STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

APPLICATION FOR APPROVAL OF PLAN OF AN ASSOCIATION OF EMPLOYERS OR EMPLOYEES, UNION OR TRUSTEES PROVIDING DISABILITY AND/OR PAID FAMILY LEAVE BENEFITS

_____
Name of Association, Union or Trustees

_____
Mailing Address (Number and Street, City, State and Zip Code)

Telephone # _____ FEIN _____ WCB Plan # _____

The _____(Association, Union or Trustees) makes the following representations and agreements pertaining to its Plan under the Disability and Paid Family Leave Benefits Law, which is hereby filed as the Plan of the Employers (herein called Participating Employers) as certified by the undersigned (copy of plan must also be attached to this form).

1. The Plan described herein is (check A or B):
   - ☐ A. Initial Form DB-801 filed by or for the Association, Union or Trustees
   - ☐ B. Modification or Extension of a Plan previously accepted on Form DB-801 and supersedes such previous Form DB-801.

     Description of Modification: _____
2. The Plan described herein provides the following benefits:
   - ☐ Both disability and paid family leave benefits
   - ☐ Disability benefits only
   - ☐ Paid family leave benefits only
3. The Plan as described herein is effective from _____ (Effective Date) to _____ (Termination Date (if indefinite, so state)) and in the event that this Plan is terminated before the Termination Date entered above - or if no Termination Date is entered above - the Association, Union or Trustees agree that the Plan benefits described herein will be continued until written notice of the termination of the Plan has been filed with the Chair.
4. The Plan covers the following employees:
   - ☐ All employees of Participating Employers eligible for benefits under the Law.
   - ☐ All employees eligible for benefits under the Law except those classes of employees eligible to receive benefits under another policy or plan accepted by the Chair.
   - ☐ Only the following class or classes of employees of Participating Employers: _____

     _____
5. The Plan is insured* by:
   - ☐ Name of Insurance Carrier: _____
   - ☐ Self-Insurance. Give date of approval as self-insurer under Disability and Paid Family Leave Benefits Law: _____

   *Acceptance of the Plan will be subject to the condition that throughout its term there is on file with the Board satisfactory evidence that the Plan is properly insured or self-insured.
6. The Association, Union or Trustees agree to pay the assessments levied on the total covered payrolls of the employees covered by the Plan, for the Special Fund for Disability Benefits and for expenses of administration under Sec. 214 and 228 of the Disability and Paid Family Leave Benefits Law except to the extent a carrier is liable for and pays such assessments.
7. The Association, Union or Trustees agree to make provision for the payment of Benefits, as described herein, to the employees of each Participating Employer certified by the undersigned and during the term of this Plan, to continue to make provision for the payment of Benefits to employees of each Participating Employer, until ten days after a written notice of termination of such Employer's participation is served on the Employer and filed with the Board by or on behalf of the Association, Union or Trustees.

EMAIL COMPLETED FORM AND ATTACHMENTS TO **PAU@WCB.NY.GOV**
OR MAIL COMPLETED FORM AND ATTACHMENTS TO:

WORKERS' COMPENSATION BOARD
PLANS ACCEPTANCE UNIT
PO BOX 5200
BINGHAMTON, NY 13902-5200

DB-801 11-19

8. PART A - Disability Benefits

If the Plan provides disability benefits, please fill out Part A. If there are more classes of employees covered, attach additional sheets as necessary.

A. WEEKLY BENEFIT AMOUNT OR RATE: The weekly benefit amount must be at least 1/2 of the employee's average weekly wage, up to a maximum of 170 dollars a week. An employee making less than 20 dollars per week must receive at least his or her average weekly wage (WCL Section 204).

B. DURATION OF BENEFIT (IN WEEKS): The duration of disability benefits must be at least 26 weeks within a 52 consecutive calendar week period or for any one period of disability, less any days taken for paid family leave (WCL Section 205).

C. WAITING PERIOD (DAYS): Under Section 204 of the WCL, the waiting period cannot be longer than 7 days of disability.

D. ELIGIBILITY REQUIREMENT: Employees working a normal work week must become eligible after 4 weeks of work; those working less than the employer's normal work week must become eligible with 25 days (WCL Section 203).

E. EMPLOYEE CONTRIBUTION PER WEEK: If the total amount of employee contributions entered above is in excess of 1/2 of 1% of wages paid or more than $.60 per week, such contributions must be entered into by agreement and reasonably related to the value of the benefits as determined by the Chair under Section 211 of the WCL.

	A	B	C	D	E
CLASS OR CLASSES OF EMPLOYEES	BENEFIT AMOUNT OR RATE	MAXIMUM DURATION (Weeks)	WAITING PERIOD (Days)	ELIGIBILITY REQUIREMENT	EMPLOYEE CONTRIBUTION (Weekly)

ATTACH ADDITIONAL SHEETS IF NECESSARY

8. PART B - PAID FAMILY LEAVE BENEFITS

If the Plan provides paid family leave benefits, please fill out Part B. If there are more classes of employees covered, attach additional sheets as necessary.

A. WEEKLY BENEFIT AMOUNT OR RATE: The minimum acceptable weekly benefit amount is, on or after January 1, 2018, at least 50% of the employee's average weekly wage or 50% of the state average weekly wage, whichever is less. Effective January 1, 2019 or later, the employer agrees to provide no less than the statutory benefits set forth in Section 204 of the WCL.

B. DURATION OF BENEFIT (IN WEEKS): Under Section 204 of the WCL, the minimum acceptable duration benefit periods are: on or after January 1, 2018, at least eight weeks during any 52 week period. Effective January 1, 2019 or later, the employer agrees to provide no less than the statutory benefits set forth in Section 204 of the WCL.

C. ELIGIBILITY PERIOD: Employees working 20 or more hours per week must become eligible after 26 consecutive weeks of work; those working less than 20 hours per week must become eligible within 175 days of work (Section 203 of the WCL). If the employee is eligible for paid family leave (after working 26 consecutive weeks or 175 days), there can be no waiting period for paid family leave benefits.

D. EMPLOYEE CONTRIBUTION PER WEEK: If the total amount of employee contributions entered above is in excess of the maximum statutory contributions set annually by the Department of Financial Services pursuant to Section 209 of the WCL, such contributions must be entered into by agreement and reasonably related to the value of the benefits as determined by the Chair under Section 211 of the WCL.

E. NOTICE REQUIRED FOR FORESEEABLE LEAVE: The Plan cannot require an employee to give more than 30 days of notice for foreseeable leave, or as soon as practicable for unforeseeable leave (Section 205 of the WCL)

F. EMPLOYEE HEALTH INSURANCE CONTRIBUTION: If an employee is covered by group health insurance, an employer cannot require an employee on paid family leave to contribute more than the amount he or she did prior to beginning leave.

NOTE: The Plan cannot negate the employee's right to reinstatement, to the same or an equivalent job, on return from paid family leave (Section 203-b of the WCL).

	A	B	C	D	E	F
CLASS OR CLASSES OF EMPLOYEES	BENEFIT AMOUNT OR RATE	MAXIMUM DURATION (Weeks)	ELIGIBILITY REQUIREMENT	EMPLOYEE CONTRIBUTION (Weekly)	NOTICE REQUIREMENT	HEALTH INSURANCE

ATTACH ADDITIONAL SHEETS IF NECESSARY

9. Is the employee contribution amount greater than .60 cents per week for disability benefits or greater than the maximum rate set by the Department of Financial Services for paid family leave benefits? ☐ Yes ☐ No

10. Except as stated above, does the Plan contain any restrictions or limitations on the payment of disability or paid family leave benefits other than as specified in the Disability and Paid Family Leave Benefits Law and in the Rules and Regulations promulgated thereunder? ☐ Yes ☐ No
If "Yes", describe each such restriction or limitation in full (Attach additional sheet, if necessary).

_____

_____

_____

_____
Association, Union or Trustees

By _____
Signature of Authorized Official

_____
Print Name and Title

Telephone Number _____ Date Signed _____

State of New York
County of_____

_____being duly sworn, deposes and says that he or she is

_____of the _____and that he or she is duly authorized to make this affidavit on behalf of said Association, Union or Trustees. That he or she has carefully read the foregoing APPLICATION AND AGREEMENT and the facts therein stated or annexed thereto are true and correct.

Sworn to me this _____ day of _____, 20____

_____ _____
Signature of Authorized Official Signature of Notary Public

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