NYSIF
New York State Insurance Fund

Reference No:

NEW YORK DISABILITY BENEFITS/PAID FAMILY LEAVE INSURANCE APPLICATION

Apply online at nysif.com	**For paper applications, be sure to include:** ☐Premium deposit check of $60 made payable to NYSIF Disability Benefits ☐Original signed application with all fields completed ☐Additional forms and/or attachments (if applicable)	**Mail to:** P.O. Box 66699 Albany, NY 12206-9927

(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

Legal Business Name:			Federal Tax ID:	
DBA (if applicable):	Business Inception Date:		Telephone:	
Mailing Address:	City:	State:	Zip:	Country:
Contact Name:	Contact Email:			

(3) NEW YORK STATE EMPLOYMENT WORK LOCATION (NO P.O. BOXES)

Address:	City:	State:	Zip:

(4) LEGAL ENTITY TYPE

☐ Corporation ☐ Sole-Proprietor ☐ LLC/LLP ☐ Domestic/Household ☐ Other (please specify) Not-for-profit: ☐ Yes ☐ No

Nature of Business:	Standard Industrial Classification (SIC) Code:	If Domestic: Does employee work less than 20 hours per week? If yes, Voluntary Coverage form & number of hours are required. DB-135 Voluntary Coverage Form ☐ Yes ☐ No

(5) ADDITIONAL ENTITY (IF APPLICABLE)

Entity Name (if more than one, attach sheet):	☐Corporation ☐ Sole-Proprietor ☐ LLC/LLP ☐Domestic/Household ☐Other (please specify)	Federal Tax ID:		
Business Address:	City:	State:	Zip:	Country

(6) BROKER INFORMATION (IF APPLICABLE)

Agency:	Address:	City:	State:	Zip:
Contact Name:	Email:	Telephone:		

(7) ACCOUNTANT INFORMATION (IF APPLICABLE)

Agency:	Address:	City:	State:	Zip:
Contact Name:	Email:	Telephone:		

(8) 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:

(9) EMPLOYEE CONTRIBUTIONS (FICA)

Indicate whether employees contribute to Disability Benefits (DB) insurance premium **(do not include contributions for 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) COVERAGE OPTIONS FOR DISABILITY CLAIM BENEFIT LEVELS

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

Please indicate desired level of claim benefit: ☐Statutory DB benefit **OR** ☐ 1.5x ☐2x ☐2.5x ☐ 3x ☐4x ☐5x

For more information on enriched benefit coverage, please visit https://ww3.nysif.com/Home/Employer/DBpolicyholder/AboutYourPolicy/EnrichedDB

(11) PAYROLL INFORMATION (REQUIRED FOR ALL NEW YORK COVERED EMPLOYEES)

Enter payroll for all New York covered employees in the sections below.

Disability Benefits (DB)	Enter number of covered employees	Enter annual wages for all covered employees, up to a maximum of $17,680 per person*	Enter gross annual wages for all covered employees (actual wages)
Male/M			
Female/F			
Non-binary or third gender/X			
Paid Family Leave (PFL)	Enter number of covered employees	Enter annual wages for all covered employees, up to a maximum of $82,917 per person*	Enter gross annual wages for all covered employees (actual wages)
Male/M			
Female/F			
Non-binary or third gender/X			

***Calculating Capped Wages**
Disability Benefits (DB): The capped wage for an employee is limited to a maximum of $17,680 per year. If an employee's annual wage is less than $17,680, please use the employee's actual wages. If the employee's annual wage is greater than $17,680, use $17,680 as their wages. If your policy has enriched disability benefit coverage, multiply $17,680 by the enrichment factor (1.5, 2, 2.5, 3, 4 or 5) for the limited capped wage amount.

Paid Family Leave (PFL): The capped wage for an employee is limited to a maximum of $82,917.64 per year. If an employee's annual wage is less than $82,917.64 use the employee's actual wages. If the employee's annual wage is greater than $82,917.64 use $82,917.64 as their wages.

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

Name	Title	Address	Covered under policy?	If yes, please provide gross annual wages
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	
			☐Yes ☐ No	

Corporations with 1 or 2 officers (in NYS): If you request not to be covered under the policy, a completed Officer Exclusion form (DB-212.3) must be submitted with the application: http://www.wcb.ny.gov/content/main/forms/db212-3.pdf

Sole Proprietor, Partnership or Members of an LLC or LLP with employees: In order to be covered under this policy, Voluntary Coverage forms **must** be submitted with the application (Voluntary Coverage forms are not required if you want to be covered and have no employees): http://www.wcb.ny.gov/content/main/forms/db135.pdf

Authorization

(13) PRINTED NAME OF OFFICER, PARTNER, OWNER, OR MEMBER	
	Date:
(14) ORIGINAL SIGNATURE OF OFFICER, PARTNER, OWNER OR MEMBER	
	Date:

Paid Family Leave Benefits coverage is provided at the benefit amounts and duration required under Workers' Compensation Law section 204(2). Paid Family Leave Benefits coverage only applies to employees who work in New York State.

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.