STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

RENEWAL APPLICATION FOR LICENSE TO APPEAR ON BEHALF OF, OR REPRESENT, CARRIERS AND/OR SELF-INSURERS

under Section 50 3-b or 50 3-d of the Workers' Compensation Law and Rules

Application is made under (CHECK ONE): ☐ Section 50 3-b ☐ Section 50 3-d

If application is made for renewal of a license on behalf of a corporation, separate forms must be filled out and submitted by the president/CEO, the secretary, and the treasurer. If application is made on behalf of a partnership, separate forms must be filled out and submitted by each partner. Applicant's failure to disclose fully and accurately any fact or information called for by any question may result in the denial of the application or, if license has been renewed before the discovery thereof, in the revocation of the license or authorization.

1. Name of applicant/organization: _____
   Type of organization: ☐ individual ☐ partnership ☐ corporation ☐ other (specify) _____

   Since last application, has any other name been used? ☐ Yes ☐ No If Yes, state other names:

   Business address: _____
   Business telephone number: _____ Fax number: _____
   Does your company have other offices in New York State? ☐ Yes ☐ No If yes, attach list (include name of office manager and authorized employees at location, business address, telephone number and fax number)

1a. Type of claims to be administered: ☐ workers' compensation ☐ disability benefits ☐ both

2. Name and home addresses of individual, partners, or officers and directors of corporation: (attach list if more than three)

Name	Home Address	Title

3. Attach list of principal stockholders (all those owning at least 20% of corporation's stock) and indicate percentage of stock owned by each.
   Each principal stockholder must complete Form OC-403.3 to be submitted with application.
   See copy attached--photocopy if additional copies are needed.

4. The following named persons will appear before the Board on my/our behalf when authorized: I agree to advise the Board of any changes and to surrender authorization cards that become invalid.
   Attach completed Form OC-403.2 for each employee listed.

   _____
   _____
   _____
   _____
   _____

5. List all self-insureds and carriers represented by licensee within the last year:

   _____
   _____
   _____

PERSONAL HISTORY OF INDIVIDUAL, PARTNER OR QUALIFYING OFFICER

Name:_____ Title:_____
Social Security No.:_____ (See Privacy Notification on Page 4. If you have no Social Security Number, explain on Page 4.)

6. List all employment during past three years: (Give present business first.)

From	To	Employer	Business Address	Salary

Since your last application for license under this section, has status changed in following areas:

7. Citizenship: ☐ Yes ☐ No If Yes: ☐ United States of America ☐ Other _____
If naturalized, give date and place of naturalization _____
If permanent resident alien, give registration no. and date _____

8. Education: ☐ Yes ☐ No
If Yes, college, university or technical schools attended:

School Name and Address	From	To	Degree

9. Have you been disbarred or had revoked for cause any license, certificate, permit or any other authorization to practice in any trade or profession? ☐ Yes ☐ No If Yes, give details: _____

10. Have you been convicted of a crime? ☐ Yes ☐ No If Yes, state when and give details: _____

11. Are there any criminal charges now pending against you? ☐ Yes ☐ No If yes, give details: _____

12. Do you have any arrangement with any health care providers in order to facilitate handling of workers' compensation claims? ☐ Yes ☐ No If Yes, give details: _____

13. Have you any arrangement at the present time with any self-insured employers and/or insurance companies to represent them in connection with workers' compensation or disability benefits claims?
☐ Yes ☐ No If Yes, give details, including a list of all clients in this category: _____

I hereby authorize duly designated employees of the Workers' Compensation Board to make inquiry into and to obtain the release and disclosure of any information, document or record required to obtain verification of any statement made in this application; and I hereby agree that in the event the Board issues a license to me to represent self-insurers under Section 50 3-b or 50 3-d of the Workers' Compensation Law, I shall practice in accordance with the Law and Board Rules and Regulations established for licensed representatives.

_____	_____	_____
Name of Organization	*Signature and Title of Qualifying Officer*	*Signature of Individual, Partner or Officer whose personal history is listed*

State of New York)
ss:
County of_____)

_____, being duly sworn, deposes and says that I am the applicant; that I have duly read and signed the foregoing application; that all the matters contained herein matters I believe to be true. are true, excepting as to such matters therein stated to be alleged on information and belief and those

Sworn to before me this

_____day of_____ ___ _____

_____	_____
Notary Public	*Signature of Individual, Partner or Officer*

TO BE COMPLETED BY THE QUALIFIED OFFICER OF CORPORATE APPLICANTS ONLY

State of New York)
City of_____ _____) ss:
County of_____)

AFFIX CORPORATE SEAL HERE

On this _____ day of _____, before me personally came _____

_____ to me known, who, being by me duly sworn, did depose and say

that (s)he resides at _____, that (s)he is the _____

_____ and qualified officer of _____, the corporation

described herein, and which executed the above application; that (s)he knows the seal of said corporation; that the seal affixed to said application is such corporate seal; that it was so affixed by order of the Board of Directors of said corporation; and that (s)he signed his/her name thereto by like order.

NOTARY'S STAMP

_____
NOTARY PUBLIC

PRIVACY NOTIFICATION

The authority to request personal information from you, including identifying numbers such as your Federal Social Security Number, and the authority to maintain such information, is found in Section 5 of the Tax Law. Disclosure of this information by you is mandatory. The principal purpose for which this information is collected is to enable the Department of Taxation and Finance to identify individuals, businesses and others who have been delinquent in filing tax returns or may have understated their tax liabilities and to generally identify persons affected by the taxes administered by the Commissioner of Taxation and Finance. The information will be used for tax administration purposes and for any other purpose authorized by the Tax Law or the Workers' Compensation Law.

inquiries regarding such records should be addressed to the Privacy Compliance Officer, Office of The information collected will be held by the Licensing Unit, Workers' Compensation Board. All the General Counsel, Workers' Compensation Board, 328 State Street, Schenectady, NY 12305. Phone: (518) 486-9564.

If you do not have a Social Security Number, please provide an explanation in the space below: (see item for Personal History on top of page 2).

_____

_____

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Signature of Applicant