NEW YORK STATE | Workers' Compensation Board

Self-Insurer Annual Report for Calendar Year _____
Disability and Paid Family Leave Benefits Law

Email completed form to selfinsurance@wcb.ny.gov

Employer: _____ FEIN: _____

Address: _____ Self-Insured ID#: _____

1. Please complete below chart:

	Disability Benefits	Paid Family Leave Benefits
Number of eligible NY employees covered by self-insurance		
Covered New York Payroll ($)		

Total number of New York employees: _____ *Must be equal to or greater than covered employees from item 1.

Total annual New York payroll ($): _____ **Must be equal to or greater than covered NY payroll from item 1.

2. Corporate Structure/Ownership Update: Have any changes in legal status or ownership, including mergers and name changes, taken place since filing the last report? ☐ Yes ☐ No

If yes, attached copies of amended certificate of incorporation, partnership agreement or foundation documents.

3. **DB Primary Contact:**

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

Additional DB Contact:(if applicable):

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

PFL Primary Contact (if different than DB):

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

Additional PFL Contact (if applicable):

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

4. Approved active subsidiaries in self-insurance program (attach additional sheets, if necessary):

Name: _____ **FEIN:** _____

Name: _____ **FEIN:** _____

Name: _____ **FEIN:** _____

Name: _____ **FEIN:** _____

☐ **Self-Administer for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

☐ **Administered by a WCB licensed claims administrator for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

DB Administrator

WCB License # T _____ Company Name: _____

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

PFL Administrator (if different)

WCB License # T _____ Company Name: _____

Contact Name: _____ Title: _____

Address: _____

Phone #: _____ Email: _____

By signing this report, the signer certifies that he/she is authorized to execute this instrument on behalf of the

_____ for the purpose set forth herein,

(Insert Business Name)

and that, pursant to that authority, he/she is executing this instrument in the name of and on behalf of said entity as an act and deed of said entity.

_____	_____	_____
Signature of Authorized Official	Title	Date

_____	_____	_____
Print Name of Authorized Official:	Phone Number	Email

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Self-Insurer Annual Report Instructions
Disability and Paid Family Leave Benefits Law

Instructions to assist in the completion of the DB-681 Annual Report

General Information:

- All information you include on the form should be current as of December 31st of the reporting year.
- The form must be **fully** executed by an Authorized Official of the self-insured entity.
- This is a consolidated report; therefore, all **approved** self-insured subsidiary data should be included in this filing.
- The Employer/Business name should be the **full legal name of the entity**, including designations such as "Inc.","LLC", etc., for all entities.
- The employer's address is the headquarters or main location of the self-insured entity.
- If you are providing Paid Family Leave benefits through a licensed carrier, or if you are a municipality and have notopted in to provide Paid Family Leave benefits, you may disregard the Paid Family Leave sections of the DB-681.
- Submit fully completed forms to: selfinsurance@wcb.ny.gov

Question #1 should be completed as follows:

- **Number of eligible New York employees covered by self-insurance** is the number of covered employees whohave reached eligibility for Paid Family Leave (PFL) and/or Disability Benefits (DB) as of 12/31. The number ofemployees may differ between those eligible for PFL and those eligible for DB because there are differentrequirements for eligibility:
  - Covered employees become eligible for Paid Family Leave once they have met the minimum time-worked requirements:

    Full-time employees: Employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.
    Part-time employees: Employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive.
  - Employees are covered and eligible for Disability Benefits after working four consecutive weeks for the same employer.
- **Covered New York payroll** is the gross annual payroll of the eligible employees listed in the above box(es).
- **Total number of New York employees** is the number of all employees employed and working in NYS as of 12/31.
- **Total annual New York payroll** is the gross annual payroll of all employees employed and working in NYS as of12/31 listed on the above line.

For Example:

1. Please complete below chart:

	Disability Benefits	Paid Family Leave Benefits
Number of eligible NY employees covered by self-insurance	100	75
Covered New York Payroll ($)	5,000,000	3,750,000

Total number of New York employees: 100 *Must be equal to or greater than covered employees from item 1.
Total annual New York payroll ($): 5,000,000 **Must be equal to or greater than covered NY payroll from item 1.

Self-Insurer Annual Report Instructions
Disability And Paid Family Leave Benefits Law

Question #2 should report whether there have been any changes in legal status or ownership in the reporting year. This includes mergers and/or name changes.

Question #3 should provide a primary contact(s) from the self-insured entity. Primary contacts cannot be a Third-Party Administrator or any other outside entity.

Please be sure to review the form for completeness and accuracy prior to submission. If you need further assistance completing this form, please contact the Office of Self Insurance at selfinsurance@wcb.ny.gov.