NEW YORK STATE | Workers' Compensation Board

EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE

for Class of Employees for Whom Disability Benefits are Not Required by Law (No Employee Contribution)

Bureau of Compliance, 328 State Street, Schenectady, NY 12305

TO THE CHAIR, WORKERS' COMPENSATION BOARD:

_____ (herein called the EMPLOYER)
Name of Employer

_____
Name under which Business is Conducted

_____ _____
Address Telephone Number

Federal Employer's Identification Number (If no FEIN, give Social Security Number): _____

Total Number of Employees: _____

Number of employees in class or classes for whom **disability benefits** are not required by law: _____

A. The EMPLOYER represents that he/she ☐ is ☐ is not a covered employer within the definition thereof in Section 202 of the New York State Disability and Paid Family Leave Benefits Law.

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

1. EMPLOYEES COVERED

☐ All employees engaged in a professional capacity.

☐ All employees engaged in a teaching capacity.

☐ Members of the clergy.

☐ Executive Officer(s), sole proprietor, or member of an LLC.

☐ All employees in New York State for whom disability benefits are not required by law.

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

_____

_____

_____

2. BENFITS TO BE PROVIDED

☐ Disability benefits as provided by a Plan to be filed under Section 211.

☐ Disability benefits as provided under Section 204, if there is no Plan for such employees.

3. METHOD OF PROVIDING BENEFITS

☐ Insurance. Certificate to be filed as required.

☐ Self-Insurance, subject to approval of the Chair.

C. The EMPLOYER agrees that:

1. No contributions to the cost of providing benefits shall be required from employees.
2. Payment of benefits will be provided for a period of at least one year, and thereafter unless and until terminated as provided in item C-3.
3. At least ninety (90) days prior written notice that the EMPLOYER wishes to discontinue coverage will be given to the Chair and to the covered employees; and provision will be made for the payment of obligations incurred on and prior to the effective termination date, including a ratable part of assessments for the current period, all subject to approval of the Chair.

I hereby affirm, under penalties of perjury, that I am _____ of the above named EMPLOYER; that I have carefully read the foregoing application, including attachments, and that the facts therein stated are true.

Date Signed _____ _____
Signature of Owner, Partner or Authorized Official

Telephone Number _____ Name and Title _____

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