	Intial Designation of Authorized Representatives
	Designation of Additional Authorized Representatives
	Supersedes DB-840 Dated_____

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
328 STATE STREET
SCHENECTADY, NY 12305

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

CARRIER'S DESIGNATION OF AUTHORIZED REPRESENTATIVES

TO: Chair, Workers' Compensation Board

The following are hereby designated as the authorized representatives of the undersigned insurance carrier in matters relating to Disability Benefits, as follows:

(A)	NAME AND SIGNATURE	DISTRICT OR REGIONAL OFFICE ADDRESS (Zip Code,Telephone Number and Area Code)	
Acceptance of Insurance Contracts	1.	Address	
			Tel. No.
	2.	Address	
			Tel. No.
(B)	1.	Address	
Acceptance of Plans			Tel. No.
	2.	Address	
			Tel. No.
(C)	1.	Address	
Claims			Tel. No.
	2.	Address	
			Tel. No.

The undersigned agrees to notify the Chair promptly if and when any subsititutions are made or additional representatives are authorized.

_____
(Name of Insurance Carrier)

_____
(Home Office Address)

Date_____ By_____

Tel. No._____ Title_____

If District or Regional Claims offices are maintained, attach a list giving the name, signature, address and telephone number of EACH AUTHORIZED CLAIMS REPRESENTATIVE and indicating the counties of New York State included in the District or Region under the supervision of each such office.

TO BE FILED IN TRIPLICATE