Workers' Compensation Board

NOTICE OF ELECTION OF POLITICAL SUBDIVISION FOR SELF-INSURANCE

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

Email completed form to: selfinsurance@wcb.ny.gov

A political subdivision may elect to self-insure for disability benefits, paid family leave benefits, or both.

Self-insurance is not transferable to another political subdivision. Each employer must file its own Notice of Election. Additional forms can be obtained from the Board's website: www.wcb.ny.gov

The undersigned submits this election to self-insure under Section 212-a of the New York State Disability and Paid Family Leave Benefits Law, and makes the following affirmations:

Political Subdivision ______________________ FEIN __________

Address ______________________ Effective Date __________

Attach a certified copy of the adopted resolution for election.

1. Type of Coverage (check all that apply): ☐ Disability Benefits ☐ Paid Family Leave Benefits

2. Payments will be made to the claimants as follows:

   ☐ **Statutory Benefits:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

   ☐ **Plan Benefits:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

   Attach the proposed or approved Plan on prescribed form.

3. Claims Administration:

   ☐ **I intend to self-administer for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

   ☐ **I intend to use a WCB licensed claims administrator for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

   DB Administrator:

   WCB License # T__________ Company Name ______________________

   Contact Name ______________________ Title ______________________

   Address ______________________

   Phone # ______________________ Email ______________________

   PFL Administrator (if different):

   WCB License # T__________ Company Name ______________________

   Contact Name ______________________ Title ______________________

   Address ______________________

   Phone # ______________________ Email ______________________

4. **DB Contact:**

   Contact Name ______________________ Title ______________________

   Address ______________________

   Phone # ______________________ Email ______________________

   PFL Contact (if different):

   Contact Name ______________________ Title ______________________

   Address ______________________

   Phone # ______________________ Email ______________________

5. Do hereby undertake and agree:

   a. To pay benefits to employees eligible under the New York State Disability and Paid Family Leave Benefits Law;
   b. To pay all obligations, including benefits for coverages as identified above, fines, expenses and assessments imposed pursuant to the New York State Disability and Paid Family Leave Benefits law;
   c. To permit the authorized representative of the Chair access to the premises of the self-insurer for the purpose of examining operations and records pertaining to financial conditions and all obligations under the New York State Disability and Paid Family Leave Benefits Law;
   d. To accept all expenses and liabilities in excess of the sum of the collected employee contributions provided that the contributions;
   e. That under no circumstances shall any employee bear any additional cost above the maximum contribution rate/amount allowed by law and that no contributions above the maximum rate/amount allowed by law shall be collected by the self-insurer;
   f. To submit all reports as required by Section 361.4 of the Rules and Regulations governing self-insurance, and any other reports or information as requested or required by the Chair or the Superintendent of Financial Services;
   g. To comply with the regulations and rules for self-insurers including such modifications thereof as the Chair may make from time to time;
   h. To comply with all orders of the Chair, relating to maintaining the status of a self-insurer, within the time specified in any notice mailed to last post office address given by such self-insurer. Failure to comply with any of the above may result in the revocation of self-insured status, and in addition, the Chair may invoke all legal and equitable remedies.

By signing this agreement, the signer certifies that they are authorized to execute this instrument on behalf of the

____ for the purposes set forth herein,
(INSERT MUNICIPALITY)

and that, pursuant to that authority, they are executing this instrument in the name of and on behalf of said entity as an act and deed of said entity.

______________________________	______________________________	__________
Signature of Authorized Official	Title	Date

______________________________	______________	______________________________
Print Name of Authorized Official	Phone #	Email

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION