

**Disability
Income
Insurance
for
County & District
Medical Society
Members**

*The coverage that works for you...
when you can't work.*



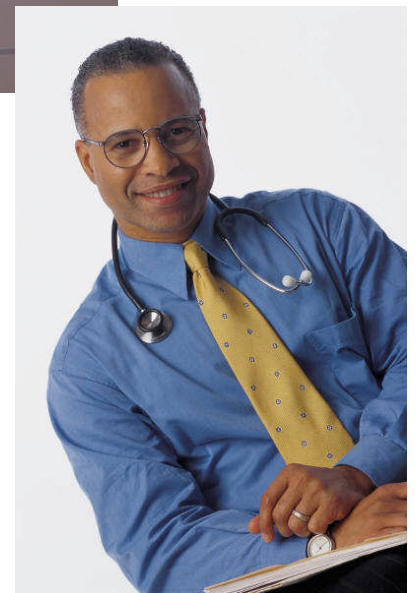
Administered by:

**Charles J. Sellers &
Company, Inc.**

Underwritten by:

**Life Insurance Company of
Boston & New York
(LICOBNY)**

***Protect Your
Family's Financial
Security
with a Medical
Society Endorsed
Disability Income
Program***



WHY YOU NEED THIS PROTECTION...



Just as you insure your home, your possessions, your life, and your health, so should you insure your income-producing capability. And that's what **Disability Income Insurance** does - it pays you monthly benefits so you can continue to support yourself, your family, and pay the bills.

However, if you're like most people, you think "it won't happen to me." But the following statistics tell a different story:

"Over 51 Million Americans are classified as Disabled (18% of the population)."¹

"In 2006, the overall percentage (prevalence rate) of working-age people with a disability ages 21 to 64 in the U.S. was 12.9 percent."²

THE COVERAGE AND HOW IT WORKS FOR YOU...

Keep in mind that a **chronic** disability can create as much financial havoc as a permanent disability.

For example, a recurring or chronic back problem can cause numerous short-term disabilities. Depending on the length of disability, you may need to satisfy a new waiting period each time.

That's why it is important to periodically review your Disability Insurance. If your income were to unexpectedly stop due to disability, would you be able to maintain your standard of living? **You need to be sure that you are protected for your needs today.**

Eligibility and Amounts of Insurance Available

Eligible applicants are members under age 60 whose applications are acceptable to the Insurance Company, including satisfactory evidence of insurability. The amount of insurance for which an applicant may apply is:

Under Age 50:	up to \$15,000 per month*
Ages 50-59:	up to \$10,000 per month*

*See rate table footnote about reductions at age 65 and 70.

Qualification

Acceptance into the Program is subject to evidence of insurability as determined by the Insurance Company. Depending upon the amount of coverage applied for, it may be necessary for you to have a paramedical exam, blood test and urinalysis, all of which can be conducted at your convenience and at no expense to you.

¹ U.S. Census Bureau, Public Information Office, November 2008

² Rehabilitation Research & Training Center on Disability Demographics & Statistics (2007) 2006 Disability Status Report. Ithaca, NY; Cornell University

Choice of Benefit Periods

Depending on your age, desired benefits and length of coverage, you may choose the benefit plan designed to meet your specific needs.

The only difference between the benefit periods is the maximum time the policy will pay benefits for any one disability as follows:

<i>Plan</i>	<i>Age at Start of Disability</i>	<i>Maximum Benefit Period</i>
65-65	Prior to Age 64 Ages 64 - 75	To Age 65 One Year
7-7	Prior to Age 64 Ages 64 - 75	Seven Years or to age 65 One Year
2-2	Prior to Age 64 Ages 64 - 75	Two years One Year

Renewal Guarantee

This coverage is automatically renewed by paying the renewal premium applicable for your particular age. The coverage will only end if you do not pay the premium within the grace period, reach age 75, retire, or cease to be actively engaged full time in your profession. Renewal can also be declined if you cease to be a member of the organization named in the application, if the organization withdraws sponsorship of the program, or sponsors a similar plan. If this happens, you can ensure uninterrupted coverage by converting to a continuation policy providing comparable benefits at the premiums then in force for continuation Disability Income policies.

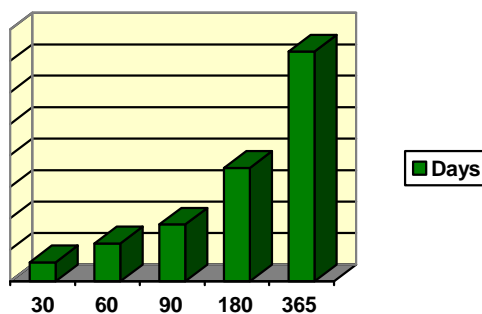
Effective Date of Coverage

Your Disability Income Protection will become effective on the first day following the approval of your application and receipt of your first premium.



Choice of Waiting Periods

You may also choose the Waiting Period designed to meet your specific needs. Your benefits can begin after 30, 60, 90, 180 or 365 day Waiting Periods.



Rates for Benefit Plans and Waiting Period options are available from Charles J. Sellers & Co., Inc.

"Own Occupation" Protection

Total Disability means that due to accident or illness, you are unable to perform the substantial and material duties of your occupation and are not performing the duties of any gainful occupation for which you are reasonably fitted based on education, training and experience. If your occupation is limited to a recognized specialty within the scope of your degree or license, the Company will deem it to be your occupation.

Waiver of Premium Benefit Included

Premium payments are suspended, while the policy is in force, after you receive total disability benefits for six continuous months provided the disability begins prior to age 60. The Waiver of Premium Benefit continues as long as you continue to receive benefits.

Residual (Partial Disability) Benefits Automatically Included Under Age 65

Following a period of Total or Residual Disability of 30 days or until the end of your waiting period, if longer, Residual Benefits are payable provided you are:

1. Residually disabled (unable, due to accident or illness, to perform one or more of the substantial and material duties of your occupation or unable to perform them for as much time as is normally required).
2. Experiencing a 20% or greater loss of prior monthly income.
3. Receiving medical care from a duly licensed physician other than yourself.
4. Not being paid Total Disability Benefits under this coverage.

Residual Benefit = Your Percentage Loss x Your Monthly Benefit

Percentage Loss = [Loss of Monthly Income ÷ Prior Monthly Income] x 100%.

The combined period for which total and residual disability benefits are payable may not exceed the maximum benefit period and in no event will payment for residual disability benefits continue beyond age 65.

IMPORTANT: If your percentage loss of income is greater than 80%, you will be considered totally disabled.

Rehabilitation Benefit Included

If you become disabled, LICOBNY will consider a rehabilitation program for you. The program is one that is mutually agreed upon by you and the Insurance Company and approved by a governmental or private agency competent to approve such programs, with consideration for such items as medical expenses, education expenses, moving expenses, accommodation expenses and family care expenses. While participating in this Rehabilitation Plan, the Insurance Company will increase your monthly benefit by the lesser of 5% or \$1,000.



Child Care Expense Benefit Rider Included

While participating in an approved Rehabilitation Program, you can be reimbursed for Child Care expenses of up to \$250 per month for each eligible child.

Accommodation Benefit Rider Included

Up to the greater of \$1,000 or 2 months' benefits is available for worksite modification to assist in return to active employment.

Recurring Disability

If you return to full-time employment in your usual occupation for 3 months or more after a total disability, a second claim for that same disability will be considered a new disability.

BENEFITS INCLUDED WITH YOUR DISABILITY INCOME PROGRAM:

- Sponsorship by your Society permits this coverage to be made available to physician members.
- Benefits are payable regardless of other insurance. No offsets for Social Security, Workers' Compensation, or other insurance policies covering you.
- Pays a scheduled minimum lump sum amount for specific fractures and dislocations. If you are disabled longer than the scheduled period, benefits can continue.

SEMI-ANNUAL PREMIUMS PER \$1,000 OF MONTHLY BENEFIT									
Age	Plan 65-65			Plan 7-7			Plan 2-2		
	Waiting Period			Waiting Period			Waiting Period		
	30-Day	60-Day	90-Day	30-Day	60-Day	90-Day	30-Day	60-Day	90-Day
Under 30	\$124.00	\$ 93.25	\$ 74.20	\$ 92.25	\$ 66.90	\$51.60	\$ 72.05	\$ 53.15	\$ 41.30
30-34	148.55	113.85	90.70	108.30	80.25	62.35	85.75	64.90	50.85
35-39	192.85	145.75	115.50	150.05	108.65	83.65	104.80	77.85	60.55
40-44	241.85	185.35	147.65	211.25	155.15	120.05	146.15	110.90	86.85
45-49	321.05	242.35	192.00	282.20	203.40	156.25	183.20	136.10	105.75
50-54	399.40	305.70	243.35	345.15	254.35	196.70	258.70	195.55	152.60
55-59	506.30	382.65	303.20	471.55	340.30	261.15	320.85	237.80	184.30
60-64	590.60	423.00	322.65	526.05	379.10	289.75	455.00	330.80	253.50
65-69*	500.95	341.10	256.15	500.95	341.10	256.15	500.95	341.10	256.15
70-74*	246.75	246.75	246.75	246.75	246.75	246.75	246.75	246.75	246.75

*Residual Benefits terminate on first renewal after age 65. Maximum Prior Monthly Income under Residual is \$15,000/month. Basic Monthly Benefit in excess of \$2,200 per Policy reduces to this amount on first renewal after age 65, and premium reduces accordingly. On the first renewal date following attainment of age 70, the Monthly Benefit in excess of \$1,000 reduces to this amount (total for all policies). At this time, the waiting period, if shorter than 90 days, changes to 90 days.

Note: Deduct \$1 service charge for annual billing.

Please call our Customer Service Department for rates for other Elimination Periods and Benefit Periods.

Exclusions and Limitations

Your policy does not cover disabilities or losses caused by, contributed by, or resulting from: War, any act of war, or military service; suicide, attempted suicide, or intentionally self-inflicted injury; test or experimental flying, operating or traveling in or flying any aircraft operated by or under the direction of the military; participation in a felony; pregnancy beginning before or during the first 30 days after your policy takes effect; Pregnancies commencing after the coverage is in effect for 30 days will be covered after a 30-day waiting period or your policy waiting period, if longer. Maximum Benefit for mental or nervous disorder, alcoholism or drug addiction is 24 months for disabilities occurring prior to age 64, and 12 months for disabilities occurring on or after the attainment of age 64. Benefits may be continued beyond 24 months if you are confined in a Hospital at the end of 24 months and if such confinement was continuous for the preceding 12 months; and if you are under age 65 such benefits would not be paid beyond your maximum benefit period or age 65.

IMPORTANT OPTIONAL BENEFITS...

1. Optional Cost of Living Adjustment for Total Disability

With this option, you may have your monthly benefit increased based on the increase in the Urban Consumer Price Index, with a cap of 6%, (according to a specified formula outlined in the contract). COLA Benefits are capped when your monthly benefit doubles.

Semi-Annual Premiums per \$1,000 of Monthly Benefit			
Attained Age	Plan 65-65	Plan 7-7	Plan 2-2
<i>Under 30</i>	\$ 20.00	\$ 13.00	N/A
<i>30 - 34</i>	32.50	22.00	N/A
<i>35 - 39</i>	32.50	22.00	N/A
<i>40 - 44</i>	74.00	59.00	N/A
<i>45 - 49</i>	74.00	59.00	N/A
<i>50 - 54</i>	125.00	101.50	N/A
<i>55 - 59</i>	125.00	101.50	N/A
<i>60 - 65*</i>	67.00	59.00	N/A

*COLA Benefits terminate on first renewal date following attainment of age 65 unless you have a claim that commences prior to age 65 and continues.

2. Optional Recovery Benefit

Upon return to practice on a full-time basis following total disability, the Insurance Company will pay a lump sum benefit equivalent to (from 1/4 to 3 months) disability payments if you were totally disabled and received benefits for 45 days or longer. For each \$1000 of monthly indemnity purchased, the additional semi-annual premium is as follows:

SEMI-ANNUAL-PREMIUMS PER \$1,000 OF MONTHLY BENEFIT									
Age	Plan 65-65 Waiting Period			Plan 7-7 Waiting Period			Plan 2-2 Waiting Period		
	30-Day	60-Day	90-Day	30-Day	60-Day	90-Day	30-Day	60-Day	90-Day
<i>Under 30</i>	\$22.50	\$16.20	\$12.60	\$22.50	\$15.30	11.50	\$22.50	\$15.30	\$11.50
<i>30-34</i>	26.00	18.70	14.55	26.00	17.70	13.25	26.00	17.70	13.25
<i>35-39</i>	26.00	18.70	14.55	26.00	17.70	13.25	26.00	17.70	13.25
<i>40-44</i>	33.00	23.75	18.50	33.00	22.45	16.85	33.00	22.45	16.85
<i>45-49</i>	33.00	23.75	18.50	33.00	22.45	16.85	33.00	22.45	16.85
<i>50-54</i>	51.00	36.70	28.55	51.00	34.70	26.00	51.00	34.70	26.00
<i>55-59</i>	51.00	36.70	28.55	51.00	34.70	26.00	51.00	34.70	26.00
<i>60-64</i>	77.50	52.70	39.55	77.50	52.70	39.55	77.50	52.70	39.55
<i>65-69*</i>	77.50	52.70	39.55	77.50	52.70	39.55	77.50	52.70	39.55

* Recovery Benefit terminates on the first renewal following attainment of age 70.

3. Optional Guaranteed Purchase Option

This option gives you the ability to increase your monthly disability benefit without medical evidence of insurability. You can increase it by 25% of the original amount on the second, fourth, sixth, and eighth anniversaries of the first renewal date up to the limits of the group.

This benefit is only available to applicants under age 40, and increases under this option cannot exceed LICOBNY's maximum issue amounts.

The premium rate for this benefit is 4% of the sum of the following premium rates:

- Base policy including total and residual disability, and
- Cost of Living Adjustment (if it is included in the policy).

The premium charge for this benefit expires on the earlier of:

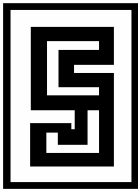
- The 8th anniversary of the first renewal date, or
- The renewal date on which the insured requests its termination, or
- When the monthly maximum benefit is reached.

HOW TO APPLY...

It's Easy to Apply... First, complete the application (Be sure to answer all questions on BOTH SIDES) then mail your application to the Program Administrator. Customer Sales Representatives are available to meet with you to complete the application process.

ABOUT THE ADMINISTRATOR...

This Disability Income Insurance Program is administered by:



Charles J. Sellers & Co., Inc.
4300 Camp Road, P.O. Box 460
Athol Springs, NY 14010

Phone: 716-627-5400 ♦ FAX 716-627-5420
National Toll-free Customer Service Numbers
Phone: 1-800-333-5440 ♦ FAX 1-800-462-1121

E-mail: insurance@sellersinsurance.com
Web Site: www.sellersinsurance.com

Charles J. Sellers & Company has been providing New York professionals and their families with insurance services since 1920. If you have questions about this new Program, or if you would like a service representative to visit you, please call the toll-free customer service number above.

ABOUT THE INSURANCE COMPANY...

This Disability Income Insurance Program is underwritten by:

Life Insurance Company of Boston & New York
277 North Avenue, Ste. 200
New Rochelle, NY 10801



Life Insurance Company of Boston & New York (LICOBNY) has a Best's Rating of A- (Excellent). This rating reflects an evaluation of the Company's financial strength, operating performance and market profile. The rating also provides an independent opinion of a company's ability to meet its obligations to policyholders. A- represents the fourth highest rating out of a possible 16 rating categories. The current rating was affirmed by AM Best on May 4, 2011. For current rating information, see. www.ambest.com.

LICOBNY underwrites sponsored Disability Income Programs for over 40 Medical Societies, Bar Associations and other professional groups in New York State through Charles J. Sellers & Co. Inc.

REQUIRED DISCLOSURE STATEMENT

This policy provides DISABILITY insurance only. It does NOT provide basic hospital, basic medical or major medical insurance as defined by the New York State Insurance Department. The expected benefit ratio for this policy is 60%. This ratio is the portion of future premiums which the company expects to return as benefits when averaged over all people with this policy. See Policy Form DIC-N (0900) NY.

This electronic brochure is for illustrative purposes only, and is not a contract. It is intended to provide a general overview of the benefits described. The Policy will provide the actual description of benefits, terms, conditions, and exclusions.



For Office Use Only - Policy No.

APPLICATION FOR DISABILITY INCOME AND/OR BUSINESS OVERHEAD EXPENSE INSURANCE

Name: _____
 Address: _____

Send bills to: address at left other _____

This Address is my Business Home Both
 Please fill in your Daytime Phone Number and Email address to assist us in contacting you, should the need arise in processing your application: Phone: (____) _____
 Are you now working at least 30 hours per week with your present employer?
 Yes No

I wish to pay premiums: Annually Semi-Annually
 Email: _____ @ _____
 Sponsor: _____

I WOULD LIKE TO APPLY FOR: <input type="checkbox"/> DISABILITY INCOME INSURANCE <input type="checkbox"/> New Application <input type="checkbox"/> Increasing Present Coverage My annual earned income for the 12 months immediately preceding the date of this application is: \$ _____ Indicate the monthly benefit desired: (in \$100 increments) \$ _____ Indicate Benefit Period: <input type="checkbox"/> 2-2 Plan <input type="checkbox"/> 7-7 Plan <input type="checkbox"/> 65-65 Plan Indicate Waiting Period: <input type="checkbox"/> 30 Day <input type="checkbox"/> 60 Day <input type="checkbox"/> 90 Day <input type="checkbox"/> 180 Day <input type="checkbox"/> 365 Day Indicate Optional Benefits: Recovery Benefit Rider <input type="checkbox"/> Yes <input type="checkbox"/> No COLA <input type="checkbox"/> Yes <input type="checkbox"/> No GPO <input type="checkbox"/> Yes <input type="checkbox"/> No Daily Hospital <input type="checkbox"/> Yes Amount \$ _____ <input type="checkbox"/> No	I WOULD LIKE TO APPLY FOR: <input type="checkbox"/> BUSINESS OVERHEAD EXPENSE INSURANCE <input type="checkbox"/> New Application <input type="checkbox"/> Increasing Present Coverage Average monthly amount of eligible overhead expenses in the preceding six months? Per Month \$ _____ Type of Organization: <input type="checkbox"/> Proprietorship <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Other _____ If Corporation or Partnership, my share of the eligible expenses is _____ % Indicate the monthly benefit desired: (in \$100 increments) \$ _____ Benefit Period: 24 months Indicate Waiting Period: <input type="checkbox"/> 15 Day <input type="checkbox"/> 30 Day <input type="checkbox"/> 60 Day <input type="checkbox"/> 90 Day Recovery Benefit Rider: <input type="checkbox"/> Yes <input type="checkbox"/> No GPO: <input type="checkbox"/> Yes <input type="checkbox"/> No
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Occupation: _____
 Beneficiary (Disability only): _____

Social Security Number: _____
 Relationship: _____

HEALTH SECTION (Must be completed in full prior to any underwriting consideration)

Height ____ Ft. ____ In. Weight ____ lbs. Sex M F Date of Birth ____/____/____ Place of Birth _____
 Name, address, and telephone number of your physician: _____

Date last consulted, and reason _____
 What treatment or medication was prescribed? _____

1. Have you been diagnosed or treated by a medical practitioner for: (Circle Specific disorders experienced)
- a. Heart trouble or murmur, chest pain, rheumatic fever, elevated blood pressure, stroke? Yes No
 - b. Injury, pain or disorder of neck or back? Sciatica? Any disabling injury? Yes No
 - c. Arthritis, chronic pain, chronic fatigue, fibromyalgia, bursitis, rheumatism or any neurological disorder? Yes No
 - d. Dizziness, epilepsy, convulsions, recurrent headaches, glaucoma, cataract, or other disorder of the eyes or ears? Yes No
 - e. Disease or disorder of rectum or anus, Varicose veins, or other vascular disorder? Yes No
 - f. Diabetes or elevated glucose? Sugar, albumin, or pus in urine? Thyroid or other glandular disorder? Yes No
 - g. Duodenal or stomach ulcer, or other disorder of stomach, liver (including hepatitis), gall bladder? Colitis, diverticulitis, or other disorder of small or large intestine? Yes No
 - h. Prostate disorder? Kidney stone or colic, nephritis, nephrosis, or other kidney disorders? Urinary infection? Yes No
 - i. Menstrual, uterine, or ovarian disorder, disorder of the breast? Yes No
 - j. Bronchitis, emphysema, pleurisy, difficult breathing, blood spitting, or other disorder of lung or nose? Yes No
 - k. Cancer or other tumor? Deformity or loss of limb? Congenital defect? Yes No
 - l. Mental or emotional problem requiring help of a physician, psychologist or mental health professional? Yes No

- m. A surgical operation? A surgical operation advised but not performed? Yes No
- n. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or disorders of the immune system? Yes No
- o. Alcohol or drug abuse? Yes No
- p. Have you ever applied for or been issued disability income insurance which has been declined, rated up, modified or renewal refused? If "Yes," please provide name of Insurance Company and details _____ Yes No

2. Have you consulted any hospital, institution, physician or practitioner within the past 5 years for any disease, disorder, injury, or other routine visit (including pregnancy) other than stated above? Yes No
3. Do you take prescription drugs or non-prescription drugs, use hormone replacement therapy or medications or any herbal remedies? Yes No

If you answered "Yes" to questions 1a-p, 2 or 3, please explain fully in the chart below. Should you require additional space, please use a separate sheet of paper and attach it to this form.

Question #	Condition	Date Occurred	Duration	Degree of Recovery	Names, Addresses And Phone Numbers of Hospitals, Physicians or Clinic Consulted

What other Disability Insurance or Business Overhead Expense Insurance do you now carry or have an application pending for? (Give Full Details)

Insurance Company	Amount of Monthly Benefit		How long are Benefits Payable?	
	Individual	Group	Accident	Sickness

Are you replacing any current disability income or business overhead expense coverage you have? Yes No If Yes, provide name of Insurance Company and Policy Number: _____

DECLARATION OF APPLICANT GIVING STATEMENT OF INSURABILITY

- To the best of my knowledge and belief, all statements made on this application are true and complete.
- I understand that my application for insurance will be accepted or declined on the basis of these statements.

AUTHORIZATION TO OBTAIN INFORMATION FOR INSURANCE UNDERWRITING PURPOSES

Life Insurance Company of Boston & New York, Director of Underwriting, and his or her authorized representatives may obtain medical information about me in order to evaluate my application for disability insurance.

I authorize any physician, medical practitioner, hospital, clinic, medical laboratory, other medical or medically-related facility, the Veterans Administration, the Medical Information Bureau, Inc., other insurance companies, my present and former employers, and other persons who possess information about medical care, treatment, diagnosis or advice rendered to me to furnish such information to Life Insurance Company of Boston & New York or its authorized representatives upon presentation of this authorization or a photocopy thereof.

This authorization includes information about drugs, alcoholism, mental illness, sexually transmitted disease, Human Immunodeficiency Virus, (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

I authorize Life Insurance Company of Boston & New York to obtain an investigative consumer report on me.
 I elect to be interviewed if an investigative consumer report is conducted.

This authorization is valid for a period of thirty months from the date signed.

I have read this authorization and understand that I or my authorized representative can receive a copy of it.

I have also received a copy of Life Insurance Company of Boston & New York's Notice of Information Privacy Practices.

Failure to sign this authorization may impair our ability to process this application and may be a basis for denying the application

FRAUD STATEMENT

Any covered 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 civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

Date _____ Signature of Applicant _____

Signature of Agent _____

Printed Name of Agent _____

Underwritten by: Life Insurance Company of Boston & New York

Fair Credit Reporting Act Pre-Notice. In some cases, the Company may ask an independent agency to prepare an investigative consumer report about you. This report may include information about your character, general reputation, personal characteristics, such as health, finance, and mode of living, except as may be related directly to or indirectly to your sexual orientation. Any information obtained by an investigative agency may be kept in its file and later given to others who have a business need for it. If an investigative consumer report is ordered by the Company, the report will include information obtained through interviews with your neighbors, friends, or others with whom you are acquainted. You may request to be interviewed in connection with the preparation of the investigative consumer about the nature and scope of an investigative consumer report. Within five (5) business days of receipt of such request, the Company will provide you with the name, address, and phone number of any agency the Company asks to prepare such a report. You should contact the specific agent to obtain a copy of its report.

Send your completed application in the postage paid envelope provided to:
Charles J. Sellers & Co., Inc. 4300 Camp Road, P.O. Box 460 Athol Springs, NY 14010
Questions? Call (716) 627-5400 or toll free 1-800-333-5440

Form DIC/BOE-APP (0900)

Detach and Save for Your Records

Disclosure Notice - Medical Information Bureau

Information regarding your insurability will be treated as confidential. Life Insurance Company of Boston & New York, its authorized representatives, or its reinsurers, may, however, make a brief report to the Medical Information Bureau. The Bureau is a non-profit membership organization of life insurance companies that operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or submit a claim for benefits to such company, the Bureau, upon request, will supply such company with the information in its files. Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your files. If you question the accuracy of information in the Bureau's files, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Fair Credit Reporting Act.

The address of the Bureau's information office is: P.O. Box 105, Essex Station, Boston, MA 02112. Telephone number is (617) 426-3660.

Life Insurance Company of Boston & New York, or its reinsurers, may also release information in its files to other life insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted.

Form DIC/BOE-APP (0900) NY