NYSIF

New York State Insurance Fund

1 Watervliet Avenue Extension, Albany, NY 12206-1629 1-866-697-4332 www.nysif.com

DBL Reference No.

APPLICATION FOR NEW YORK STATE DISABILITY BENEFITS INSURANCE

To apply for coverage, complete this Application, include an initial Premium Deposit Check for $60.00 or the minimum premium deposit made payable to NYSIF Disability Benefits and mail originals to:

DOCUMENT CONTROL CENTER
NYSIF - DISABILITY UNDERWRITING
1 WATERVLIET AVE EXT
ALBANY, NY 12206-1649

You are required to provide disability benefits insurance coverage for your employees unless they are exempt from coverage under the New York State Disability Benefits Law (DBL). For information about whether your employees are covered by the DBL, please telephone the NYS-WCB Disability Benefits Bureau at 1-800-353-3092.

By completing this application, you are applying to the NYSIF for a policy insuring your liability for the payment of benefits to your employees under the New York State Disability Benefits Law. **Coverage will not take effect unless we receive the required Premium Deposit check along with this original signed application** and unless and until this application is accepted by the NYSIF and a policy is issued. Coverage will begin on the inception date stated in the policy. By signing this application, you agree to be bound by the terms and provisions of the policy Any policy of insurance issued based on this application will not provide coverage under Workers' Compensation Law except for Disability Benefits under Article 9 of that law, or under the Volunteer Firefighters' Benefit Law, or the Volunteer Ambulance Workers' Benefits Law. To secure insurance to cover your liabilities under those laws, you must submit separate applications.

PLEASE TYPE OR PRINT IN THE WHITE SPACES PROVIDED. IF ADDITIONAL SPACE IS REQUIRED, PLEASE ATTACH AN ADDENDUM.

(1) Policy Inception Date will be 12:01 A.M. Eastern Standard Time following the Postmark Date, unless a future date is indicated
MO/DA/YEAR (policies cannot be backdated) Inception Date:

(2) Employer Information (REQUIRED)				
Name of Business:				Federal Tax I.D. Number or S.S. No.
Trade Name or Doing-Business-As Name:				Telephone:
Mailing Address: Number / Street / Suite	City or Town:	State/Province:	Zip/Postal:	Country: USA
Primary Contact Name: Title:	E-Mail:			Fax:

(3) If the mailing address is outside of New York State or listing a PO Box, you must list a physical New York State street address			
Address: Number / Street / Suite (PO Box is not acceptable)	City or Town:	State:	Zip Code:

(4) Business Type: Co-Partnership, Corporation, Individual, LLC, LLP, Domestic, Other, Political Subdivision or Unincorporated Assoc.		
Business Type (REQUIRED):	Indicate if Not-for-Profit:	If Other, specify business type:
Nature of Business, describe your organizations activity(s).		

(5) Additional Entity with employee(s) working in New York State that you would like to add to this policy (if applicable)				
Additional Entity Name:	Business Type: (Individual, Co-Partnership, Corp, LLC)			Federal Tax I.D. Number:
Address: Number / Street / Suite (PO Box is not acceptable)	City or Town:	State/Province:	Zip/Postal:	Country: USA

(6) **Coverage:** Does your organization desire all Employees and Corporate Officers (Officers applicable only to Corporations) working in New York State, as defined in and subject to New York State Disability Benefits Law, to be covered under this NYSIF Disability Benefits insurance policy?

☐ Yes

☐ No

If No, check the appropriate reason below and submit the required form with your Application to apply for this exclusion.

☐ Executive Officer Exclusion, only applicable to Corporations with no more than two Executive Officers, is required with application.

☐ Spouse Exclusion, only applicable to Sole Proprietors or Partnerships, is required with application.

☐ Other Employees / Trade Union employees, provide Trade Union Name and Number below.

Describe Other Employees or Trade Unions:	Trade Union Name(s):	Trade Union Number(s):

(7) Domestic / Household Employers Coverage (if applicable)

List the Number of Full-Time and Part-Time Domestic or Household Employees working in New York State.

☐ Number of Full-Time Domestic Employees working a minimum of 40 hours per week and/or live-in (overnight) employees.

☐ Number of Part-Time Domestic Employees working less than 40 hours per week.

Part-Time Employees of Domestic (Household) Employers by Law are not required to be covered by New York State Disability Benefits Insurance. If a Domestic Employer wishes to insure their Part-Time employees an Employers Application for Voluntary Coverage form or must be filed and approved by the New York State Workers Compensation Board Disability Benefits Bureau prior to coverage with the NYSIF.

(8) Current Insurance Provider Information (if applicable)

Name of current Workers' Compensation insurance provider:		Workers' Compensation policy number:
Name of current Disability Benefits insurance provider:	No. of Disability claims in last 3 years	Dollar amount of disability claims in the last 3 years

(9) Claim Benefit: NYSIF allows policyholders to choose the level of claim benefit for their employees. Annual Premium is determined from the Total Limited Annual Employee Wages based upon the **Employers "Selection of Coverage" for which the employer is charged premium. (REQUIRED)**

Choose either: the required New York **Statutory Benefit Coverage** equal to one half the average weekly wage of the employee up to a maximum claim benefit of $170 per week for maximum of 26 weeks if qualified, or **Enriched Benefit Coverage** for a maximum of 26 weeks if qualified:

☐ Statutory Benefit Coverage (minimum required New York State disability benefits insurance)

☐ Enriched Benefit Coverage (provides greater disability claim benefits to qualified employees while satisfying the New York Statutory requirement)

If choosing Enriched Benefit, enter here your "Selection of Coverage": 1.5, 2, 2.5, 3, 4, or 5 times the Statutory Benefit Coverage. ▼

(10) Employee Contributions: Employers providing Disability Benefits insurance to their employees are entitled to withhold employee wages at a rate limited to 1/2 of 1 percent of the weekly wage of the employee, but not to exceed $0.60 per week for Statutory Benefits to contribute to the cost of the premium. Employers providing Enriched Benefits Coverage are entitled to an employee contribution reasonably related to the value of benefit.

☐ Employer will withhold the allowable employee wage contribution to assist in covering the cost of NYS Disability Benefits Insurance.

☐ Employer will NOT withhold an employee wage contribution to assist in covering the cost of NYS Disability Benefits Insurance.

(11) Employee Census & Annual Wage information for covered employees working in New York State (REQUIRED)

Enter the Total Number of covered Male and Female Employees, and their Total Limited Annual Employee Wages. Wages must include every form of earnings including: tips, bonuses, commissions, room, board, etc.

Total Limited Annual Employees Wages for applicants selecting **Statutory Benefit Coverage** is limited to $17,680 per person for each employee earning $17,680 or more annually. For the employees earning less than $17,680 annually, include their cumulative actual annual wages to this total.

Total Limited Annual Employees Wages for applicants selecting **Enriched Benefit Coverage** is limited to $17,680 times the "Selection of Coverage": 1.5x = $26,520, 2x = $35,360, 2.5x = $44,200, 3x = $53,040, 4x = $70,720 or 5x = $88,400 for every employee dependent upon the employers "Selection of Coverage" for all employees. For employees earning less than the limit chosen, include their cumulative actual annual wages to this total.

For Corporations only, please list the number of Corporate Officers and the Total Limited Annual Officers Wages for Officers working in New York State, unless they are excluded from coverage. Officers, Owners and Members of all other business types are excluded from coverage.

NYS Employees	Total Number of Employees	Total Limited Annual Employees Wages		
Male				
Female				

(12) Accountant or CPA (optional)				
Agency Name:	Address: Number / Street / Suite	City or Town:	State: NY	Zip:
Contact Name:	Email:		Telephone:	

(13) Insurance Broker / Representative (optional)				
Agency Name:	Address: Number / Street / Suite	City or Town:	State: NY	Zip:
Contact Name:	Email:		Telephone:	

(14) List all Corporate Officers, Owners, Partners or Members of the Organization, also include if Out-of-State (REQUIRED)					
Name:	Title:	Address:	City or Town:	State: NY	Zip:
Name:	Title:	Address:	City or Town:	State: NY	Zip:
Name:	Title:	Address:	City or Town:	State: NY	Zip:
Name:	Title:	Address:	City or Town:	State: NY	Zip:

The information which you provide on this Application will be used to calculate your NYSIF disability benefits insurance premium. By signing this application, you acknowledge that you have a continuing obligation to notify the NYSIF of any changes in: the size of your workforce or payroll, or in the structure or ownership of any business entity insured under the policy.

NYSIF disability benefits insurance policies renew automatically one year from the inception date. By signing this application, you acknowledge that you are required by NYS law to submit payroll report(s) each period on a form we provide of all reportable wages under the terms specified in the policy no later than thirty days after the end of such period. Such report(s) are subject to minimum charges for each period or any part thereof as specified in the policy.

By law, you are required to provide NYSIF with 30 days written notice of your intent to cancel your policy with NYSIF. Policy renewal cancellations must also be made 30 days in advance of the renewal date. You are responsible for payment for coverage that extends beyond the renewal date if the cancellation request is received less than 30 days from the renewal date.

"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 the purpose of 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."

Original Signature of Owner, Partner, Officer, or Member (REQUIRED)	Date: MO/DA/YEAR (REQUIRED)

(15) Print or Type Name of Owner, Partner, Officer, or Member (REQUIRED)

INFORMATION YOU PROVIDED IS PROTECTED BY THE PERSONAL PRIVACY PROTECTION LAW:

The authority to obtain the personal information requested herein is found in Section 83 of the Workers' Compensation Law as supplemented by Sections 450.1, 450.3 and 450.5 of Chapter VI of Title 12(C) of the Official Compilation of Codes, Rules and Regulations of the State of New York. The principal purpose for which the information is sought is to assist the New York State Insurance Fund in processing your insurance coverage with the New York State Insurance Fund, and its release is governed by the limitations of the Personal Privacy Protection Law. This information will be maintained by the Director of Underwriting, New York State Insurance Fund, 199 Church Street, New York, NY 10007.

To obtain an annual premium Quote estimate and quote Reference Number go to: www.nysif.com then follow the instructions provided for "New Customers Get A Quote" for Disability Benefits.

If you obtained a NYSIF disability benefits Quote and Reference Number from our website, please include this Reference Number on the top of page 1 of this application and on the premium deposit check. Please mail the original application and premium deposit check made payable to NYSIF Disability Benefits to:

DOCUMENT CONTROL CENTER
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1 WATERVLIET AVE EXT
ALBANY, NY 12206-1649

For customer service assistance, visit our website at www.nysif.com and click on "CONTACT US" or telephone 1-866-697-4332

NYSIF®

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DISABILITY BENEFITS INSURANCE INFORMATION

The New York State Insurance Fund, NYSIF, provides employers with short-term disability benefits insurance for their EMPLOYEES in compliance with New York State Disability Benefits Law. Employers who employ one or more employees, except in specified categories, for at least 30 days in a calendar year are required to obtain a disability benefits insurance policy from an approved provider. Sole proprietors, partners of a partnership, members of a limited liability company and owners, and officers, of other organizations, other than corporations, are not eligible to be covered under a disability benefits insurance policy.

NYSIF disability benefits insurance provides employees with partial wage replacement from *Off-the-Job* injury or illness. Disability benefits coverage must be in effect after 4 weeks from the date of hiring employees or immediately when hiring employees who had previous disability benefits insurance coverage from their last employer.

NYSIF Disability Benefits Insurance options for Employee Claim Benefits effective April 1, 2010:

(1) STATUTORY disability insurance claim benefits equal ½ the average weekly wage of the employee, up to a Maximum Weekly Claim Benefit of $170, for 26 weeks (if required) within a 52 week period.

(2) ENRICHED disability insurance claim benefits equal ½ the average weekly wage of the employee, for the "Selection of Coverage" at the "Maximum Weekly Claim Benefit" (see table below), for 26 weeks (if required) within a 52 week period.

NYSIF Disability Benefits Insurance Premium Rates effective January 1, 2010:

(1) STATUTORY disability benefits premium for a standard risk policyholder is calculated at $.14 per person, applicable to each $100 of covered payroll limited to a maximum payroll of $340 per week, per employee. The Statutory Annual Premium Calculation = $0.14 x ($340/100) x 52 weeks = $24.75 per person.

(2) ENRICHED disability benefits premium for a standard risk policyholder is calculated at $.14 per person, applicable to each $100 of covered payroll limited to a maximum payroll of $340 per week times the Selection of Coverage chosen by the policyholder. For Enriched Coverage at 1.5 x $170 the Annual Premium Calculation = $0.14 x (1.5 x $340/100) x 52 weeks = $37.13 per person.

Selection of Coverage	Maximum Weekly Claim Benefit	Annual Premium per person	Weekly Premium per person	Minimum Annual Policy Premium
Statutory	$170	$24.75	$0.48	$60.00
Enriched at 1.5 x $170	$255	$37.13	$0.71	$90.00
Enriched at 2.0 x $170	$340	$49.50	$0.95	$120.00
Enriched at 2.5 x $170	$425	$61.88	$1.19	$150.00
Enriched at 3.0 x $170	$510	$74.26	$1.43	$180.00
Enriched at 4.0 x $170	$680	$99.01	$1.90	$240.00
Enriched at 5.0 x $170	$850	$123.76	$2.38	$300.00

Employee wages include reasonable value of tips, board, housing, or measurable compensation received from employment.

NYSIF Standard Rates may be increased by a premium modification based upon the cost of claims and other underwriting conditions. Applicants with existing coverage and 15 or more employees are requested to submit their current 3 year disability benefits insurance claims history from their current insurance provider to qualify for Standard Rates.

To assist the employer in the cost of disability benefits insurance premium paid to the insurance provider, employers have the option to withhold up to ½ of 1 percent of the weekly wage for each employee. However, this withholding is not to exceed a maximum weekly wage withholding of $0.60 per week for Statutory Coverage. Employers with Enriched Benefits coverage are entitled to withhold an employee contribution reasonably related to the value of benefit approved by the Chairman of the New York State Workers' Compensation Board. The maximum weekly wage withholding must not be greater than the weekly premium per person.

To obtain coverage, the completed original signed Application and minimum annual policy Premium Deposit check must be submitted to NYSIF. The Premium Deposit equals: 100% of the policy estimated premium when the premium is between $60 to $499 annually, 50% of the policy estimated premium when the premium is between $500 to $999 annually, and 25% of the policy estimated premium when the annual premium is $1,000 or greater. The balance of premium will be billed in 9 equal monthly installments and will include a $10 per month installment fee. The installment fee is waived for policyholders who pay their total annual estimated premium in advance.

NYSIF disability benefits insurance becomes effective the day following the postmark on the envelope in which the completed Application and Premium Deposit are mailed together, or at a future date if requested. Policies cannot be backdated.

If NYSIF disability benefits insurance is no longer required, policyholders must provide written notice, signed by an Officer of the organization, requesting to cancel coverage not less than 30 days before the effective date of such cancellation and/or policy renewal. NYSIF insurance policies automatically renew on the policy anniversary date.