NEW YORK STATE | Paid Family Leave

PUBLIC EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE

for Class of Employees for Whom Paid Family Leave Benefits are Not Required by Law (No Employee Contribution)

Bureau of Compliance, 328 State Street, Schenectady, NY 12305

TO THE CHAIR, WORKERS' COMPENSATION BOARD

_____

Name of Employer

_____

Name Under Which Business is Conducted

_____ _____

Address Telephone Number

Federal Employer Identification Number (if no FEIN, give Social Security Number) _____

Total Number of Employees _____

Class or classes of employees at the place or places of employment as follows _____

Number of employees in class or classes for whom paid family leave benefits are not required by law _____

A. The employer represents that he or she ☐ is ☐ is not a public employer within the definition thereof in Section 212-b of the New York State Disability and Paid Family Leave Benefits Law.

B. The employer hereby gives notice of his/her election, under Section 212-b of Law, to provide benefits to the extent and in the manner described below.

1. BENEFITS TO BE PROVIDED

☐ Paid family leave benefits as provided by a Plan to be filed under Section 211.

☐ Paid family leave benefits as provided under Section 204, if there is no Plan for such employees.

2. METHOD OF PROVIDING BENEFITS

☐ Insurance. Certificate to be filed by insurance carrier as required.

☐ Self-Insurance, subject to approval of the Chair.

C. The employer agrees that:

1. No contributions to the cost of providing benefits shall be required from employees.
2. Public employees not represented by an employee organization are provided 90 days' notice prior to contributions taken from each employee. Payment of benefits will continue unless and until the employer provides 12 months notice to the Board and such employees of their decision to opt out.
3. Public employees represented by an employee organization are provided benefits described above as collectively bargained between the employer and the employee organization. Payment of benefits will continue unless and until opting out is collectively bargained.
4. Failure to maintain NYS DB and PFL coverage for the required period as outlined above may result in penalties assessed against the employer.

I hereby affirm, under penalties of perjury, that I am _____ of the above named employer; that I have carefully read the foregoing application, including attachments, and that the facts therein stated are true.

Date Signed _____ _____

Signature of Owner, Partner or Authorized Official

Telephone Number _____ Name and Title _____