



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
BUREAU OF COMPLIANCE
20 PARK STREET
ALBANY, NY 12207
www.wcb.state.ny.us

THIS AGENCY EMPLOYS AND SERVES
PEOPLE WITH DISABILITIES WITHOUT
DISCRIMINATION.

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ABC Wesleyan Church
123 Street
Anytown, NY 12345

WCB EMPLOYER #: 222222
NC PERIOD #: 222222
FEDERAL TAX ID (FEIN) or
SOCIAL SECURITY # (SSN): 12345678
UIER #: 222222

Make Sure Correct

|||||

DATE: 09/30/2009

WORKERS' COMPENSATION EMPLOYER INQUIRY NOTICE

The New York State Workers' Compensation Law requires that employers provide Workers' Compensation insurance coverage for their employees, with limited exceptions.

You have received this notice because GUIDEONE MUTUAL INS CO has notified the Workers' Compensation Board that policy 01223475F which provided Workers' Compensation insurance coverage for expired on 09/28/2009. At the present time, the Board is requesting coverage and/or business status information for the period beginning 09/28/2009 through the present.

To promptly address this notice go to the Workers' Compensation Board web site at www.wcb.state.ny.us and select the box for EMPLOYERS and click RESPOND TO EMPLOYER NOTICE. If you do not have internet access, please complete all parts of the enclosed form, sign it and return it to the address listed on the back of the form.

Failure to respond to this notice by 10/30/2009 could result in the issuance of a penalty. Section 52(5) of the Workers' Compensation Law provides for the issuance of a \$2,000.00 penalty for every 10 days that you are reported to have had employees and no Workers' Compensation insurance coverage. If a work-related injury occurs while you do not have Workers' Compensation insurance coverage, you will also be liable for the entire cost of the claim (compensation and medical costs) and penalties, if a law judge so rules. If you have employees, but do not have a Workers' Compensation policy, you are urged to obtain a policy immediately. The penalty will no longer increase and you will not be liable for any future claims.

All information submitted by the employer is subject to review by the Workers' Compensation Board. If you provide coverage information, the coverage will not be applied until confirmed by the carrier.

Please keep in mind that most employers are also required to carry NYS Disability Benefits insurance coverage. Therefore, we urge you to review your records to ensure you are in compliance with the Disability Benefits Law as well.

New York State Workers' Compensation Board
Bureau of Compliance
(866) 298-7830

WCB EMPLOYER #:
 NC PERIOD #:
 FEDERAL TAX ID (FEIN) or
 SOCIAL SECURITY # (SSN):
 UIER #:

Period of Non-Compliance 09/28/2009 through the present.

This form applies ONLY to HIGGINS WESLEYAN CHURCH.

PART 1. FEIN Verification:

Federal Tax ID (FEIN) or Social Security Number (SSN)

Complete this line w/FEIN #

PART 2. Policy Information:

- a. ☒ The policy with GUIDEONE MUTUAL INS CO has been RENEWED or REINSTATED.
- b. ☐ HIGGINS WESLEYAN CHURCH has or had insurance coverage during all or part of the period for which information is requested. The information is as follows:

Carrier	Policy Number	Effective Date
Guide One Mutual	1223-475	9/28/09 - 9/28/10

Please review your policy. If the name on your policy does not match the employer name at the top of this form or the FEIN or SSN on your policy does not match the number you provided in PART 1, please contact your carrier. Have it submit a corrected "Proof of Coverage" transaction to the Board immediately.

PART 3. Business Status Information: If the above employer did not have a policy for all or part of the period for which information is requested because you believe that the above employer was not legally responsible to provide Workers' Compensation insurance coverage, please check all that apply below:

- ☐ The above employer has been replaced by a new business entity and all employees have been transferred to the new entity. Please provide date employees transferred _____

FEIN for New Entity : _____

Name of New Entity : _____

Doing Business As - dba (if any) _____

Street _____ City _____

State _____ Zip _____ Country _____

- ☐ No employees other than:
- Sole proprietor, Or
 - General Partners in a partnership, LLC or LLP, Or
 - One or two officers who own all of the stock of the corporation and hold all of the offices. Each officer must own at least one share of the stock of the corporation.

- ☐ Out of state employer with no NYS employees.
 Date last had employees in NYS _____ ☐ Never had employees in NYS

- ☐ No longer in business (specify date employees last worked) _____

- ☐ Business temporarily closed. Please provide the last date employee(s) worked and expected date of reopening. Date employee(s) last worked _____ Expected date of reopening _____

WCB EMPLOYER #:
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UIER #:

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- ☐ Business never opened and never had payroll.
- ☐ Seasonal business. Please provide the last date employee(s) worked and expected date of reopening. No employees from date _____ to date _____
- ☐ Business does not yet have payroll. Please provide date you expect to have payroll _____
- ☐ Domestic worker in a private household who is on premises less than 40 hours per week.
Note: You must obtain a Workers' Compensation policy for domestic workers who work more than 40 hours per week on premises. Domestic workers include chauffeurs, nannies, home health aides, au pairs, nurses, babysitters, maids, cooks, housekeepers, laundry workers, butlers, companions and gardeners working in a private household. Please do not submit a homeowners' policy as proof of Workers' Compensation insurance coverage for domestic workers.

☐ If none of the above apply, please explain: _____

Part 4. Legal Entity Information: Please review the employer name and address at the top of this notice. If any of the information listed is not correct, please update the information below: (Do not report a new entity here.)

Legal Entity Name _____

Doing Business As - dba (if any) _____

Street _____ City _____

State _____ Zip _____ Country _____

Complete this section

By signing and submitting this form, the undersigned attests that all information provided is true, that he/she is the individual whose name is submitted, and that he/she is the employer named in the letter, or an officer of the employer with authority to sign on behalf of the employer, or the employer's legal representative, or other individual responding with the knowledge and permission of the employer

It is a felony to make a false statement or representation for the purpose of evading the provisions of the Workers' Compensation Law of New York State.

Complete ☒ Owner, Partner or Corporate Officer Signature

Print Name _____

Date _____

Title _____

Telephone Number () _____

Preparer E-Mail address _____

PLEASE RETURN THIS SIGNED, COMPLETED FORM TO:

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
BUREAU OF COMPLIANCE
100 BROADWAY
ALBANY, NY 12241-0005

OR COMPLETE ON-LINE AT

www.wcb.state.ny.us - Respond to Employer Notice

If you have questions regarding this form, please call (866) 298-7830.

Mail