4300 CAMP ROAD, PO BOX 331, ATHOL SPRINGS, NY 14010

LIFE INSURANCE COMPANY OF BOSTON&NEW YORK

For Office Use Only - Policy No.

APPLICATION FOR DISABILITY INCOME INSURANCE

Name: _____

Residential Street Address: _____

_____

Sex_____ Date of Birth: ____/____/____

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

Occupation:_____

Send bills to: ❑ Residential Address ❑Business Address

Business Address:_____

_____

I wish to pay premiums:
❑ Annually ❑ Semi-Annually

Email:_____

Sponsor: Medical Society of the State of New York

Social Security No. _____

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 $4,500)

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

1. To the best of my knowledge and belief, all statements made on this application are true and complete.
2. 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.

Date: Signature of Applicant:

Signature of Agent:

Printed Name of Agent:

Underwritten by: Life Insurance Company of Boston & New York

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