

## REGISTRATION FOR DB 820/829 FLAT FILE TRANSMISSION

For more information regarding Flat File Transmission, including minimum requirements, visit the Board's web site at [www.wcb.ny.gov](http://www.wcb.ny.gov) and select "Proof of Coverage Submission DB" from the On-line Services menu, then select "DB 820/829 Flat File Transmission".

### TYPE OF REQUEST (Select One)

**Insurance Carrier requests to submit Disability Benefits DB 820/829 forms via Flat File Transmission.**

If the Insurance Carrier will be submitting their own proof of coverage forms to the Board, complete section A, then fax this form to the Board, Attn: DB POC Support. (518) 402-6294.

**Insurance Carrier requests to designate the following organization to submit Disability Benefits DB 820/829 forms via Flat File Transmission on their behalf.**

If the Insurance Carrier is designating another organization to submit proof of coverage forms to the Board on their behalf, the Insurance Carrier must obtain the required information in Section B from the designated organization. Sections A and B of this form must be faxed together to the Board, Attn: DB POC Support. (518) 402-6294.

### A. INSURANCE CARRIER or INSURANCE GROUP REQUIRED INFORMATION

Select the appropriate Organization Type from the list below and complete **all** contact information.

Organization Type

\*Insurance groups are defined by the NYS Insurance Department and contain one or more insurance businesses.

#### INSURANCE CARRIER or GROUP - Name and Address

Carrier or Group Name

Address

City

State

Zip + 4

FEIN Number

NAIC Number

Board Assigned Number

#### \*Insurance Carrier or Group Contact's Information

Contact's Name

Address

City

State

Zip + 4

e-Mail Address

Telephone

Fax

#### LIST ANY SUBSIDIARIES' NAMES AND IDENTIFICATION NUMBERS

If your organization has more than five subsidiary companies, please provide information in the comments box.

Name	FEIN	NAIC #	Board Assigned B #
			B
			B
			B
			B
			B

Section A Prepared By \_\_\_\_\_

Title \_\_\_\_\_

2011-12-01

## B. REQUIRED INFORMATION FOR DESIGNATED SUBMITTING ORGANIZATION

### DESIGNATED SUBMITTING ORGANIZATION'S TYPE

Select the appropriate organization type and complete information below.

### DESIGNATED SUBMITTING ORGANIZATION - Name and Address

Name

Address

City  State  Zip + 4

FEIN Number  NAIC Number  Board Assigned Number

### \*Designated Organization Contact 's Information

Contact's Name

Address

City  State  Zip + 4

e-Mail Address  Telephone  Fax

Section B Prepared By \_\_\_\_\_ Title \_\_\_\_\_ 2011-12-01

### Comments - Attach additional pages as needed.

\*Contact information must be entered.