # Males _____ # Females _____

Separate bill YES NO NY REG# _____ FEIN# _____

Policy to be cancelled: All entities Only the following: _____

Reason Out of business Business sold Employer not subject to DB Law/no employees

Replaced coverage (copy of new D8-820 Certificate of Insurance must be provided)

New carrier _____ New Policy # _____

Other change/comment _____

Signature _____

Title/Company _____

Telephone/E-Mail _____