EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE

for Class of Employees for Whom Disability and Paid Family Leave Benefits are Not Required by Law (Employee Contribution Required)

NYS Workers' Compensation Board, Bureau of Compliance, PO Box 5200 Binghamton, NY 13902-5200

TO THE CHAIR, WORKERS' COMPENSATION BOARD:

_____ (herein called the EMPLOYER)
Name of Employer

_____
Name under which Business is Conducted

_____ _____
Address Telephone Number

Federal Employer's Identification Number (If no FEIN, give Social Security Number): _____

Total Number of Employees: _____

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

A. The EMPLOYER represents that he/she ☐ is ☐ is not a covered employer within the definition thereof in Section 202 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 of the Law, to provide disability and paid family leave benefits to the extent and in the manner described below.

1. EMPLOYEES COVERED

☐ All employees engaged in a professional capacity for a not-for-profit.

☐ All employees engaged in a teaching capacity for a not-for-profit.

☐ Members of the clergy.

☐ Executive officer(s), sole proprietor, or member of an LLC.

☐ Domestic employees not required to be covered (See Section 202 of the Law)

☐ All employees in New York State for whom disability and paid family leave benefits are not required by law.

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

_____

_____

2. BENFITS TO BE PROVIDED

☐ Provided by a Plan to be filed under Section 211.

☐ Provided under Section 204, if there is no Plan for such employees.

3. 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. Payment of benefits will be provided for a period of at least one year, and thereafter unless and until terminated as provided in item C-2.
2. At least ninety (90) days prior written notice that the Employer wishes to discontinue coverage will be given to the Chair and to the covered employees. Failure to maintain NYS disability and paid family leave coverage for the required period as outlined above may result in penalties assessed against the employer.

D. The EMPLOYER hereby certifies that:

1. More than one-half of the employees for the class herein for whom benefits are to provided have agreed to contribute to the cost of providing the benefits.
2. The agreement of such employees was made in writing or by election held on: _____
3. The contribution of each employee is at the rate of _____ and the maximum contribution of any employee of $ _____ per _____

PLEASE COMPLETE REQUIRED INFORMATION ON REVERSE

The undersigned hereby affirms, under the penalties of perjury that he or she is _____ of the above named EMPLOYER; that he or she has carefully read the foregoing application, including attachments, and that the facts therein stated are true.

Date Signed _____ _____
Signature of Authorized Official

Telephone Number _____ Name _____

CERTIFICATE OF UNIONIZED EMPLOYEE REPRESENTATIVE(S)

The undersigned authorized representative(s) of employees covered by this application hereby certifies (certify) that such election was made at least thirty days prior to this application.

Date Signed _____ _____
Signature of Employee Representative

Telephone Number _____ Title _____

_____
Name of Employee Association or Union

Date Signed _____ _____
Signature of Employee Representative

Telephone Number _____ Title _____

_____
Name of Employee Association or Union