



APPLICATION FOR NEW JERSEY TEMPORARY DISABILITY BENEFITS POLICY TO NATIONAL BENEFIT LIFE INSURANCE COMPANY

Application is hereby made to National Benefit Life Insurance Company for a policy of group insurance to provide disability benefits in accordance with article 111 of the New Jersey Temporary Disability Benefits Law.

1. **EMPLOYER:** _____

ADDRESS: _____

CITY _____ **STATE** _____ **ZIP** _____

2. **NATURE OF BUSINESS** _____ **TAX ID #** _____ **NAIC CODE** _____

3. **CLASSES OF EMPLOYEES TO BE COVERED:** All employees of the employer are eligible for this coverage except for those in the following:- class(es)

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

4. **IS PLAN CONTRIBUTORY?** YES NO. **PERCENTAGE OF BENEFIT THAT IS TAXABLE** _____ %

***If plan is contributory, a ballot showing 51% approval by employees is required

5. **NUMBER OF EMPLOYEES TO BE COVERED:** Males _____ Females: _____ **EFFECTIVE DATE OF COVERAGE:** _____

6. NAME OF BROKER Address _____ BROKER # _____	NAME OF GENERAL AGENT GENERAL AGENT # _____	POLICY NUMBER _____
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*** (Note: Broker must have a New Jersey's broker or life and health license.)

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

WEEKLY BENEFIT	WAITING PERIOD	MAXIMUM DURATION	PREMIUM BASIS
	Benefit commences on the _____ day for accident _____ day for sickness		Per Capita _____ Payroll _____

8. 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 Number

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

Signature _____ Title _____

Telephone Number _____ Date _____