NYSIF

New York State Insurance Fund

# NEW YORK DISABILITY BENEFITS AND PAID FAMILY LEAVE INSURANCE EMPLOYER APPLICATION

| Apply online at www.nysif.com | **For paper applications, be sure to include:**<br>☐ Premium deposit check of $60 made payable to NYSIF Disability Benefits<br>☐ Original signed application with all fields completed<br>☐ Additional forms and/or attachments | **Mail to:**<br>Document Control Center – NYSIF Disability Underwriting<br>1 Watervliet Ave Ext<br>Albany, NY 12206-1649 |
|---|---|---|

## (1) POLICY INCEPTION DATE

The policy inception date is the day following the postmark date unless a future date is requested  Future Inception Date MM/DD/YYYY:

## (2) BUSINESS INFORMATION (MUST USE NEW YORK STATE ADDRESS, NO P.O. BOXES)

| Legal Business Name: | | | Federal Tax ID (SSN if applicable): | |
|---|---|---|---|---|
| DBA (if applicable): | | | Telephone: | |
| Address: | City: | State: | Zip: | Country: |
| Contact Name: | Contact Email: | | | |

## (3) MAILING ADDRESS (IF DIFFERENT THAN ABOVE)

| Address: | City: | State: | Zip: | Country: |
|---|---|---|---|---|

## (4) LEGAL ENTITY TYPE

◯ Corporation ◯ Sole-Proprietor ◯ Partnership ◯ LLC ◯ LLP ◯ Union ◯ Other (please specify):  Not-for-profit: ◯ Yes ◯ No

| Nature of Business: | Standard Industrial Classification (SIC) Code: |
|---|---|

## (5) ADDITIONAL ENTITY (IF APPLICABLE)

| Entity Name (if more, attach sheet): | ◯ Corporation ◯ Sole-Proprietor ◯ Partnership ◯ LLC ◯ LLP ◯ Union ◯ Other - please specify: | Federal Tax ID: |
|---|---|---|

| Business Address: | City: | State: | Zip: | Country: |
|---|---|---|---|---|

## (6) INSURANCE BROKER/REPRESENTATIVE (IF APPLICABLE)

| Agency: | Address: | City: | State: | Zip: | Country: |
|---|---|---|---|---|---|
| Contact Name: | Email: | Telephone: | | | |

## (7) CURRENT INSURANCE PROVIDER INFORMATION (IF APPLICABLE)

| Workers' Compensation Insurance Carrier: | Current Disability Benefits Insurance Provider: | Total Dollar Amount of Disability Claims for the Last Three Years: |
|---|---|---|

## (8) COVERAGE OPTIONS FOR DISABILITY CLAIM BENEFIT LEVELS

**Premium is determined based upon the level of coverage chosen**. **NYSIF allows policyholders to choose the level of claim benefit for their employees.**

◯ Statutory Benefit Coverage-50% of average weekly wage up to $170 per week. (minimum required New York State disability benefits insurance)

◯ Enriched Benefit Coverage-Indicate desired multiple of the statutory benefit: ◯ 1.5x ◯ 2x ◯ 2.5x ◯ 3x ◯ 4x ◯ 5x (provides greater disability claim benefits to qualified employees while satisfying the New York statutory requirement)

## (9) EMPLOYEE CONTRIBUTIONS

Indicate whether employees contribute to disability benefits (DB) insurance premium (**do not include contributions toward Paid Family Leave**):

◯ No, they do not contribute to DB insurance premium  ◯ Yes, they contribute to DB insurance premium

Employers providing disability benefits insurance are entitled to withhold at a rate limited to 1/2 of 1 percent of the weekly wage of the employee (not to exceed $0.60 per week for statutory benefits). Employers providing enriched benefits coverage are entitled to an employee contribution reasonably related to the value of benefit.

## (10) CORPORATE OFFICERS, OWNERS, PARTNERS OR MEMBERS OF THE ORGANIZATION (ALSO INCLUDE IF OUT-OF-STATE)

Covered individuals in this section must also be included in section (11) PAYROLL INFORMATION, below.

| Name | Title | Business Address | Covered in Policy |
|---|---|---|---|
| | | | ☐Yes ☐ No |
| | | | ☐Yes ☐ No |
| | | | ☐Yes ☐ No |
| | | | ☐Yes ☐ No |

Some coverage exclusions are allowed by the New York Disability Benefits Law. Please select the reason and submit the following required form(s) found under "Commonly Used Forms" at www.nysif.com:

☐Executive Officer Exclusion - only applicable to corporations with one or two Executive Officers. (Complete form **DB-212.3**)

☐Spouse Exclusion - only applicable to Sole Proprietors or Partnerships. (Complete form **DB-212.5**)

☐Business owners(s) of a Sole Proprietor, Partnership, or Members of an LLC or LLC Exclusion. (No form required)

## (11) PAYROLL INFORMATION

| ***Disability Benefits (DB)*** | *# of Covered Employees* | *Total Wages for all employees, subject to an annual cap of $17,680 per employee* | *Total Gross Annual Payroll* |
|---|---|---|---|
| Male | | | |
| Female | | | |

| ***Paid Family Leave (PFL)*** | *# of Covered Employees* | *Annual Total Wages (Limit the weekly wage to a maximum of $1358 per employee, multiply by 52 for annual total)* |
|---|---|---|
| Male | | |
| Female | | |

Additional information/comments if needed:

## Authorization

| (12) PRINTED NAME OF OWNER, PARTNER, OFFICER, OR MEMBER | |
|---|---|
| | Date MM/DD/YYYY: |
| **(13) ORIGINAL SIGNATURE OF OWNER, PARTNER, OFFICER, OR MEMBER** | |
| | Date MM/DD/YYYY: |

**Family Leave Benefits coverage is provided at the benefit amounts and duration required under Workers' Compensation Law section 204(2).**

**Family Leave Benefits coverage does not cover out of state employees.**

**A sole proprietor, member of a limited liability company, member of a limited liability partnership, or other self-employed person who elects coverage under Article 9 of the Workers' Compensation Law shall be subject to a waiting period of 2 years before PFL benefits are payable unless the policy is issued within 26 weeks of when the employer first becomes a sole proprietor, limited liability company, limited liability partnership or other self-employed person.**

**Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.**

**By signing this application, you agree to be bound by the terms and provisions of the policy.**

**Reference No**: