NEW YORK STATE INSURANCE FUND

NYSIF Document Control Center-Disability Underwriting
1 Watervliet Ave Ext, Albany, NY 12206
(866) 697- 4332

Policy Number	Document Type	Document Number	Period Covered *	Date
DBL 6982 44-2	INFORMATION PAGE	D 6306900	01/01/2023 To 01/01/2024	11/17/2022

ASSURED:
MERCY HOUSE OF THE SOUTHERN TIER, I
212 N MCKINLEY AVE
ENDICOTT NY 13760

REPRESENTATIVE: 55895
JOHN M PAULIN - STATE FARM
672 MAIN ST
JOHNSON CITY NY 13790 1845

* PERIOD OF COVERAGE BEGINS AND ENDS AT TWELVE AND ONE MINUTE O'CLOCK A.M. EASTERN STANDARD TIME.

TYPE OF BUSINESS: CORPORATION

DISABILITY BENEFITS AND PAID FAMILY LEAVE INFORMATION PAGE: RENEWAL

THIS POLICY IS WRITTEN TO BE EFFECTIVE AND WILL REMAIN IN FORCE UNTIL CANCELLED IN ACCORDANCE WITH THE PROVISIONS OF THE POLICY AS PER THE ENCLOSED INSURING AGREEMENTS.

DISABILITY BENEFITS COVERAGE ENTITLES YOUR EMPLOYEES TO A CLAIM BENEFIT RATE EQUAL TO ONE HALF THE AVERAGE WEEKLY WAGE OF THE EMPLOYEE UP TO MAXIMUM CLAIM BENEFIT RATE OF $170.00 PER WEEK FOR 26 WEEKS, IF REQUIRED.

PAID FAMILY LEAVE BENEFITS ARE DETAILED IN THE PAID FAMILY LEAVE RIDER SENT UNDER SEPARATE COVER.

EARNED PREMIUMS SHALL BE DETERMINED FOR THE PERIOD FROM 1/1/2023 TO 1/1/2024 AND ANNUALLY THEREAFTER IN ACCORDANCE WITH PAYROLL EXPENDITURES TO BE REPORTED BY THE POLICYHOLDER ON A FORM PRESCRIBED BY THE STATE FUND OR BY ACTUAL PREMIUM AUDIT.

THE MINIMUM DISABILITY PREMIUM SHALL BE $60.00 FOR EACH YEARLY PERIOD OR LESS.

DISABILITY BENEFITS			
MALE WAGES	$17,680.00	.14%	$24.75
FEMALE WAGES	$459,680.00	.14%	$643.55
1. STANDARD RATE PREMIUM (WITH DB OPTION 1 x STATUTORY COVG)			$668.30
2. STATE FUND MODIFICATION (0% OF ITEM 1)			$0.00
3. DISABILITY STATE FUND PREMIUM			$668.30
4. DISABILITY DEPOSIT REQUIRED (25% OF ITEM 3)			$167.08
*PAID FAMILY LEAVE			
MALE WAGES (PFL)	$24,483.00	.455%	$111.40
FEMALE WAGES (PFL)	$555,259.00	.455%	$2,526.43
5. PFL PREMIUM			$2,637.83
6. PFL DEPOSIT REQUIRED (25% OF ITEM 5)			$659.46
COMBINED DISABILITY AND PFL PREMIUM			
A. TOTAL STATE FUND PREMIUM (ITEM 3 PLUS 5)			$3,306.13
B. TOTAL DEPOSIT REQUIRED (ITEM 4 PLUS 6)			$826.54

*Please note that these rates reflect the current year Paid Family Leave (PFL) premium rates. The Department of Financial Services sets the PFL rate annually. All policies, regardless of the policy's issue date or renewal date, will be billed at that new rate for all days of coverage after January 1.

THIS POLICY PREMIUM WILL BE RECONCILED UPON THE RECEIPT OF COMPLETED PAYROLL REPORT(S) OR AUDIT FOR THE PERIOD INDICATED ABOVE. IF THE ANNUAL PAYROLL IS NOT REPORTED WITHIN 30 DAYS FROM THE AUDIT PERIOD, NYSIF WILL ADD A PREMIUM ADJUSTMENT TO THE AUDIT PERIOD UNTIL PAYROLL IS REPORTED.

IF YOU HAVE ANY QUESTIONS PLEASE CALL (866) 697-4332

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

DISABILITY BENEFITS LAW TO EMPLOYEES

1. If you are unable to work because of an illness or injury not work-related, you may be entitled to receive weekly benefits from your employer, or his or her insurance company, or from the Special Fund for Disability Benefits.
2. To claim benefits you must file a claim form, within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.
3. Use one of the following claim forms:
   -If, when your disability begins, you are employed or are unemployed for four weeks or less, use claim form DB-450, which you may obtain from your employer, his or her insurance carrier, your health provider or any office of the Workers' Compensation Board, and send it to your employer or the insurance carrier named below.
   -If, when your disability begins, you have been unemployed more than four weeks, use claim form DB-300, which you may obtain from any Unemployment Insurance Office, your health provider or any office of the Workers' Compensation Board. Send completed claim form to the Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241.
   IMPORTANT: Before filing your claim, your health care provider must complete the "Health Care Provider's Statement" on the claim form, showing your period of disability.
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provides for the payment of such bills under a Disability Benefits Plan or Agreement.
5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.
6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271).
7. Other information about Disability Benefits may be obtained by writing or calling the nearest Workers' Compensation Board Office.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
Binghamton, 13901 - State Office Bldg.-44 Hawley St. - (866) 802-3604
Brooklyn, 11201 - 111 Livingston St. - Brooklyn - (800) 877-1373
Buffalo, 14202 - Statler Towers - 107 Delaware Ave. - (866) 211-0645
Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354
Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630
New York, 10027 - 215 W.125th St. - Manhattan - (800) 877-1373
Peekskill, 10566 - 41 North Division St. - (866) 746-0552
Queens, 11432 - 168-46 91st Ave. - Jamaica (800) 877-1373
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St. - (866) 802-3730

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACION OBRERA

AVISO DE CUMPLIMIENTO

LEY DE BENEFICIOS POR INCAPACIDAD A LOS EMPLEADOS

1. Si usted no puede debido a enfermedad o lesión no relacionada con el trabajo, podría tener derecho a recibir beneficios semanales de su patrón o de la compañía de seguros de él/ella o del Fondo Especial para Beneficios por Incapacidad.
2. Par reclamar beneficios usted debe presentar una forma de reclamación, dentro 30 días a partir de la primera fecha de su incapacidad, pero en ningun caso más de 26 semanas de dicha fecha.
3. Use una de las siguientes formas de reclamación:
   -Si, cuando comience su incapacidad usted a ésta empleando o ha estado desempleando por cuatro semanas o menos, use la forma de reclamación (Form DB-450), la cual puede obtener de su patrón o de la compañía de seguros de él/ella, o de su proveedor de cuidados de salud, o bien de cualquier oficina de la Junta de Compensación Obrera, y envíela a su patrón o a la compañía de seguros nombrada abajo.
   -Si, cuando comience su incapacidad, usted ha estado desempleado más de cuatro semanas, use la forma de reclamación (Form DB-300), la cual puede obtener en cualquier Oficina de Seguro Desempleo, de su proveedor de salud, o bien de cualquier oficina de la Junta de Compensación Obrera. Envíe la forma de reclamación, debidamente terminada, a Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241.
   IMPORTANTE: Antes de presentar usted su reclamación, es necesario que su proveedor de salud complete la declaración del médico ("Health Care Provider's Statement") en la forma de reclamación, indicando el period de su incapacidad.
4. Usted tiene derecho a ser tratando por cualquier médico, quiropractico dentista, enfermera-partera, podiatra o psicólogo que usted elija. Pero contrario a la compensación obrera, sus cuentas médicas no serán pagadas a menos que su patrón y/o Union proporcione pago de tales cuentas médicas bajo un Plan o Convenio de Beneficios por Incapacidad.
5. Si estuviera usted enfermo o lesionado durante el tiempo que este recibiendo beneficios del Seguro de Desempleo, presente una reclamación para Beneficios por Incapacidad, siguiendo las instrucciones arriba descritas, tan pronto como sufra la lesión o la enfermedad.
6. Si usted está desempleado por mas de siete días, su patrón está obligado madarle a usted la Declaración de Derechos de Beneficios por Incapacidad (Form DB-271).
7. Otras informaciones relativas a Beneficios por Incapacidad pueden obtenerse escribiendo o llamando a la oficina más cercana de la Junta de Compensación Obrera

Clarissa M. Rodriguez
Chair (Presidenta)

www.wcb.state.ny.us

The undersigned employer is in compliance with the provisions of the Disability Benefits Law
(El patrón abajo firmante esti en conformidad con las disposiciones de la Ley de Beneficios por incapacidad).
Disability Benfits, when due, will be paid by (Los Beficios por incapacidad, cuando debidos, seran pagados por):

THE STATE INSURANCE FUND
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Effective: From **01/01/2022** To **01/01/2023**
(En Vigor Desde) (Hasta)
Policy No. **DBL 6982 44-2**
(Poliza No.)

The benefits provided are (Los beneficios provistos son)

X	Statutory (Estatutorios)		Under a Plan or Agreement (Bajo un Plan o Convenio)

Class(es) of employees covered (Clases(s) de empleados amparados)

Name of Employer (Nombre del patrón)

By **MERCY HOUSE OF THE SOUTHERN TIER, I**

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

DB-120 (7-09)

Prescribed by Chair
Workers' Compensation
Board State of New York

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.