NEW YORK STATE Workers' Compensation Board

SELF-INSURER ANNUAL REPORT FOR CALENDAR YEAR _____
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

Email completed form to: selfinsurance@wcb.ny.gov

Employer _____ FEIN _____

Address _____ Self-Insured ID# _____

1. Please complete below chart:

	Disability Benefits	Paid Family Leave Benefits
Number of eligible NY employees covered by self-insurance		
Covered New York Payroll ($)		

Total number of New York employees _____

Total annual New York Payroll ($) _____

2. Corporate Structure/Ownership Update: Have any changes in legal status or ownership, including mergers and name changes, taken place since filing the last report? __ Yes __ No

If Yes, attach copies of amended certificate of incorporation, partnership agreement or foundation documents.

3. **DB Primary Contact:**

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

Additional DB Contact (if applicable)**:**

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

PFL Primary Contact (if different than DB)**:**

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

Additional PFL Contact (if applicable)**:**

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

4. Approved active subsidiaries in self-insurance program (attach additional sheets, if necessary):

Name	FEIN

5. Claims Administration:

__ **Self-Administer for:** __ Disability Benefits __ Paid Family Leave Benefits

__ **Administered by a WCB licensed claims administrator for:** __ Disability Benefits __ Paid Family Leave Benefits

DB Administrator:

WCB License # T_____ Company Name _____

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

PFL Administrator (if different):

WCB License # T_____ Company Name _____

Contact Name _____ Title _____

Address _____

Phone # _____ Email _____

By signing this report, the signer certifies that he/she is authorized to execute this instrument on behalf of the _____ for the purposes set forth herein,
(INSERT BUSINESS NAME)
and that, pursuant to that authority, he/she is executing this instrument in the name of and on behalf of said entity as an act and deed of said entity.

_____	_____	_____
Signature of Authorized Official	Title	Date
_____	_____	_____
Print Name of Authorized Official	Phone #	Email

ACKNOWLEDGMENT

STATE OF _____ }
:SS.:
COUNTY OF _____ }

On the _____ day of _____ 20___, before me personally appeared _____ known to me to be the person who executed the foregoing instrument, who, being duly sworn by me did depose and say that he/she resides in _____, and further that (check one):

__ **If a corporation**: he/she is the _____ of the corporation described in the said instrument; that by authority of the Board of Directors of said corporation, he/she is authorized to execute the foregoing instrument on behalf of the corporation for purposes set forth therein; and that, pursuant to that authority, he/she executed the foregoing instrument in the name of and on behalf of said corporation as the act and deed of said corporation.

__ **If a partnership**: he/she is the _____ of the partnership described in said instrument; that by the terms of said partnership, he/she is authorized to execute the foregoing instrument on behalf of the partnership for the purposes set forth therein; and that pursuant to that authority, he/she executed the foregoing instrument in the name and on behalf of said partnership as the act and deed of said partnership.

__ **If Other** (please specify:_____): he/she is the _____ of the entity described in said instrument; that he/she is authorized to execute the foregoing instrument on behalf of the entity for purposes set forth therein; and that, pursuant to that authority, he/she executed the foregoing instrument in the name of and on behalf of said entity as the act and deed of said entity.

_____
Notary Public

NEW YORK STATE | Workers' Compensation Board

SELF-INSURER ANNUAL REPORT INSTRUCTIONS
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

Instructions to assist in the completion of the DB-681 Annual Report

General Information:

- All information you include on the form should be current as of **December 31st** of the reporting year.
- The form must be **fully** executed by an Authorized Official of the self-insured entity, and the acknowledgement must be completed by a Notary, including a Notary stamp/seal.
- This is a consolidated report; therefore, all **approved** self-insured subsidiary data should be included in this filing.
- The Employer/Business name should be the **full legal name of the entity**, including designations such as "Inc.", "LLC", etc., for all entities.
- The employer's address is the headquarters or main location of the self-insured entity.
- If you are providing Paid Family Leave benefits through a licensed carrier, or if you are a municipality and have not opted in to provide Paid Family Leave benefits, you may disregard the Paid Family Leave sections of the DB-681.
- Submit fully completed and notarized forms to: **selfinsurance@wcb.ny.gov.**

Question #1 should be completed as follows:

- **Number of eligible New York employees covered by self-insurance** is the number of covered employees who have reached eligibility for Paid Family Leave (PFL) and/or Disability Benefits (DB) as of 12/31. The number of employees may differ between those eligible for PFL and those eligible for DB because there are different requirements for eligibility:
    - Covered employees become eligible for **Paid Family Leave** once they have met the minimum time-worked requirements:

      Full-time employees: Employees who work a regular schedule of 20 or more hours per week are eligible after 26 consecutive weeks of employment.

      Part-time employees: Employees who work a regular schedule of less than 20 hours per week are eligible after working 175 days, which do not need to be consecutive.
    - Employees are covered and eligible for **Disability Benefits** after working four consecutive weeks for the same employer.
- **Covered New York payroll** is the gross annual payroll of the eligible employees listed in the above box(es).
- **Total number of New York employees** is the number of **all** employees employed and working **in NYS** as of 12/31.
- **Total annual New York payroll** is the gross annual payroll of **all** employees employed and working **in NYS** as of 12/31 listed on the above line.

For Example:

1. Please complete below chart:

	Disability Benefits	Paid Family Leave Benefits
Number of eligible NY employees covered by self-insurance	100	75
Covered New York Payroll ($)	5,000,000	3,750,000

Total number of New York employees 100
Total annual New York Payroll ($) 5,000,000

Question #2 should report whether there have been any changes in legal status or ownership in the reporting year. This includes mergers and/or name changes.

Question #3 should provide a primary contact(s) from the self-insured entity. Primary contacts cannot be a Third-Party Administrator or any other outside entity.

Please be sure to review the form for completeness and accuracy prior to submission. If you need further assistance completing this form, please contact the Office of Self Insurance at selfinsurance@wcb.ny.gov.