



For Office Use Only - Policy No.

**APPLICATION FOR DISABILITY INCOME INSURANCE**

Name: \_\_\_\_\_

Send bills to:  Residential Address  Business Address

Residential Street Address: \_\_\_\_\_

Business Address: \_\_\_\_\_

Sex \_\_\_\_\_ Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

I wish to pay premiums:  
 Annually  Semi-Annually

Please fill in your Daytime Phone Number and Email address to assist us in contacting you, should the need arise in processing your application:

Email: \_\_\_\_\_

Phone: (\_\_\_\_) \_\_\_\_\_

Sponsor: Medical Society of the State of New York

Are you now working at least 30 hours per week with your present employer?  Yes  No

Social Security No. \_\_\_\_\_

Occupation: \_\_\_\_\_

My annual earned income for the 12 months immediately preceding the date of this application is: \$ \_\_\_\_\_

Indicate the monthly benefit desired: (in \$100.00 increments) \$ \_\_\_\_\_ (not to exceed \$3,000)

Beneficiary: \_\_\_\_\_ Address: \_\_\_\_\_ Relationship: \_\_\_\_\_

Name: \_\_\_\_\_ Telephone No. \_\_\_\_\_ SSN# \_\_\_\_\_

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:

**APPLICANT'S DECLARATION AND AGREEMENT**

- 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.

**FRAUD STATEMENT**

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

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Date: \_\_\_\_\_ Signature of Applicant: \_\_\_\_\_

Signature of Agent: \_\_\_\_\_

Printed Name of Agent: \_\_\_\_\_

Underwritten by: Life Insurance Company of Boston & New York

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*Send your completed application 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

## Regulation 194 Disclosure

Charles J. Sellers & Co., Inc. (Sellers & Co.) is an independent agent and broker (insurance producer) licensed by the State of New York. Insurance producers are authorized by their licenses to confer with insurance purchasers about the benefits, terms, and conditions of insurance contracts; to offer advice concerning the substantive benefits of particular insurance contracts; to sell insurance; and to obtain insurance for purchasers. The role of the producer in any particular transaction typically involves one or more of these activities.

Sellers & Co. specializes in insurance programs for members of Professional Associations, Professional Societies and similar organizations, underwritten by insurance companies that are sponsored on an exclusive basis to provide such insurance. Sellers & Co. provides customer policy service as well as underwriting, rating, premium collection, and claims services for those programs.

Compensation will be paid to Sellers & Co. based on the sponsored insurance contract sold, depending upon the premium required for the options the purchaser selects. Compensation is paid by the insurer to Sellers & Co. Compensation received for various sales may not be readily comparable due to differences in insurers' distribution systems and compensation structures.

The insurance purchaser may obtain information about compensation expected to be received by the producer based in whole or in part on the sale of insurance to the purchaser, and (if applicable) compensation expected to be received based in whole or in part on any alternative quotes presented to the purchaser by the producer, by requesting such information from the producer.

By signing below, the customer acknowledges receipt of this disclosure form.

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Customer Signature

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Date

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Customer Name (Printed)