NEW YORK STATE | Paid Family Leave

EMPLOYER'S APPLICATION FOR VOLUNTARY COVERAGE

for Class of Employees for Whom Paid Family Leave Benefits are Not Required by Law (Employee Contribution Required)

Bureau of Compliance, 328 State Street, Schenectady, NY 12305

TO THE CHAIR, WORKERS' COMPENSATION BOARD

_____

Name of Employer

_____

Name Under Which Business is Conducted

_____ _____

Address Telephone Number

Federal Employer Identification Number (if no FEIN, give Social Security Number) _____

Total Number of Employees _____

Class or classes of employees at the place or places of employment as follows _____

Number of employees in class or classes for whom paid family leave benefits are not required by law _____

A. The Employer represents that he or she ☐ is ☐ is not a covered employer within the definition thereof in Section 202 of the New York State Disability and Paid Family Leave 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. BENEFITS TO BE PROVIDED

☐ Paid family leave benefits as provided by a Plan to be filed under Section 211.

☐ Paid family leave benefits as provided under Section 204, if there is no Plan for such employees.

2. 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 ninety (90) days (or 12 months for public employers) 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 ratable part of assessments for the current period, all subject to approval of the Chair.

D. The employer hereby certifies that:

1. More than one-half of the 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 _____ and upon 30 days' notice to the employees.
3. The contribution of each employee is at the rate of _____ said rate being less than or equivalent to the current maximum contribution as set by the Department of Financial Services.

PLEASE COMPLETE REQUIRED INFORMATION ON REVERSE

I hereby affirm, under penalties of perjury, that I am _____ of the above named employer; that I have carefully read the foregoing application, including attachments, and that the facts therein stated are true.

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

Telephone Number _____ Name and 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 has duly agreed to contribute to the cost of paid family leave benefits as described herein.

Date Signed _____ _____
Signature of Employee Representative

Telephone Number _____ Title _____

_____
Name of Employee Association or Union

Date Signed _____ _____
Signature of Employee Representative

Telephone Number _____ Title _____

_____
Name of Employee Association or Union