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: 05 04 07

A. INSURER/CARRIER

1 INSURER/CARRIER NAME	2. INSURER/CARRIER CODE	3 INSURER/CARRIER TELEPHONE NO
Zurich American Insurance Company	B170009000	(631) 845-2200
4 CONTACT NAME	**5 TITLE**	**6. TODAY'S DATE**
Roseann Sultan	Administrative Services Manager	05 04 07

B. CURRENT EMPLOYER INFORMATION

7 WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9 EMPLOYER FEIN
	86 04154	13 2600199

10 EMPLOYER'S LEGAL NAME INCLUDING (DBA/AKA/TA)	13 LEGAL STATUS (SEE BACK OF FORM)
LEGAL SERVICES FOR NEW YORK CIIY	03
11 ADDRESS	**14 # OF EMPLOYEES**
C/O IRAVERS, O'KEEFE AND ASSOC. INC. 11 HANOVER SQUARE, 21ST FLOOR	298

12. CITY	STATE	ZIP CODE	15 TELEPHONE NO.
NEW YORK,	NY	10005	(212) 431-7200

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*
5290893 001	01 01 07	992- E
19. WCB PLAN NUMBER (Only for Assoc. Union or Trustee with Form DB-801 on file)		**20 PREMIUM AMOUNT**
		19438

D. REASONS FOR CANCELLATION

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

CANCELLATION OR TERMINATION SENT TO EMPLOYER: Date:

E. Complete if SUPERSEDES box is checked at top of form

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	22. ADDRESS	23. CITY	STATE	ZIP CODE
LEGAL SERVICES FOR NEW YORK CIIY	C/O IRAVERS, O'KEEFE AND ASSOC. INC. 11 HANOVER SQUARE, 21ST FLOOR	NEW YORK,	NY	10005

24 EMPLOYER FEIN	25. POLICY EFFECTIVE DATE	26. POLICY NUMBER

F. POLICYHOLDER - If different from Employer

27. POLICYHOLDER NAME	28. POLICYHOLDER ADDRESS	29. CITY	STATE	ZIP CODE	30. POLICYHOLDER FEIN

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

a. X 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 X 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 _____ or amended Form DB820 3 filed thereafter.
Date

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 Chairman.

This form can be filed with the Workers' Compensation Board via the internet by accessing the Workers' Compensation Board web site at www.wcb.state.ny.us

INSTRUCTIONS

- Check **only one** transaction box
- All dates should be entered in the MM/DD/CCYY format
- The transaction effective date is the date that the Initial filing, Cancellation, Reinstatement or Supersedes is to be effective
- **You must enter a valid Federal Employer Identification Number (FEIN) in box 9 for all transactions.**
- Enter only one complete employer legal entity name in box 10.
- Carriers should record employer location information in their own records. **Do not file a form for this purpose.**

SECTIONS A, B, C AND G MUST ALWAYS BE COMPLETED

Initial Filing or Certificate of Insurance: Sections A, B, C and G must be completed

Cancellations: Sections A, B, C, D and G must be completed. Place an "X" in the box next to the reason for cancellation and provide effective date if required. **All cancellations must be filed strictly in accordance with Section 226, subdivision 5 of the Disability Benefits Law.**

Reinstatements: Sections A, B, C and G must be completed

Supersedes: Sections A, B, C, E and G must be completed. Provide the new information in Sections B or C and give the previously reported information in the appropriate field(s) in Section E.
NOTE: If there has been a legal entity change, do not file as supersedes.
To process legal entity changes, you must file a cancellation for the old legal entity and file an initial filing with a current coverage effective date for the new legal entity.

Section G: If the policy provides only statutory benefits for all eligible New York employees; 1a and 2a should be checked. If the policy provides other than statutory benefits for all eligible New York employees, please check appropriate boxes under 1 and 2, and attach any required forms.

Failure to supply all of the required information will impede the processing and could result in rejection of this document.

LEGAL STATUS - (INSURED LEGAL STATUS)

01 INDIVIDUAL
02 PARTNERSHIP
03 CORPORATION
04 ASSOCIATION, LABOR UNION, RELIGIOUS ORGANIZATION
05 LIMITED PARTNER
06 JOINT VENTURE
10 LIMITED LIABILITY COMPANY (LLC)
11 TRUST OR ESTATE
12 EXECUTOR OR TRUSTEE
13 LIMITED LIABILITY PARTNERSHIP (LLP)
99 OTHER

LEGAL SERVICES FOR NEW YORK CITY
C/O TRAVERS, O'KEEFE AND ASSOC., INC.
11 HANOVER SQUARE, 21ST FLOOR
NEW YORK, NY 10005

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