STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

APPLICATION TO HAVE ASSOCIATION, UNION OR TRUSTEES PLAN ACCEPTED/TERMINATED AS EMPLOYER'S PLAN

An association of employers or employees, union or trustees shall file this application with/without an Employer.

☐ **Initial** ☐ **Termination** ☐ **Reinstatement** ☐ **Supersedes** **Transaction Effective Date:** _____

SECTIONS A, B and C MUST ALWAYS BE COMPLETED.
Initial: Sections A, B, C, F and G (Employer's Certification on reverse) must be completed.
Terminations: Sections A, B, C, D and F must be completed.
Reinstatements: Sections A, B, C and F must be completed.
Supersedes: Sections A, B, C, E and F must be completed.

A. CURRENT EMPLOYER INFORMATION

1. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	**4. EMPLOYER FEIN**
2. EMPLOYER STREET ADDRESS	**5. NUMBER (#) OF EMPLOYEES**
3. EMPLOYER CITY, STATE and ZIP CODE	**6. TELEPHONE NUMBER**

B. PLAN INFORMATION

7. WCB PLAN NUMBER	**8. EFFECTIVE DATE OF COVERAGE**	**9. Plan Coverage** ☐ Self-Insurance ☐ Insurance Carrier
10. NAME OF ASSOCATION, UNION OR TRUSTEES PLAN		
11. NAME AND CARRIER IDENTIFICATION NUMBER (If Plan coverage through carrier)		**12. INSURANCE POLICY NUMBER** (If applicable)

C. COVERAGE

a. The policy provides coverage for:

- ☐ Both disability and paid family leave benefits
- ☐ Disability benefits only
- ☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

- ☐ All employees
- ☐ 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 class or classes of employees listed here:

D. Complete if TERMINATION box is checked at top of form (attach DB-118 if employer is terminating status as covered employer)

- ☐ Non-Payment of Premium
- ☐ Not Subject/No Eligible Employees Date: _____
- ☐ Out of Business Date: _____
- ☐ Seasonal Date: _____
- ☐ Other: _____

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER: _____

E. Complete if SUPERSEDES box is checked at top of form

Reason(s) for modification:

F. CERTIFICATION BY ASSOCATION, UNION OR TRUSTEES

I certify that the above information is true, and agree that during the term of the Plan as accepted by the Chair of the Workers' Compensation Board, the EMPLOYER'S participation will continue to be effective until ten days after a written notice of termination is served on the EMPLOYER and filed with the Chair of the Workers' Compensation Board by or on behalf of the Association, Union or Trustees.

Date Signed _____ By _____
Signature of Association, Union or Trustee Official

Telephone Number _____ Name and Title _____

G. INITIAL CERTIFICATION BY EMPLOYER

State of New York
County of _____

_____ being duly sworn, deposes and says:

A. The EMPLOYER requests acceptance of this PLAN identified by WCB Plan Number _____

of _____ as the EMPLOYER'S Plan.
Association, Union or Trustees

B. The EMPLOYER agrees:

1. That all eligible employees will be provided Benefits either by the Plan or in one or more of the ways specified in Sec. 211 of the Disability and Paid Family Leave Benefits Law.

2. That any excess of the aggregate contributions of employees over the cost of providing Benefits and any uncommitted balance of employee contributions remaining at the termination of this Plan shall be distributed or applied for the sole benefit of employees or otherwise be applied or disposed of pursuant to Sec. 210, subdivision 4, and Sec. 216 of the Disability and Paid Family Leave Benefits Law.

3. That unless paid by the Association, Union or Trustees, the employer will pay all assessments to the special fund under Sec. 214 of the Workers' Compensation Law and all assessments for expenses of administration under Sec. 228.

4. That the Plan Benefits will be continued until the Employer has filed written notice with the Chair of the termination of the Plan.

_____
Employer

Date Signed _____ By _____
Signature of Owner, Partner or Authorized Officer

Telephone Number _____ Name and Title _____

Sworn to before me this

_____ day of _____

_____
Signature of Notary Public

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