

STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

Initial
 Cancellation
 Reinstatement
 Supersedes
 Transaction Effective Date:

A. INSURER/CARRIER

1. INSURER/CARRIER NAME		2. INSURER/CARRIER CODE	3. INSURER/CARRIER TELEPHONE NO.
4. CONTACT NAME		5. TITLE	6. TODAY'S DATE

B. CURRENT - EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		13. LEGAL STATUS (SEE BACK OF FORM)
11. ADDRESS		14. # OF EMPLOYEES
12. CITY	STATE	ZIP CODE
		15. TELEPHONE NO.

C. POLICY

** If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete items 16 and 18.*

16. POLICY NUMBER*	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER*
19. WCB PLAN NUMBER (Only for Assoc., Union or Trustee with Form DB-801 on file.)		20. PREMIUM AMOUNT

D. REASONS FOR CANCELLATION

Non-Payment of Premium Other
 Not Subject/No Eligible Employees Date: _____
 Out of Business Date: _____
 Seasonal Date: _____

CANCELLATION OR TERMINATION SENT TO EMPLOYER: Date:

E. Complete if SUPERSEDES box is checked at top of form.		F. POLICYHOLDER - If different from Employer	
21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		27. POLICYHOLDER NAME	
22. ADDRESS		28. POLICYHOLDER ADDRESS	
23. CITY	STATE	ZIP CODE	29. CITY
			STATE
			ZIP CODE
24. EMPLOYER FEIN	25. POLICY EFFECTIVE DATE	30. POLICYHOLDER FEIN	
26. POLICY NUMBER			

G. 1. The policy covers Employer's employees as follows:

a. ___ All employees eligible under the New York State Disability Benefits Law.

b. ___ All employees eligible under the New York State Disability Benefits Law except those classes of employees eligible to receive benefits under another policy or plan accepted by the Chair.

c. ___ Only the following class or classes of employees:

2. The employee contributions required and benefits insured are:

a. ___ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

b. ___ As described in the attached supplement, Form DB820.1.

c. ___ As described in Employer's Application for Acceptance of a Plan, Form DB800, filed with and accepted by the Chair.

d. ___ As described in Certificate of Insurance, Form DB820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ DATE or amended Form DB820.3 filed thereafter.

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204) _____
 OR benefits under a plan accepted by the Chair.