STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS BUREAU
100 BROADWAY - MENANDS
ALBANY, NY 12241-0005

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE FOR CLASS OF EMPLOYEES FOR WHOM DISABILITY BENEFITS ARE NOT REQUIRED BY LAW
(Employee Contribution Required)

TO THE CHAIR, WORKERS' COMPENSATION BOARD:

.....(herein called the EMPLOYER)
Name of Employer

.....
Name Under Which Business is Conducted

..... (.....).....
Address Telephone No.

Federal Employer's Identification Number (if Sole Proprietor, give Social Security Number).....

U. I. Employer Registration 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 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. ☐ Executive Officer(s). ☐ All employees in New York State employment for whom Disability Benefits are not required by law. ☐ Class or classes of employees at the place or places of employment as follows:
2. BENEFITS TO BE PROVIDED	☐ As provided by a Plan to be filed under Section 211. ☐ 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. 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-2.

2. At least (90) ninety 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 rateable part of assessments for the current period, all subject to approval of the Chair.

PLEASE COMPLETE REQUIRED INFORMATION ON REVERSE

D. The EMPLOYER hereby certifies that:

1. More than one-half of employees for the class herein for whom benefits are to be provided have agreed to contribute to the cost of providing the benefits.

2. The agreement of such employees was made in writing or by election held on.....

3. The contribution of each employee is at the rate of..... and the maximum contribution of any employee of $..... per.....

The undersigned hereby affirms, under the penalties of perjury, that he/she is ..... of the above named EMPLOYER; that he/she has carefully read the foregoing application, including attachments, and that the facts therein stated are true.

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

Tel. Number..... Title.....

CERTIFICATE OF 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 have duly agreed to contribute to the cost of Benefits as described herein.

Date Signed..... .....
Signature of Employee Representative

Tel. Number..... Title.....

.....
Name of Association of Employee or Union

Date Signed..... .....
Signature of Employee Representative

Tel. Number..... Title.....

.....
Name of Association of Employee or Union