

(Please type or print legibly)

See reverse side for eligibility requirements.

Check one of the following: Corporation Partnership Proprietorship LLC/LLP Other

Name of Owner(s) or Partner(s): _____
Name must appear exactly as filed with N.Y. State Division of Unemployment

Street Address: _____

City: _____ State _____ Zip Code _____

Contact Name: _____ Telephone No.: () _____

Name under which employer's business is conducted, if different from above: _____

Mailing Address, if different from above: _____

City: _____ State _____ Zip Code _____

Business of Employer: _____ SIC Code, if known: _____

Tax Identification Number: _____ - _____ (required)

Is this business seasonal? Yes No

If "Yes", specify months in full-time operation and estimate monthly covered payroll: _____

Is voluntary coverage desired for any of the following classes of employees:

Partner(s) Proprietor(s) Member(s) Owner(s) Clergy Teacher(s) Part-Time Domestic(s) Other _____

If "Yes", complete Voluntary Disability Benefits for Proprietor(s), Partner(s), Member(s), Owner(s) application for each person or DB-135 or DB-136 for all other classes.

If union employees are to be excluded, give name and local number.

Name: _____ Local Number: _____

What is employer's Unemployment Insurance Employer Registration number? _____ - _____

Total number of employees to be Insured: _____ Number of males: _____ Number of females: _____

Billing Options (Based on Total Number of Employees): (required) 50% or more employees part-time? Yes No

Annual (1-25 Employees) Quarterly (11-49 Employees)

Will employees contribute to this insurance? Yes No

If "Yes", is the contribution the maximum permitted by law? Yes No Amount: \$ _____ per _____

If your employees make a contribution toward the cost of this insurance, please specify the percentage, based on a three year average, of the **total cost** assumed by the employer: _____ %.

Do you require year-end W-2 Forms? Yes No

Employer currently is: Insured for statutory DBL Insured for benefits in excess of statutory Self-insured

New venture, not previously insured

Name of previous carrier, if applicable: _____

When and why was previous coverage terminated? _____

Will subsidiaries or affiliates be covered? Yes No

If "Yes", please complete the reverse side of this form. (Additional locations must be listed on reverse side.)

Requested effective date: _____

Workers' Compensation Board requires receipt within 30 days.

Agent or Broker: _____ Date: _____

Address: _____

City: _____ State _____ Zip Code _____

Please list all subsidiaries or affiliates. Attach additional page(s), if needed.

Name	Address, City, State and Zip Code	Unemployment Insurance Employer Registration No.	Number of Employees		Subsidiary to be Billed Separately	
			M	F	Yes	No

Eligibility Requirement Summary

Employees are eligible if they are working or have recently worked for a “covered” employer for at least four consecutive weeks. Part-time employees become eligible on the 25th day of employment. There are however, some exceptions. The law EXCLUDES certain categories of employees as follows;

- Minor child of the employer;
- Government, railroad, maritime or farm workers;
- Ministers, priests, rabbis, members of religious orders, sextons, Christian Science readers;
- Corporate officers and persons engaged in a professional or teaching capacity in or for a religious, charitable or educational institution of a “non-profit” character, and persons receiving rehabilitation services in a sheltered workshop operated by such institutions under a certificate issued by the U.S. Department of Labor;
- Persons receiving aid from a religious or charitable institution, who perform work in return for such aid;
- One or two corporate officers who either singly or jointly own all of the stock and hold all of the offices of a corporation which employs no other employees;
- Golf caddies;
- Daytime students in elementary or secondary school, who work part-time during the school year or their regular vacation period;
- Members of LLC/LLP companies; and
- Part-time domestic or personal employees (working less than 40 hours per week).

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.