




**Workers' Compensation Board**

**CERTIFICATE OF INSURANCE COVERAGE under the NYS DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW**

<b>PART 1. To be completed by Disability and Paid Family Leave Benefits Carrier or Licensed Insurance Agent of that Carrier</b>	
<p>1a. Legal Name and Address of Insured (Use street address only)</p> <p>HealthNow New York, Inc. 257 West Genesee Street Buffalo, NY 14202</p> <p>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</p>	<p>1b. Business Telephone Number of Insured</p> <p>1c. Federal Employer Identification Number of Insured or Social Security Number</p> <p><b>16-1105741</b></p>
<p>2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)</p> <p>New York State Department of Health NY State of Health Corning Tower, Empire State Plaza, Rm 2580 Albany, NY 12237</p>	<p>3a. Name of Insurance Carrier</p> <p><b>Metropolitan Life Insurance Company</b></p> <p>3b. Policy Number of entity listed in box "1a":</p> <p><b>148762</b></p> <p>3c. Policy effective period:</p> <p><b>January 1, 2012 to Cancellation</b> <b>DB120.1 valid: January 1, 2020 to December 31, 2020</b></p>
<p>4. Policy provides the following benefits:</p> <p><input checked="" type="checkbox"/> A. Both disability and paid family leave benefits.</p> <p><input type="checkbox"/> B. Disability benefits only.</p> <p><input type="checkbox"/> C. Paid family leave benefits only.</p> <p>5. Policy covers:</p> <p><input checked="" type="checkbox"/> A. All of the employer's employees eligible under the NYS Disability and Paid Family Leave Benefits Law.</p> <p><input type="checkbox"/> B. Only the following class or classes of employer's employees:</p> <p>Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has NYS Disability Benefits and/or Paid Family Leave insurance coverage as described above.</p> <p>Date Signed: <u>March 3, 2020</u> By: </p> <p>(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)</p> <p>Telephone Number: <u>678-319-1603</u> Title: <u>State Plan Consultant</u></p> <p>IMPORTANT: If Boxes 4A and 5A are checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that carrier, this certificate is COMPLETE. Mail it directly to the certificate holder. If Box 4B, 4C or 5B " is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the NYS Disability and Paid Family Leave Benefits Law. It must be mailed for completion to the Workers' Compensation Board, Plans Acceptance Unit, PO Box 5200, Binghamton, NY 13902-5200.</p>	
<b>PART 2. To be completed by NYS Workers' Compensation Board (Only if box 4C or 5B of Part 1 has been checked)</b>	
<p><b>State of New York</b> <b>Workers' Compensation Board</b></p> <p>According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability and Paid Family Leave Benefits Law with respect to all of his/her employees.</p> <p>Date Signed: _____ By: _____</p> <p>(Signature of Authorized NYS Workers' Compensation Board Employee)</p> <p>Telephone Number: _____ Title: _____</p>	

**Please Note:** Only insurance carriers licensed to write NYS disability and paid family leave benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.