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

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

Application is hereby made to THE STATE INSURANCE FUND for a policy insuring the applicant's liability for the payment of benefits to the applicant's employees under the New York Workers' Compensation Law. No coverage will be effected unless the required deposit premium is received along with this application. Applicant understands that no liability attach to THE STATE INSURANCE FUND under this application and that insurance shall not be effective unless and until such application is accepted by THE STATE INSURANCE FUND as evidenced by the inception date indicated in a policy, the terms and provisions of which will be binding upon applicant. Applicant further understands that a policy of insurance issued pursuant to this application will not extend coverage under the Disability Benefits Law, the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law, any liabilities of the applicant under such laws to employees, executives or others in separately insured under a Disability Benefits insurance policy, Volunteer Firefighters' Benefit Law policy or Volunteer Ambulance Workers' Benefit Law policy for which separate applications must be submitted.

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

(1) REQUESTED EFFECTIVE DATE OF INSURANCE: ___________ 12:01 AM., EASTERN STANDARD TIME

(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 designates service of notice upon all insureds; and (b) each insured person or entity is jointly or severally liable with the others for all 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 COMPANY;
☐ REGISTERED LIMITED LIABILITY PARTNERSHIP; ☐ OTHERSPECIFY:

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 INSURED:

<table>
<thead>
<tr>
<th>Name</th>
<th>Street</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>City or Town</th>
<th>State</th>
<th>Zip Code</th>
<th>Telephone</th>
</tr>
</thead>
</table>

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

For the purpose of serving notice of cancellation in accordance with section 34(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 any such policy.
(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 BELOW 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.

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>DUTIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>HOME ADDRESS</td>
<td>ANNUAL SALARY</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>NAME</th>
<th>TITLE</th>
<th>DUTIES</th>
</tr>
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<tbody>
<tr>
<td>HOME ADDRESS</td>
<td>ANNUAL SALARY</td>
<td></td>
</tr>
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</tr>
</thead>
<tbody>
<tr>
<td>HOME ADDRESS</td>
<td>ANNUAL SALARY</td>
<td></td>
</tr>
</tbody>
</table>

(Attach an additional sheet if necessary.)

(9b) NAME OF PARTNERSHIP OR CORPORATION

ADDRESS

PERCENTAGE OF STOCK 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

Westbrook Building
8 Tolley Road
Pittsford, NY 14524-9909

(Please use: 716-331-8370 (Zip Code)
Fax 716-331-3565)

(City or Town)

(State)

(Telephone)

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

POLICY NUMBER:

PERIOD OF COVERAGE:
(12) Has any insurance company declined to offer coverage to you during the last 12 months? 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?

(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?

(17) Is your business or company an affiliate or a subsidiary of any other company? If yes, complete the following:

<table>
<thead>
<tr>
<th>Name of affiliate or subsidiary</th>
<th>Address</th>
<th>Relationship</th>
<th>Name of present workers' compensation insurance company</th>
</tr>
</thead>
</table>

(18) What is your New York State unemployment insurance number?

(19) What is your Federal TIN number?

(Attach a separate list showing UI numbers for any additional employers that are to be covered under the policy.)

(Attach a separate list showing Federal TIN numbers for any additional employers that are to be covered under the policy.)
10) DESCRIBE YOUR BUSINESS OPERATIONS INCLUDING THE PRODUCTS OR SERVICES SOLD.


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

<table>
<thead>
<tr>
<th></th>
<th>NUMBER OF EMPLOYEES</th>
<th>PAYROLL</th>
</tr>
</thead>
<tbody>
<tr>
<td>CLERKS/BOOKKEEPERS/DRAFTSMEN</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OUTSIDE SALESMEN/MESSENGERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>EXECUTIVE OFFICERS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>OTHER-DESCRIBE:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attach an additional sheet if necessary</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

You must notify us promptly of any change in the number of your employees or your payroll so that we can keep our records correct on a premium basis and of any change in the nature of the work performed by your employees so that we can properly make or change classifications.

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

At least one of the following items of payroll verification MUST accompany this application. Failure to provide this information may 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 the 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 the space below.

(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 LAW.

The authority to obtain the personal information requested herein is found in Section 83 of the Workers’ Compensation Law as supplemented by Sections 450.5 and 6 of Chapter VI of Title 12 of the Official Compilation of Codes, Rules and Regulations of the State of New York. The principal purpose for which it is 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 of privacy protection law. This information will be maintained by the Director of Underwriting, The State Insurance Fund, 199 Church Street, New York, NY.

District Offices of The State Insurance Fund are located at:

<table>
<thead>
<tr>
<th>District Office</th>
<th>Address 1</th>
<th>Address 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Albany</td>
<td>15 Computer Drive W, Albany, NY 12205</td>
<td>(518) 485-8800</td>
</tr>
<tr>
<td>Rochester</td>
<td>1000 Marine Midland, Rochester, NY 14605</td>
<td>(716) 228-2000</td>
</tr>
<tr>
<td>Buffalo</td>
<td>223 Oak St, Buffalo, NY 14203</td>
<td>(716) 851-2000</td>
</tr>
<tr>
<td>Manhattan</td>
<td>159 No. Franklin St, New York, NY 11550</td>
<td>(516) 538-7800</td>
</tr>
<tr>
<td>Long Island</td>
<td>2900 Expressway Drive S, Islandia, NY 11722</td>
<td>(516) 223-3700</td>
</tr>
<tr>
<td>White Plains</td>
<td>701 Westchester Ave, White Plains, NY 10604</td>
<td>(914) 997-4800</td>
</tr>
<tr>
<td>Liverpool</td>
<td>10417 North St, Liverpool, NY 13088</td>
<td>(315) 455-6500</td>
</tr>
</tbody>
</table>
APPLICATION

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

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

1. _____________________________________________________________ (herein called the policy)

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 continue in force until canceled in accordance with the policy provisions. The benefits provided shall be as follows:

<table>
<thead>
<tr>
<th>Waiting Period Accident-Sickness</th>
<th>Maximum Duration</th>
<th>% of Wages</th>
<th>Weekly Benefits Maximum</th>
<th>In-Hospital Indemnity</th>
</tr>
</thead>
<tbody>
<tr>
<td>7 Days - 7 Days</td>
<td>26 Weeks</td>
<td>50%</td>
<td>$170.00</td>
<td>Included</td>
</tr>
</tbody>
</table>

5. Name, Address, Unemployment Insurance Account No. and Federal Taxpayer Identification Number of 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 insured 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 are 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/ | OTHER |
      |----------------------|------|--------|------------|-------|
      | Annual Premium (Remit Premium in Advance) | $30.60 | $73.80 | $95.50 | $1   |
      | Annual Premium (Including In-Hospital Indemnity) | $39.00 | $90.60 | $116.40 | $1   |

   B. 11 to 49 Employees
      MONTHLY PER CAPITA RATES: (Billed Quarterly)
      
      |                      | MALE | FEMALE | PROPRIETOR/ | OTHER |
      |----------------------|------|--------|------------|-------|
      | Statutory Benefits (including In-Hospital Indemnity) | $2.90 | $6.75 | $8.65 | $1   |
      | Statutory Benefits, Payroll Rate Factor _____________ |

   C. 50 or More Employees: (Billed Quarterly in Arrears)
      
      |                      | MALE | FEMALE | PROPRIETOR/ | OTHER |
      |----------------------|------|--------|------------|-------|
      | 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 contributions
employee toward the total premium shall not exceed 1/2 of 1% of wages received on and after the end
of this policy, subject to a maximum of 80 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 facts 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)

(Reservation)

By (Authorized Signature)
NEW YORK STATE
REAL ESTATE OWNERS & MANAGERS
WORKERS' COMPENSATION SAFETY TRADE GROUP
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

Re: State Insurance Fund Policy #

DATE: __________________

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. The 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 The 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 GROUP
Underwritten by The New York State Insurance Fund

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MAILING ADDRESS

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TELEPHONE NUMBER (WITH AREA CODE)

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ACCOUNTING CONTACT & PHONE NUMBER

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SIGNATURE ____________________________________________________________________________

PRINT NAME __________________________________________________________________________

TITLE ________________________________________________________________________________

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