



Promark Associated

Agencies, Inc.
Your AE Specialists

**DISABILITY
APPLICATION**

Applicant's Name: _____ **DBA:** _____
 Address: _____ Agent: _____
 City, State, Zip: _____ Contact: _____
 County: _____ E-mail: _____
 Contact: _____ Phone: _____
 Email & Website: _____ Fax: _____

Individual Partnership Corporation LLC Other:

Date business established: _____ Requested Effective Date: _____

Federal Identification No.: _____ NY Employer Registration No. (IU): _____

Number of NY Employees to be Insured:

_____ Males
 _____ Females

If you are a corporation with 2 or less executive officers:
 Exclude executive officers? Yes No

If you are a Partnership, LLC, or Sole Proprietor:
 Include partners, members, or sole proprietor? Yes No

Please list names of all partners, members or sole proprietor to be included:

Are employee contributions deducted from their pay?

No (benefits are 100% taxable) Yes- taxable % ____ (1/2 of 1% of wages, but not more than \$.60 per week)

Prior Carrier: _____ Exp Date: _____ Premium: _____

Please explain any coverage lapses: _____
