

STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

APPLICATION FOR APPROVAL OF PLAN OF AN ASSOCIATION OF
EMPLOYERS OR EMPLOYEES, UNION OR TRUSTEES PROVIDING DISABILITY
AND/OR PAID FAMILY LEAVE BENEFITS

Name of Association, Union or Trustees		
Mailing Address (Number and Street, City, State and Zip Code)		
Telephone #	FEIN	WCB Plan #

The _____ (Association, Union or Trustees) makes the following representations and agreements pertaining to its Plan under the Disability and Paid Family Leave Benefits Law, which is hereby filed as the Plan of the Employers (herein called Participating Employers) as certified by the undersigned (copy of plan must also be attached to this form).

- The Plan described herein is (check A or B):
 A. Initial Form DB-801 filed by or for the Association, Union or Trustees
 B. Modification or Extension of a Plan previously accepted on Form DB-801 and supersedes such previous Form DB-801.
Description of Modification: _____
- The Plan described herein provides the following benefits:
 Both disability and paid family leave benefits
 Disability benefits only
 Paid family leave benefits only
- The Plan as described herein is effective from _____ to _____ and in the event that this Plan is terminated before the Termination Date entered above - or if no Termination Date is entered above - the Association, Union or Trustees agree that the Plan benefits described herein will be continued until written notice of the termination of the Plan has been filed with the Chair.
Effective Date Termination Date (if indefinite, so state)
- The Plan covers the following employees:
 All employees of Participating Employers eligible for benefits under the Law.
 All employees eligible for benefits under the Law except those classes of employees eligible to receive benefits under another policy or plan accepted by the Chair.
 Only the following class or classes of employees of Participating Employers: _____
- The Plan is insured* by:
 Name of Insurance Carrier: _____
 Self-Insurance. Give date of approval as self-insurer under Disability and Paid Family Leave Benefits Law: _____
- The Association, Union or Trustees agree to pay the assessments levied on the total covered payrolls of the employees covered by the Plan, for the Special Fund for Disability Benefits and for expenses of administration under Sec. 214 and 228 of the Disability and Paid Family Leave Benefits Law except to the extent a carrier is liable for and pays such assessments.
- The Association, Union or Trustees agree to make provision for the payment of Benefits, as described herein, to the employees of each Participating Employer certified by the undersigned and during the term of this Plan, to continue to make provision for the payment of Benefits to employees of each Participating Employer, until ten days after a written notice of termination of such Employer's participation is served on the Employer and filed with the Board by or on behalf of the Association, Union or Trustees.

EMAIL COMPLETED FORM AND ATTACHMENTS TO PAU@WCB.NY.GOV
OR MAIL COMPLETED FORM AND ATTACHMENTS TO:
WORKERS' COMPENSATION BOARD
PLANS ACCEPTANCE UNIT
PO BOX 5200
BINGHAMTON, NY 13902-5200

9. Is the employee contribution amount greater than .60 cents per week for disability benefits or greater than the maximum rate set by the Department of Financial Services for paid family leave benefits? Yes No
10. Except as stated above, does the Plan contain any restrictions or limitations on the payment of disability or paid family leave benefits other than as specified in the Disability and Paid Family Leave Benefits Law and in the Rules and Regulations promulgated thereunder? Yes No
- If "Yes", describe each such restriction or limitation in full (Attach additional sheet, if necessary).

I affirm this _____ day of _____, 20_____, under the penalties of perjury under the laws of New York, which may include a fine or imprisonment, that the foregoing is true, and I understand that this document may be filed in an action or proceeding in a court of law.

Association, Union or Trustees

By _____
Signature of Authorized Official

Print Name and Title

Telephone Number _____ Date Signed _____