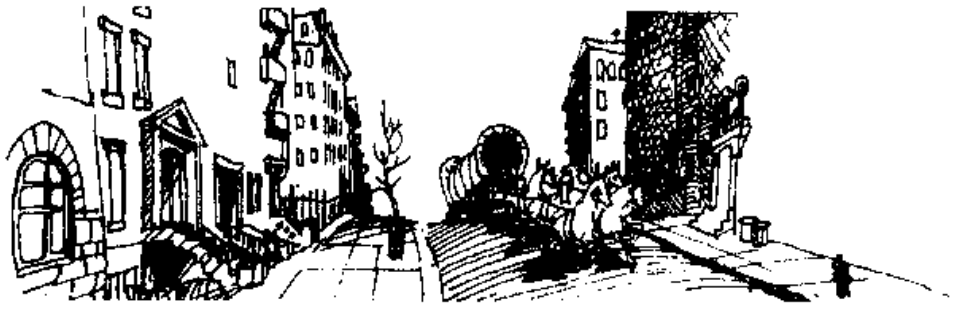

UHAB THE URBAN HOMESTEADING ASSISTANCE BOARD
120 WALL STREET 20th FLOOR NEW YORK, NY 10005•(212)479•3300•FAX (212)344•6457

Information on New York State Disability Insurance and Workers' Compensation Insurance

All employers in New York State are required to have Workers' Compensation and Disability Insurance for their employees at all times.

It is very important that as part of our payroll work with the buildings that we ensure that the TA/HDFC has obtained coverage and that that coverage continues to be in effect. There are heavy fines levied on employers who fail to obtain or keep these mandatory insurances in place. Thousands of dollars in fines can mount up in only a few months' time.

UHAB staff can help buildings to obtain and maintain this insurance by referring them to **Bollinger / R & F, Inc.,** UHAB's insurance broker for FLIP and other insurance. There is **no broker's fee** for NYS Disability and Worker's Compensation Insurance. It is a service provided by R & F. The service consists consists of: (1) assistance in completing application forms, (2) monitoring payments and (3) contacting the TA/HDFC when insurance may be cancelled. With our close relationship with R & F, we can know much sooner when a building is in danger of losing their insurance, so UHAB staff can contact the officers to avoid cancellation and the large fines which will follow.

Disability Insurance — Disability insurance covers employees when they get hurt *off the job*. It pays a

small stipend for the time that the employee is unable to work.

There are two applications for Disability Insurance in this packet. The first is for the *State Insurance Fund* which has a minimum premium of $100 per year. The second is for *First Rehabilitation Life Insurance Company* which has a minimum premium of $60 per year. Bollinger/R & F says that First Rehab has the lower minimum premium and is a little better to work with than the State Insurance Fund. If buildings want to switch companies, they will need to sign a "Broker of Record Letter" to designate R & F as their broker and then complete the First Rehab application. First Rehab policies begin in July, so May would be a good time to consider changing companies.

Workers' Compensation — Workers' Compensation covers an injury *on the job*. It pays certain medical expenses as well as provides certain income to the employee while s/he is unable to work. Worker's Compensation rates are currently going up in every class.

In order to get a quote for Workers' Compensation Insurance, the TA/HDFC must ocmplete the Application for Workers' Compensation and submit it to R & F. Workers' Compensation automatically covers the officers of the corporation and assumes that they receive at least $18,000 per year. Since officers in TA/HDFCs don't make that amount, each officer should complete the *Notice of Exclusion for Officers* form and submit it with the Workers' Compensation application.

There are **stiff** penalties for failure to have Workers' Compensation. **The penalty is $200 for every 15 days that there is not a policy in effect.**

If a building already has Workers' Compensation, they can sign a "Broker of Record Letter" to designate R & F as their broker so that R & F can monitor their policy and contact them when there is a problem.

The **Flanders' Group** is a membership trade group of Real Estate Owners & Managers which pools the workers' compensation experience of the trade group and shares the savings among the members. TIL and HDFC buildings can join the trade group and pay the membership fee which will entitle them to the savings benefit in their second year. An application for the Flanders' Group is in the packet and can be submitted with the Workers' Compensation application to R & F.

Bollinger/R & F is located at One Wall Street Court, 12th floor. Their phone number is (212) 269-8080 ext 213 for Ingrid Kaminski.

THE STATE INSURANCE FUND
199 CHURCH STREET, NEW YORK, NY 10007
(212) 312-9000

FOR OFFICE USE ONLY
File Check _____
Rate Card _____
Correspondence _____
Payments _____
Policy No. _____

APPLICATION FOR NEW YORK WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

ıny person who wilfully makes a false statement or representation, deliberately conceals any material fact, or engages in any ·audulent scheme or device, for the purpose of obtaining or attempting to obtain, or for the purpose of aiding or abetting any pe btain insurance in the State Insurance Fund at less than the proper rate for such insurance, or payment out of the State Ins 'und to which such person is not entitled, is guilty of a crime. In addition, the State Insurance Fund shall have a right of ac ecover civil damages equal to three times the amount wrongfully obtained, or five thousand dollars, whichever is greater. Thi f action is in addition to any other remedy provided by law.

\pplication is hereby made to THE STATE INSURANCE FUND for a policy insuring the applicant's liability for the paym enefits to the applicant's employees under the New York Workers' Compensation Law. **No coverage will be effected u he required deposit premium is received along with this application.** Applicant understands that no liabilit ttach to THE STATE INSURANCE FUND under this application and that insurance shall not be effective unless and unt ıpplication is accepted by THE STATE INSURANCE FUND as evidenced by the inception date indicated in a policy, the ter ›rovisions of which will be binding upon applicant. Applicant further understands that a policy of insurance issued pursuant ıpplication will not extend coverage under the Disability Benefits Law, the Volunteer Firefighters' Benefit Law or the Vol \mbulance Workers' Benefit Law; any liabilities of the applicant under such laws to employees, executives or others m eparately insured under a Disability Benefits insurance policy, Volunteer Firefighters' Benefit Law policy or Volunteer Amb Workers' Benefit Law policy for which separate applications must be submitted.

PLEASE PRINT OR TYPE. **YOU MUST ANSWER ALL QUESTIONS AND SIGN THE APPLICATI OTHERWISE YOUR INSURANCE PREMIUM MAY BE ADVERSELY AFFECTED.**

(1) REQUESTED EFFECTIVE DATE OF INSURANCE: _____ 12:01 A.M., EASTERN STANDARD T
(Date)

(2) FULL NAME(S) OF EMPLOYER(S): _____
(Attach a separate sheet listing the names of all **employers**, if more than one **employer** is to be covered.)

If more than one person or entity are to be insured under the policy, each agrees: (a) that service of any notice upon the person or entity design Question (5) constitutes service of notice upon all insureds; and (b) each insured person or entity is jointly or severally liable with the others premiums due under the policy.

(3) TRADE NAME(S), IF ANY: _____

(4) APPLICANT IS: ☐ SOLE PROPRIETOR/SELF EMPLOYED; ☐ PARTNERSHIP; ☐ CORPORATION;
☐ POLITICAL SUBDIVISION; ☐ LIMITED LIABILITY COMPANY; ☐ PROFESSIONAL SERVICE LIABILITY COMPA
☐ REGISTERED LIMITED LIABILITY PARTNERSHIP; ☐ OTHER-SPECIFY: _____
IF YOU ARE A CORPORATION, IN WHAT STATE ARE YOU INCORPORATED? _____
DATE OF INCORPORATION: _____

(5) NAME, ADDRESS AND TELEPHONE OF THE PERSON OR ENTITY DESIGNATED BY APPLICANT (WHICH MAY BE THE APPLICANT OR ANOTHER) TO RECEIVE NOTICES ON BEHALF OF ANY AND ALL INSUREDS:

_____
(Name) (Street)

_____ ( )
(City or Town) (State) (Zip Code) (Telephone)

IF MAILING ADDRESS & LOCATION ARE THE SAME, PLEASE CHECK BOX ..... ☐

For the purpose of serving notice of cancellation in accordance with section 54(5) of the New York Workers' Compensation Law, the insured(s) agree(s) that service of notice upon the person or entity designated at the address specified is service of notice upon all insureds insured under

(6) LIST ALL BUSINESS LOCATIONS TO BE COVERED IN NEW YORK STATE :
(P.O. BOX IS NOT ACCEPTABLE AS A LOCATION. ONLY NEW YORK STATE LOCATIONS CAN BE COVERED.)

(Attach an additional sheet if necessary)

(7) WHAT IS THE NAME AND ADDRESS OF YOUR BANK? _____

(8) WHAT IS THE NAME, ADDRESS AND TELEPHONE NUMBER OF THE PERSON YOU WISH US TO CONTACT FOR PREMIUM AUDIT? _____

(9) LIST ALL EXECUTIVE OFFICERS, PARTNERS, ELECTED OR APPOINTED OFFICIALS, OR MEMBERS OF GOVERNING BOARD, IF APPLICABLE. IF ANY OF THE PARTNERS OR CORPORATE OFFICERS LISTED BELO IS A PARTNER OR CORPORATE OFFICER FOR A PARTNERSHIP OR CORPORATION OTHER THAN THE EMPLOYER(S) SPECIFIED IN ITEM (2), LIST THE NAME OF ALL SUCH PARTNERSHIPS AND/OR CORPORATION WITH THE PRINCIPAL BUSINESS ADDRESS AND, FOR A CORPORATION, THE PERCENTAGE OF STOCK OWNERSHIP IN ITEM (9b) BELOW.

NAME _____ TITLE _____ DUTIES _____

HOME ADDRESS _____ ANNUAL SALARY _____

NAME _____ TITLE _____ DUTIES _____

HOME ADDRESS _____ ANNUAL SALARY _____

NAME _____ TITLE _____ DUTIES _____

HOME ADDRESS _____ ANNUAL SALARY _____

NAME _____ TITLE _____ DUTIES _____

HOME ADDRESS _____ ANNUAL SALARY _____

(Attach an additional sheet if necessary.)

(9b)

NAME OF PARTNERSHIP OR CORPORATION	ADDRESS	PERCENTAGE OF STO OWNERSHIP IN ITEM

(Attach a separate sheet if more than one partnership or corporation.)

(10) NAME, ADDRESS AND TELEPHONE NUMBER OF INSURANCE REPRESENTATIVE, IF ANY:

THE FLANDERS GROUP
West Brook Building
8 Tobey Road
Pittsford, NY 14534-9939
Phone 716-381-6070
Fax 716-381-3565

(Name) (Street)

(City or Town) (State) (Zip Code) ( ) (Telephone)

(11) WHAT IS THE NAME AND ADDRESS OF YOUR PREVIOUS INSURANCE COMPANY? IF NONE, WRITE "NONE":

POLICY NUMBER: _____ PERIOD OF COVERAGE: _____

HOW MANY CLAIMS HAVE BEEN FILED BY OR ON BEHALF OF YOUR EMPLOYEES DURING THE LAST 12 MON

IF NONE, WRITE "NONE": _____

(12) HAS ANY INSURANCE COMPANY DECLINED TO OFFER COVERAGE TO YOU DURING THE LAST 12 MONT
IF YES, WHAT COMPANY AND WHY WAS COVERAGE DECLINED?

_____

_____

(13) HAVE YOU EVER BEEN INSURED IN THE STATE INSURANCE FUND? _____

IF YES, WHAT WAS YOUR STATE FUND POLICY NUMBER(S), AND PERIOD(S) OF COVERAGE:

_____

(You must answer "yes" if you or any person who directly or indirectly owns or controls or is the president, vice president, s or treasurer of an employer identified in Item (2) above either directly or indirectly owns or controls or is president, vice pr secretary or treasurer of an employer that has had a workers' compensation policy with the State Insurance Fund tha cancelled, or directly or indirectly owned or controlled or was president, vice president, secretary or treasurer of an emplo the time that employer's workers' compensation insurance policy with the State Insurance Fund was cancelled. The Wo Compensation Law prohibits any person from contracting for a subsequent policy with the State Insurance Fund while th premium on such a cancelled policy remains uncollected.)

(14A) WHAT IS THE POLICY NUMBER OF YOUR DISABILITY BENEFITS INSURANCE AND THE NAME OF YOUR DISABILITY BENEFITS INSURANCE CARRIER? _____

(14B) WHAT IS THE NAME, ADDRESS AND POLICY NUMBER OF YOUR GENERAL LIABILITY INSURANCE COMPANY? _____

(15) HAS YOUR COMPANY BEEN IN BUSINESS FOR LESS THAN 3 YEARS? _____

IF YES, ON WHAT DATE DID BUSINESS START: _____

(16) HAVE YOU EVER BEEN IN BUSINESS UNDER A DIFFERENT NAME? _____

IF YOU ARE INCORPORATED, HAVE THE PRINCIPALS OF THE CORPORATION PREVIOUSLY MANAGED A BUSINESS BY ANOTHER NAME? _____

IF YES, WHAT NAME(S) WAS (WERE) USED (INCLUDE TRADE NAMES, IF ANY):

_____

DATE(S) USAGE OF NAME(S) WAS (WERE) STOPPED OR CHANGED: _____

(17) IS YOUR BUSINESS OR COMPANY AN AFFILIATE OR A SUBSIDIARY OF ANY OTHER COMPANY? _____

IF YES, COMPLETE THE FOLLOWING:

NAME OF AFFILIATE OR SUBSIDIARY	ADDRESS	RELATIONSHIP	NAME OF PRESENT WORK COMPENSATION INSURA COMPANY

(Attach a separate sheet if more than one affiliate or subsidiary.)

(18) WHAT IS YOUR NEW YORK STATE UNEMPLOYMENT INSURANCE NUMBER? _____
(Attach a separate list showing UI Numbers for any additional employers that are to be covered under the policy.)

(19) WHAT IS YOUR FEDERAL TAX IDENTIFICATION NUMBER? _____
(Attach a separate list showing Federal ID Numbers for any additional employers that are to be covered under the policy.)

20) DESCRIBE YOUR BUSINESS OPERATIONS INCLUDING THE PRODUCTS OR SERVICES SOLD

_____

_____

21) LIST YOUR ESTIMATED ANNUAL PAYROLL BY TYPE OF WORK OR DUTIES:

	NUMBER OF EMPLOYEES	PAYROLL
CLERKS/BOOKKEEPERS/DRAFTSMEN		
OUTSIDE SALESMEN/MESSENGERS		
EXECUTIVE OFFICERS		
OTHER-DESCRIBE:		
OTHER-DESCRIBE:		

(Attach an additional sheet if necessary.)

You must notify us promptly of any change in the number of your employees or your payroll so that we can app correct premium basis and of any change in the nature of the work performed by your employees so that we ca proper classifications.

(22) PAYROLL VERIFICATION (this requirement does not apply to employers of domestic servants or to municipalities political subdivisions):

At least one of the following items of payroll verification MUST accompany this application. Failure to provide this infor increase your premium. Please attach at least one of the following items to your application:

- a copy of your previous insurance company's premium audit bill showing the classifications and payrolls for th recent policy period
- copies of Federal Tax Form 941 for the last four quarters
- copies of New York State Unemployment Insurance Form 1A for the last four quarters
- copies of New York State Form WRS-2 for the last four quarters

If none of the foregoing documents are available because you are a new business or did not have employees, then check th

(23) DATE _____

_____
(Name of Applicant - Print or Type)

_____
(Signature of Owner, Partner or Officer)

Applicant, please note:

INFORMATION YOU PROVIDE IS PROTECTED BY THE PERSONAL PRIVACY PROTECTION LA

The authority to obtain the personal information requested herein is found in Section 83 of the Workers' Compensation Law as supplemented by Sections 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 t sought is to assist The State Insurance Fund in processing your insurance coverage with The State Insurance Fund and its release is governed by the limitation Privacy Protection Law. This information will be maintained by the Director of Underwriting, The State Insurance Fund, 199 Church Street, New York, NY 1

District Offices of The State Insurance Fund are located at:

15 Computer Drive W. Albany, NY 12205 (518) 485-8800	225 Oak St. Buffalo, NY 14203 (716) 851-2000	159 No. Franklin St. Hempstead, NY 11550 (516) 538-7800	2950 Expressway Drive S. Islandia, NY 11722 (516) 233-3700	1000 Marine Midlan Rochester, NY 1460 (716) 258-2000
	701 Westchester Ave. White Plains, NY 10604 (914) 997-4800		1045 7 North St. Liverpool, NY 13088 (315) 453-6500	

THE FIRST REHABILITATION LIFE INSURANCE COMPANY OF AMERICA
600 NORTHERN BOULEVARD, GREAT NECK, N.Y. 11021-5202

The First Rehabilitation Life Insurance Company of

APPLICATION

To be attached to and forming part of Policy No. of The First Rehabilitation Life Insur
Company of America

We hereby apply for a **GROUP DISABILITY POLICY** to be based upon the following statements and to benefits that will meet with the requirements of the New York State Disability Benefits Law for the em of: (Complete Legal Name)

1. _____

_____(herein called the pol

2. Business Location _____

_____

Mailing Address for Billing _____

_____

Telephone Number at Business Location _____

3. Nature of Business _____ (Unemployment Insurance Account No.) ____

Federal Taxpayer Identification Number (TIN) _____

4. This policy is to be effective from 12:01 A.M. Eastern Standard Time on _____ and shall contin force until canceled in accordance with the policy provisions. The benefits provided shall be as fo

Waiting Period Accident-Sickness	Maximum Duration	Weekly Benefits % of Wages	Weekly Benefits Maximum	In-Hospit Indemnity
7 Days - 7 Days ☐	26 Weeks ☐	50% ☐	$170.00 ☐	Excluded Included

5. Name, Address, Unemployment Insurance Account No. and Federal Taxpayer Identification Number other Employers to be covered by this application, (If none, so state)

_____

_____

6. (a) All employees as defined in and subject to the New York Disability Benefits Law are to be insur except the following (If none, so state)(If union employees excluded, so state. Please provide local name and local number)

_____

_____

(b) Any Sole Proprietor, Partner(s) or other voluntary employees who desire to be insured and who specifically named herein

_____

_____

_____

7. Total number of Employees to be insured? _____ Male _____ Female _____
(Include Corporate Officers)

8. (a) Name of Policyholder's Workers' Compensation Insurance Carrier _____

(b) Previous Disability Carrier _____

9. Premiums: Based on information furnished the Company, premiums shall be calculated in the manner: (Check applicable option).

A. Groups of 1 to 49 Employees	MALE	FEMALE	PROPRIETOR/ PARTNER	OTHER EM
☐ Annual Premium – (Remit Premium in Advance)	$30.60	$73.80	$95.50	$
☐ Annual Premium – (Including In–Hospital Indemnity)	$39.00	$90.60	$116.40	$

B. 11 to 49 Employees MONTHLY PER CAPITA RATES: (Billed Quarterly)	MALE	FEMALE	PROPRIETOR/ PARTNER	OTHER EM
☐ Statutory Benefits	$2.90	$6.75	$8.65	$
☐ Statutory Benefits (including In–Hospital Indemnity)	$3.55	$8.15	$10.55	$
☐ Statutory Benefits, Payroll Rate Factor _____				

C. 50 or More Employees: (Billed Quarterly in Arrears)

☐ Monthly Rate based upon covered payroll (first $340 per week per employee)

Payroll Rate Factor _____

☐ Monthly per Capita Rates Male $_____ Female $_____

MAXIMUM EMPLOYEE CONTRIBUTION. The Policyholder understands and agrees that the contributio employee toward the total premium shall not exceed 1/2 of 1% of wages received on and after the e date of this policy, subject to a maximum of 60 cents per week.

☐ Contributory ☐ Non–Contributory

Required Statement: "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."

Dated at _____ this _____ day of _____

BOLLINGER INC, R & F OF NEW YORK DIVISION
(Producer)

PO BOX 982
NEW YORK NY 10268
(Address)

_____
(Employer)

_____
By (Authorized Signature)

0000-7479 / 017

NEW YORK STATE
REAL ESTATE OWNERS & MANAGERS
WORKERS' COMPENSATION SAFETY TRADE GROUI
Underwritten by The New York State Insurance Fund

Group Manager: The Flanders Group Inc.
West Brook Building • Eight Tobey Road • Pittsford, New York 14534-9939
(716) 381-8070 • (800)462-6435 • Fax : (716)381-3565

FIRM NAME

STREET ADDRESS

MAILING ADDRESS

CITY, STATE, ZIP

TELEPHONE NUMBER (WITH AREA CODE)

FAX NUMBER (WITH AREA CODE)

ACCOUNTING CONTACT & PHONE NUMBER

CLAIMS CONTACT & PHONE NUMBER

SERVICE CONTACT & PHONE NUMBER

NUMBER OF EMPLOYEES

E-MAIL ADDRESS

THE NEW YORK STATE INSURANCE FUND
199 Church Street
New York, N.Y. 10007

DATE:_____

Re: State Insurance Fund Policy #_____

We (I) desire to have our (my) compensation insurance placed in the New York State Real Estate Owners Managers Safety Trade Group #512.

We (I) understand that their Administrative Charge is 8% of the annual total rating board premium. We (I) understand that this charge is due and payable at the policy inception. The Administrative Charge will be adjusted at audit.

We (I) understand and agree that such Administrative Charges will continue on an annual basis as long as Workers' Compensation policy remains in Safety Trade Group #512 through The State Insurance Fund. Thi charge is due at the inception date of each subsequent policy renewal.

We (I) understand that our (my) membership is subject to the written approval of the State Insurance Fund the Group Manager.

We (I) agree to abide by all the rules and regulations governing the conduct of such Group and authorize TH FLANDERS GROUP INC. of West Brook Building, Eight Tobey Road, Pittsford, N.Y. 14534-9939, Group Manager, to act as our representative in all matters with the State Insurance Fund.

SIGNATURE

PRINT NAME

TITLE

DATE:_____

Re: State Insurance Fund Policy #_____

The above applicant is acceptable as a member of the Real Estate Owners and Managers Safety Trade Group #512.

NEW YORK STATE
REAL ESTATE OWNERS & MANAGERS
WORKERS' COMPENSATION SAFETY TRADE GROUI
Underwritten by The New York State Insurance Fund

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