PUBLIC EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE

for Class of Employees for Whom 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

_____
Name of Employer

_____
Name Under Which Business is Conducted

_____ _____
Address Telephone Number

Federal Employer Identification Number _____

Total Number of Employees _____

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

A. The employer represents that he or she is a public employer within the definition thereof in Section 212-b of the New York State Paid Family Leave Benefits Law.

B. The employer hereby gives notice of his/her election, under Section 212-b of Law, to provide benefits to the extent and in the manner described below.

1. BENEFITS TO BE PROVIDED

☐ Paid Family Leave Benefits as provided by a Plan to be filed under Section 211.

☐ Paid Family Leave Benefits as provided under Section 204, if there is no Plan for such employees.

2. 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. Public employees not represented by an employee organization are provided 90 days' notice prior to contributions taken from each employee. Payment of benefits will continue unless and until the employer provides 12 months notice to the Board and such employees of their decision to opt out.
2. Public employees represented by an employee organization are provided benefits described above as collectively bargained between the employer and the employee organization. Payment of benefits will continue unless and until opting out is collectively bargained.
3. Failure to maintain New York State Paid Family Leave Benefits coverage for the required period as outlined above may result in penalties assessed against the employer.

D. The employer hereby certifies that:

1. The contribution of each employee is at the rate of _____ said rate being less than or equivalent to the current maximum contribution as set by the Department of Financial Services.

PLEASE COMPLETE REQUIRED INFORMATION ON REVERSE

I hereby affirm, under penalties of perjury, that I am _____ of the above named employer; that I have carefully read the foregoing application, 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 more than one-half of such employees has duly agreed to contribute to the cost of paid family leave benefits as described herein.

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