NEW YORK STATE | Workers' Compensation Board

APPLICATION FOR SELF-INSURANCE

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

Email completed form to: selfinsurance@wcb.ny.gov

An employer may apply for self-insurance for disability benefits or for disability and paid family leave benefits. An employer may not apply to self-insure for paid family leave benefits only.

An application to self-insure is not transferable to subsidiaries or successors. Each entity must file its own application. Additional applications can be found on the Board's website: www.wcb.ny.gov.

PLEASE NOTE: Submission of an application does not guarantee approval for self-insurance. Coverage must be maintained until you have received a Notice of Qualification.

The undersigned makes application as a self-insurer under Section 211(3) of the Disability and Paid Family Leave Benefits Law of New York State, and makes the following affirmations for the purpose of enabling the Chair, Workers' Compensation Board, to determine that the applicant possesses sufficient financial ability and has adequate resources to render certain the payment of disability or disability and paid family leave benefits to their employees as specified in the Law.

Attach a statement of financial condition (Form 10-K or a certified independently audited financial statement).
If deemed a candidate for self-insurance, a conditional approval will be issued. Notice of Qualification as a self-insurer will not be issued until all conditions have been met including, but not limited to: submitting and maintaining an adequate security deposit and the submission of an Agreement and Undertaking for Paying Benefits as a Self-Insurer (Form DB-152).

Applicant _____ FEIN _____

Address (Principal Office) _____ Requested Effective Date _____

1. Type of Coverage: ☐ Disability Benefits ☐ Disability and Paid Family Leave Benefits
2. Filing Status:
   - ☐ Single entity
   - ☐ Parent Company with subsidiaries (separate application required for each subsidiary)
   - ☐ Subsidiary to consolidate with parent

   Name of Parent _____ FEIN _____
3. Number of New York employees covered by self-insurance: _____
   Total number of New York employees: _____
4. Covered New York payroll $: _____
   Total annual New York payroll $: _____
5. Type of Entity: ☐ Corporation ☐ LLC ☐ Partnership
   Attach a copy of certificate of incorporation, partnership agreement or foundation documents.
6. If a subsidiary, enter parent's percentage of stock ownership: _____ %
   Names of officers or partners and official titles:

   _____

   _____

   _____

   _____
7. If an association of employers, association of employees or trustee or trustees:
   (a) Attach a list of participating employers.
   (b) Attach a certified list of trustees/governing body.
   (c) Attach a copy of your plan with prescribed form DB-801, which can be found on the Workers' Compensation Board Website.
8. Payments will be made to the claimants as follows:
   - ☐ **Statutory Benefits:** ☐ Disability Benefits ☐ Paid Family Leave Benefits
   - ☐ **Plan Benefits:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

   If you are not an association of employers, association of employees or trustee or trustees and are providing Plan Benefits, Attach a copy of your plan with prescribed form DB-800, which can be found on the Workers' Compensation Board Website.

9. Claims Administration:

☐ **I intend to self-administer for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

☐ **I intend to use a WCB licensed claims administrator for:** ☐ Disability Benefits ☐ Paid Family Leave Benefits

DB Administrator:	**PFL Administrator (if different):**
WCB License # T _____	WCB License # T _____
Company Name _____	Company Name _____
Contact Name _____	Contact Name _____
Title _____	Title _____
Address _____	Address _____
Phone # _____	Phone # _____
Email _____	Email _____

10.

DB Contact:	**PFL Contact (if different):**
Contact Name _____	Contact Name _____
Title _____	Title _____
Address _____	Address _____
Phone # _____	Phone # _____
Email _____	Email _____

By signing this Application, the signer certifies that they are authorized to execute this instrument on behalf of the

_____ for the purposes set forth herein,
(INSERT BUSINESS NAME)

and that, pursuant to that authority, they are 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 #	Email

CORPORATE or PARTNERSHIP ACKNOWLEDGMENT

STATE OF _____ }
:SS.:
COUNTY OF _____ }

On the _____ day of _____ 20____, before me personally appeared _____

known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that they reside in _____ , and further that (check one):

☐ **If a corporation**: they are the _____ of the corporation described in the said instrument; that by authority of the Board of Directors of said corporation, they are authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, they executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

☐ **If a partnership**: they are the _____ of the partnership described in said instrument; that by the terms of said partnership, they are authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that pursuant to that authority, they executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

_____
Notary Public