ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

07/25/2023

JAQUIN & CO INC
1524 WEST FAYETTE STREET
SYRACUSE NY 13204

RE: REDDING HUNTER INC
Policy Number: DBL208356

Dear Producer:

Enclosed is a duplicate copy of the above-named policyholder's New York State Disability policy (DBL) with Paid Family Leave (PFL) benefits if applicable, and associated notices and forms.

Please note that under the federal Electronic Signatures in Global and National Commerce Act ("E-SIGN") and New York State's Electronic Signatures and Records Act ("ESRA"), the policyholder must provide affirmative consent to receiving policy documents in electronic form. Prior to consenting, the policyholder must be clearly informed of (i) any right or option of the policyholder to have the policy documents provided or made available on paper or in nonelectronic form, and (ii) the right of the policyholder to withdraw the consent to have the policy documents provided or made available in an electronic form and of any conditions, consequences, or fees in the event of such withdrawal. If the policyholder does not provide affirmative consent to electronic delivery, you must deliver a paper copy of the policy documents to the policyholder.

Thank you for choosing ShelterPoint. If you require additional assistance, please do not hesitate to contact us at (800) 365-4999 or customerservice@shelterpoint.com.

Sincerely,

Kathleen A. McAuliffe
Sr. Vice President, Client Services & Administration

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www.shelterpoint.com

REDDING HUNTER INC
1089 STARR ROAD
CORTLAND NY 13045

7/25/2023

Dear Policyholder:

We at ShelterPoint Life thank you for accepting us as your insurance carrier for New York State disability (DBL) benefits, including Paid Family Leave (PFL) benefits if applicable. Our coverage is provided in accordance with the provisions of New York State Workers' Compensation Law, Article 9. We require an authorized signature on the Disability Policy application for our records. If you have not already done so, please sign and return the enclosed application as soon as possible using the address indicated above.

We will file the Workers' Compensation Board Form DB-820/829 (commonly referred to as Certificate of Insurance) with the Workers' Compensation Board to show proof of your disability coverage. This filing is required by law.

Claim forms, posting notices, and other materials are available on our website www.shelterpoint.com.

If any additional coverage was requested during the application process, the relevant materials, policies, certificates and applications are also included in this package..

Should you have any questions about your disability benefits insurance policy, please do not hesitate to contact us.

Sincerely,

Kathleen A. McAuliffe
Sr. Vice President, Client Services & Administration

Welcome to ShelterPoint Life!

ShelterPoint Life is pleased to present your new Statutory Disability Benefits Law (DBL) policy providing disability benefits in New York State.

In placing your DBL policy with ShelterPoint Life, your broker has ensured something beyond compliance: the ease and security of working with **The DBL Experts**, and an industry leader in statutory disability insurance. We currently insure more than 150,000 policyholders and are proud to welcome you as one of them.

For service around the clock, visit our website:

www.shelterpoint.com

Here you'll find our **policyholder online services** (some may require registration) which make working with us faster, easier, and more efficient. The following time-saving tools are some of our top online features which will be most useful to you.

- **Pay premiums online** with our E-pay feature (DBL & BaseLine Insurance) – no registration is required!
- **Check DBL claim status and claim payments 24/7** for a specific claimant or for the whole group. (Your employees can also register to monitor their own claim status.)
- **Download a DB-120.1 and DB-120**

Additionally, here are some helpful tips on how to make your DBL claims process with us as smooth as possible:

The DB-450 Claim Form is the initial form used to file a disability benefits claim. It's important that this form be filled out **completely and legibly**. You and your employees can instantly download this form and fill it out electronically at:

www.shelterpoint.com/DB450form

Below are the most common mistakes made when filling out this form:

- Filing a claim before your employee is out of work and certified as disabled by their health care provider.
- Filing a claim without medical certification of disability.
- Filing a claim without employment confirmation details.

We've put together a **handy step-by-step guide** with complete details on how to fill out each section of the DB-450. You and your employees can download it at:

www.shelterpoint.com/dblclaimsguide

If you still need more help, your broker has direct access to all of our departments, so you can count on expert attention and fast service on your claims. Your ShelterPoint Life broker is:

JAQUIN & CO INC
1524 WEST FAYETTE STREET
SYRACUSE NY 13204

Phone: 315-473-9623
Fax: 315-492-6693

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www.shelterpoint.com

New York State Disability Benefits Policy Summary

Dear Policyholder:

The following is a summary of your New York State DBL Policy (DBL), including Paid Family Leave (PFL) benefits if applicable. Please review this information and the pages that follow. If you require assistance or changes to your coverage, please contact your ShelterPoint Life producer.

Sincerely,

Policy Service
ShelterPoint Life

Policyholder:	REDDING HUNTER INC
Address:	1089 STARR ROAD CORTLAND NY 13045
Your Policy Number:	DBL208356
Effective Date of Coverage:	01/01/2004
Anniversary Date:	01/01/2005
Benefit Level:	1 & 1/2 Times Statutory Benefits
Current Employee Count:	43
Billing Cycle:	Quarterly Billing Cycle
Rate for Coverage:	DBL Rate: 2.45 per Male 5.25 per Female PFL Rate: 0.455% of Covered Payroll up to the annualized NYSAWW
Your ShelterPoint Life Producer:	JAQUIN & CO INC 1524 WEST FAYETTE STREET SYRACUSE NY 13204 315-473-9623
The following Riders & Endorsements have been included:	* Paid Family Leave Rider FORM (SPL DB 0922 F) * 1 & 1/2 Times Statutory Benefits Rider FORM (SPL DB 0717 E)

Benefit Summary

Exclusively for Employees of: REDDING HUNTER INC

Each Employee must retain a copy for their records!
Additional posters are available for download at: www.shelterpoint.com/employerresources
Employees covered under ShelterPoint Life DBL are covered under all of the following benefits - even part-time employees:

DBL Benefit Level: 1.5x

- 50% of your average weekly wage to a **maximum benefit of $255/week**.
- Maximum duration: 26 weeks of consecutive disability.
- Waiting period: 7 days (benefits begin on the 8th consecutive day of disability).

Paid Family Leave Rider

- In 2023; provides up to 12 weeks of job-protected paid leave to bond with a new child, care for a seriously ill family member, or attend to family matters due to a military exigency
- No waiting period
- Benefits payable: 67% of your average weekly wage to a max benefit of $1,131.08 per week in 2023
- Learn more at www.shelterpoint.com/pfl

Submit Claims to:

Download claim forms at: www.shelterpoint.com.
Print and send completed form to: **claimforms@shelterpoint.com**

You can submit prior claim incidents for consideration!

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www.shelterpoint.com

NEW YORK DISABILITY BENEFITS LAW INSURANCE POLICY

This Policy is Governed by the Laws of the State of New York

POLICY NO. DBL208356

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In return for payment of the stated premiums by the policyholder named in the application attached to this policy, ShelterPoint Life Insurance Company (ShelterPoint Life or the Company) will pay disability benefits to each employee in a listed class as required under Section 204 of the New York State Disability Benefits Law (New York State Workers' Compensation Law Article 9), subject to the terms and conditions stated in this policy and the statements in the attached application.

This policy provides benefits only

1. for a disability which begins during the term of this policy; or
2. for any employee whose employment with the policyholder terminates during the term of this policy, for a disability that begins within 4 weeks after termination of his employment and prior to the first day employee performs any work for remuneration, profit or benefit received, for an employer other than the policyholder or a subsidiary or an affiliate of the policyholder, provided the new employer is a covered employer under the Disability Benefits Law.

See **VIII. Effective Date of Employee's Coverage** for specific information on the date coverage begins.

This policy becomes effective at 12:01 a.m. on the date shown in the master application. Policy anniversaries will be 12:01 a.m. each year after the policy effective date. Policies are continuous; renewal dates are for premium information only.

This policy is signed at the Home Office of the Company in New York on the date of issue.

This policy is subject to all of the terms contained in the following pages. All provisions of the New York State Disability Benefits Law are considered a part of this policy, as if the provisions were contained herein, so far as those provisions apply to the disability benefits provided by the policy.

The policyholder may act for or on behalf of any and all employers, subsidiaries and affiliates named in the master application attached to this policy in all matters pertaining to this policy. Any act taken by the policyholder shall be binding on those employers, subsidiaries and affiliates named in the master application.

This policy, any attached riders and endorsements, and the signed master application are the entire contract of insurance. Any statement made in connection therewith by an applicant, policyholder, or insured, absent fraud, will be deemed a representation and not a warranty. No misrepresentation made by an applicant, policyholder, or insured will reduce benefits or avoid the insurance, unless that statement is contained in a written document, signed by the applicant, policyholder, or insured and the applicant, policyholder, or insured is or has been furnished with a copy of the document. Such misrepresentation must be material. No misrepresentation shall be deemed material unless the Company's knowledge of the facts misrepresented would have led to the Company's refusal to issue the policy.

No change or amendment to the terms of this policy will be valid unless it has been approved by the Chief Executive Officer, a Vice President, or the Secretary of the Company and is shown by an endorsement to this policy or is attached hereto. No agent has the authority to change this policy or waive any of its provisions;

to accept any premiums in arrears; to extend the due date of any premium; to waive any notice of claim required by this policy; or to extend the date for submission of a notice of claim.

I. ASSIGNMENT BY POLICYHOLDER

This policy shall not be assigned or transferred without the written consent of the Chief Executive Officer, a Vice President, or the Secretary of the Company.

II. CANCELLATION OF THE POLICY

This policy may be canceled in whole or for any one or more classes of employees for non-payment of premium. Cancellation for non-payment of premium will be effective 10 days after the date stated in a written notice of cancellation provided by the Company to the policyholder, to each employer whose employees will no longer be covered and to the Chairman of the Workers' Compensation Board .

The policyholder must provide written notice at least 20 days prior to any premium due date of any cancellation of coverage for the employees of any one or more subsidiaries or affiliates, effective on the next premium due date. Confirmation of the cancellation notice and dat e of cancellation will be sent to the policyholder and to each employer whose employees will no longer be covered, as stated above.

Cancellation for any reason other than non-payment of premium shall be effective 31 days after the date stated in a written notice of cancellation provided by the Company to the policyholder or by the policyholder to the Company and at least 31 days after notice of cancellation is filed in the office of the Chairman of the Workers' Compensation Board of the State of New York. Cancellation due to obtaining insurance from another carrier shall be effective as of the effective date of that new insurance, rather than as of the date stated in the cancellation notice.

The policyholder shall be required to pay all unpaid premiums for insurance on employees of a subsidiary or affiliate to the date of cancellation of insurance. Premiums for cancelled insurance shall be adjusted on a pro-rata basis from the last premium date to the date of cancellation.

Coverage of an insured will end on the earliest of:

1. the date this policy is terminated;
2. 10 days after the date stated in the written notice of cancellation sent to the policyholder for failure to pay the premium due; or
3. the date the employee ceases to be eligible for coverage under this policy.

III. PROVISIONS REQUIRED BY STATUTE

An employee who suffers a disabling injury or illness and gives notice to his employer shall be deemed to have given notice to ShelterPoint Life. For the purpose of the Disability Benefits Law and this policy, jurisdiction shall be deemed to be New York State. ShelterPoint Life shall be bound in all actions pertaining to this policy by the New York State Disability Benefits Law, and the orders, findings, or decisions rendered in connection with the payment of benefits under that law and the New York State Insurance Law and Regulations thereunder.

The Chairman of the Workers' Compensation Board of the State of New York shall have the right to enforce any provision of this policy on behalf of an employe e entitled to benefits under this policy. Enforcement shall be by filing of a separate application or by making ShelterPoint Life a party to the original application. Payment in whole or in part of any benefits by the policyholder, the subsidiary or affil iate employer or the Company shall be a bar to recovery against the non-paying policyholder, subsidiary or affiliated employer or the Company.

Bankruptcy or insolvency of the policyholder, subsidiary or affiliated employer shall not relieve the company of any of its obligations under this policy.

In accordance with the requirements of the Disability Benefits Law, when this policy is terminated, any excess of employee contributions applied to the cost of the insurance but not used to pay premiums to the date of termination shall be used by the policyholder only as set forth in Section 216 of the Disability Benefits Law. Rules governing the distribution of these excess employee contributions are set by the Chairman of the Workers' Compensation Board.

All benefits payable under this policy or under any attached rider or endorsement shall be payable in accordance with the provisions of the Disability Benefits Law. Any provision of this policy which is contrary to the Disability Benefits Law shall be null and void as to that provision only; all other provisions shall remain in effect.

IV. INFORMATION REQUIRED FROM POLICYHOLDER

The policyholder will give to the Company all information which the Company may reasonably require with regard to this policy. All documents, books, and records which pertain to this policy shall be open for inspection by the Company at all reasonable times during the continuance of this policy and for 6 years after the final termination of this policy.

V. CLAIM NOTICES

Written notice of a claim must be given to the policyholder or covered subsidiary or affiliated employer and sent to the Company within 30 days after the start of the disability. The notice must contain all information necessary to identify the policyholder, the subsidiary or affiliated employer. The notice must also specify the employee's name and address, and the time, place, circumstances and nature of the disability. No benefits shall be required to be paid for any period more than 2 weeks prior to the date on which required proof of disability is provided to the Company unless it is shown to the satisfaction of the Chair of the Worker's Compensation Board to be not reasonably possible for the insured to have provided proof sooner and such proof was provided as soon as possible. No benefits shall be paid unless the required proof of disability is provided to the Company within 26 weeks of the start of the period of disability.

VI. PREMIUM & PREMIUM RATES

Premiums will be calculated and must be paid on the basis specified in the attached application. The Company will bill for each premium after the initial premium. The policy anniversary date shall be 12 months following the first day of the calendar quarter coinciding with or next following the effective date of this policy. There is a grace period of 31 days from the premium due date for all payments except the initial payment. The policy remains in effect during the grace period. All premiums due under this policy are to be remitted to the Company by the policyholder.

The Company may establish new premium rates as of the effective date of any amendment to the Disability Benefits Law which affects or alters the Company's obligation under this policy. Any such change will be set forth in a rider to be attached to this policy. The Company reserves the right to change the premium rates after this policy has been in effect for 12 calendar months, or on any premium due date thereafter, by notifying the policyholder in writing at least 31 days in advance of the date the rate change becomes effective. If the policyholder does not pay the new premium, this policy will automatically terminate for non-payment 31 days after the due date of the first premium payment reflecting the rate change.

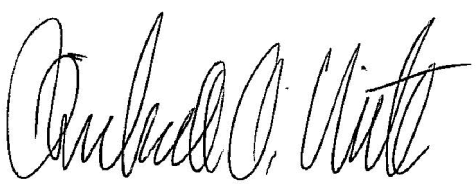
VII. STATUTORY ASSESSMENTS

The Company will pay any assessments levied on the total payrolls of employees covered under this policy pursuant to Sections 214-2, 214-3 and 228 of the Disability Benefits Law of New York.

VIII. EFFECTIVE DATE OF EMPLOYEE'S COVERAGE

Each employee eligible for insurance under this policy shall become insured as of the date of his eligibility to be placed in a class of employees. An employee who returns to work for the same employer/Policyholder after an agreed and specified leave of absence or unpaid vacation shall become eligible for benefits immediately upon return to work.

David G. Melman
Chief Legal Officer



Richard A. White
Chief Executive Officer

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Rider

Family Leave Benefits

For Policy Number: **DBL208356**

This rider amends your New York Statutory Disability Benefits Law (DBL) policy to provide family leave (PFL) benefits as required by law and described below. This rider replaces any previous family leave benefits rider. This rider is subject to all of the provisions of the DBL policy except as specifically modified by this rider. This rider and the DBL policy to which it is attached are governed by the laws of New York State.

This rider is effective: **01/01/2023.**

I. Definitions

Arbitration means the submission of a dispute to one or more impartial persons (as selected by the Chair) for a final and binding decision, known as an award.

Average Weekly Wage means for the purpose of computing the PFL benefit, the amount determined by dividing either the total wages of the employee in the employment of his last covered employer for the eight weeks or portion thereof that the employee was in such employment immediately preceding and including his last day worked prior to the first day of PFL, or the total wages of the last eight weeks or portion thereof immediately preceding and excluding the week in which PFL began, whichever is the higher amount, by the number of weeks or portion thereof of such employment.

For a sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person who elects coverage under Article 9 of the Workers' Compensation Law (WCL), *average weekly wage* shall be determined by computing such person's total net income in the 52 week period immediately preceding the period of leave and dividing such total wages by 52.

Chair means the Chair of the NYS Workers' Compensation Board (WCB).

Child means a biological, adopted, or foster son or daughter, a stepson or stepdaughter, a legal ward, a son or daughter of a domestic partner, or the person to whom the employee stands in loco parentis.

Family Member means a child, parent, grandparent, grandchild, sibling, spouse, or domestic partner.

Foreseeable Qualifying Events include an expected birth, placement for adoption or foster care, planned medical treatment for a serious health condition of a family member, the planned medical treatment for a serious injury or illness of a covered service member, or other known military exigency.

Grandchild means a child of the employee's child.

Grandparent means the parent of the employee's parent.

Parent means a biological, foster, or adoptive parent, a parent-in-law, a stepparent, a legal guardian, or other person who stood in loco parentis to the employee when the employee was a child.

Providing Care may include necessary physical care, emotional support, visitation, assistance in treatment, transportation, arranging for a change in care, assistance with essential daily living matters, and personal attendant services.

Serious Health Condition means an illness, injury, impairment, or physical or mental condition, including transplantation preparation and recovery from surgery related to organ or tissue donation, that involves inpatient care in a hospital, hospice, or residential health care facility, or continuing treatment or continuing supervision by a health care provider.

Sibling means a biological or adopted sibling, a half-sibling or stepsibling.

Statewide Average Weekly Wage means the average weekly wage of employees in this State for the previous calendar year as reported by the NYS Commissioner of Labor.

Superintendent means the Superintendent of the NYS Department of Financial Services.

Wages means the money rate at which employment with a covered employer is recompensed by the employer as more fully set forth in 12 NYCRR 357.1 and in the case of a self-employed person, the person's self-employment income as defined in 26 U.S.C. § 1402(b).

II. Eligibility: Eligible Employees

A. A New York employee of a New York covered employer whose regular employment schedule is 20 or more hours per week will become eligible to receive PFL benefits during employment with such employer if:

(1) the employee has been in employment of the covered employer for at least 26 consecutive work weeks preceding the first full day leave begins;

(2) the employee has been in employment of the covered employer during the work period usual to and available during the entirety of at least 26 consecutive weeks preceding the first full day leave begins in any trade or business in which the employee is regularly employed and in which hiring from day to day is the usual employment practice; or

(3) the employee has been in employment of the covered employer during the work period usual to and available during the entirety of at least 26 consecutive weeks preceding the first full

day leave begins and such consecutive weeks are tolled by the employer during periods of absence that are due to the nonconsecutive nature of that employment and employment is not terminated during those periods of absence.

B. A New York employee of a New York covered employer whose regular employment schedule is less than 20 hours per week will become eligible to receive PFL benefits during employment with such employer if the employee has been in employment of the covered employer and has worked 175 days in such employment preceding the first full day leave begins.

C. The use of scheduled vacation time; the use of personal, sick or other time away from work that has been approved by the employer; or other periods where the employee is away from work but is still considered to be an employee by the employer are counted as days/weeks of employment for purposes of determining eligibility to receive PFL benefits during employment, so long as the required PFL premium is paid by the employee during such periods of time.

D. Periods of temporary disability taken pursuant to DBL shall not be counted as days/weeks of employment for purposes of determining eligibility to receive PFL benefits during employment.

E. An employee who is eligible for both DBL benefits and PFL benefits during the same period of 52 consecutive calendar weeks shall not receive more than 26 total weeks of combined DBL benefits and PFL benefits during that period of time.

F. FMLA. In the event that a period of PFL benefits received by an eligible employee is concurrently designated as leave pursuant to the Family and Medical Leave Act (“FMLA”) by an employer, the employer shall comply with the notification requirements pursuant to 12 NYCRR 380-2.5(g).

III. Premium

A. The employer is responsible to collect the premium contributions for the statutory PFL coverage from each covered employee. The employer is not required to fund any portion of the statutory PFL benefit.

B. The employer may collect employee premium contributions for PFL while an employee is receiving PFL benefits.

C. The employer may not collect employee premium contributions for PFL if an employee is taking DBL leave and has not yet acquired eligibility for PFL benefits.

IV. Statutory PFL Benefits

A. An eligible employee may be entitled to benefits for leave taken from work for the following qualifying events:

(1) To participate in providing care, including physical or psychological care for a family member of the employee made necessary by a serious health condition of the family member;

(2) For the employee to bond with the employee's child:

- during the first 12 months after the child's birth;
- during the first 12 months after the placement of the child for adoption or foster care; or
- before the actual placement or adoption of a child if an absence from work is required for the placement for adoption or foster care to proceed; or

(3) Due to any qualifying exigency pursuant to FMLA, arising out of active duty or an impending call or order to active duty in the Armed Forces of the United States for the spouse, domestic partner, child or parent of the employee.

B. The weekly benefit for family leave commencing on or after January 1, 2021 shall be:

- up to 12 weeks during any 52 consecutive week period; and
- paid at 67% of the employee's average weekly wage, not to exceed 67% of the statewide average weekly wage.

The benefit rate for the employee's period of family leave shall be the rate that is in effect on the first day of family leave taken.

52 consecutive weeks is computed retroactively to the first day for which benefits are currently being claimed. A single claim may not cover more than 52 consecutive weeks.

C. Liability of ShelterPoint Life. The liability for PFL benefits payable for a single qualifying event in a 52-week period shall be the liability of ShelterPoint Life if ShelterPoint Life was providing coverage on the first day of family leave.

V. Requesting PFL Benefits

A. Foreseeable leave.

(1) The employee must provide 30-days advance notice to the employer prior to the first day of leave taken for a foreseeable qualifying event. If 30-days advance notice is not practicable, then notice must be given as soon as practicable. A sole proprietor, member of a limited liability company, member of a limited liability partnership or other self-employed person, must provide 30-days advance notice to ShelterPoint Life prior to the first day of leave taken for a foreseeable qualifying event or as soon as practicable.

(2) The advance notice must include the anticipated timing and duration of the leave for;

(a) continuous leave; or

(b) intermittent leave. The employee should consult the employer on whether the employer may require the employee to provide notice as soon as practicable before each day of intermittent leave. The employee shall advise the employer and ShelterPoint Life of the schedule of intermittent leave. ShelterPoint Life may withhold payment pending submission of a request for payment together with the dates of intermittent leave.

(3) The employee shall advise the employer of any change in the timing and/or duration of the leave. The sole proprietor, member of a limited liability company, member of a limited liability partnership or other self-employed person shall advise ShelterPoint Life of any change in the timing and/or duration of the leave.

(4) If the employee fails to give 30-days advance notice of foreseeable leave to the employer, the employer may request that ShelterPoint Life delay the payment of benefits to the employee (known as a partial denial) for a period of up to 30 days from when the notice was given.

B. Unforeseeable Leave.

(1) When the need for continuous leave is unforeseeable, the employee must provide notice to the employer as soon as practicable. When the need for leave is unforeseeable, the sole proprietor, member of a limited liability company, member of a limited liability partnership or other self-employed person must provide notice to ShelterPoint Life as soon as practicable.

(2) When the need for intermittent leave is unforeseeable, the employer may require the employee to provide notice as soon as practicable before each day of intermittent leave. The employee shall advise the employer and ShelterPoint Life of the schedule of intermittent leave. ShelterPoint Life may withhold payment pending submission of a request for payment together with the dates of intermittent leave.

C. Requirements for Filing a Claim.

(1) The employee requests PFL benefits by completing the request for PFL which is either the PFL-1 claim form available on the New York State Paid Family Leave website or from ShelterPoint Life, or the format designated by ShelterPoint Life.

(2) The employee provides the employer with the request for PFL to complete the employer information section. The employer must complete its section and return the completed request to the employee within 3 business days. ShelterPoint Life may not deny a claim for failure of the employer to complete its section.

(3) The employee completes the appropriate certifications or proof of claim documentation. No benefits are required to be paid by ShelterPoint Life until the completed request for PFL together with the necessary certifications or proof of claim documentation have been submitted to ShelterPoint Life. (See item G. Certification/Proof of Claim Documentation below for additional information.)

(4) The employee submits the completed request for PFL together with the necessary certifications or proof of claim documentation to ShelterPoint Life no later than 30 days from the first day of leave. For a previously unspecified day of intermittent leave, the request for payment must be made within 30 days of the leave. If the Chair agrees that it was not reasonably possible to furnish the completed request for PFL together with the necessary certifications or proof of claim documentation within 30 days, then it must be submitted as soon as possible within the period of actual leave taken pursuant to Section IV. B. above.

(5) Once ShelterPoint Life receives the completed request for PFL together with the necessary certifications or proof of claim documentation, ShelterPoint Life must pay or deny the claim within 18 days.

(6) ShelterPoint Life shall make all reasonable efforts, consistent with the principles set forth in Executive Order 26, issued October 6, 2011, to communicate with respect to the PFL claim in the language identified by the employee in the request for PFL.

D. Incomplete Request for PFL using the PFL-1 claim form.

(1) ShelterPoint Life may deny a claim for PFL without prejudice within 18 days if:

(a) the claim is incomplete; or

(b) the certification or proof of claim documentation is insufficient.

(2) ShelterPoint Life must notify the employee of each piece of required missing information.

(3) When a PFL claim is denied without prejudice, the employee must refile within 30 days of the first day of leave. If the employee does not refile the completed request for PFL together with the necessary certifications or proof of claim documentation within 30 days of the first day of leave, ShelterPoint Life may deny the claim.

(4) Once ShelterPoint Life receives the completed request for PFL together with the necessary certifications or proof of claim documentation, ShelterPoint Life must pay or deny the claim within 18 days.

E. Advance Request for PFL for Foreseeable Qualifying Events.

(1) An Advance Request for PFL for a foreseeable qualifying event shall not be denied on the grounds that the request for PFL is incomplete.

(2) Within 5 business days of receipt of an incomplete request for PFL, ShelterPoint Life will provide the employee with:

(a) notice that the claim is pending;

(b) a list of the required missing information;

(c) instructions for how to submit the missing information; and

(d) contact information.

(3) Once ShelterPoint Life receives a completed request for PFL, ShelterPoint Life shall provide the employee a confirmation of receipt of the completed claim within 3 business days.

(4) If a completed request for PFL is received more than 18 days before the occurrence of a qualifying event, ShelterPoint Life shall send payment to the employee within 5 days following the qualifying event.

F. Denial of PFL Benefits. If ShelterPoint Life denies a request for PFL for reasons other than the claim is incomplete or the certification or proof of claim documentation is insufficient, the employee

may not refile. A PFL denial must state the reason, repeat any relevant information filed in the request and include any other information considered by ShelterPoint Life in making the decision.

G. Certification/Proof of Claim Documentation.

(1) Certification Updates. ShelterPoint Life may require updates to the request for PFL, certifications, or proof of claim documentation for subsequent periods of PFL not covered by the initial documentation during the 52-week period following the initial request for PFL.

(2) Bonding Certification. For PFL taken to bond with the employee's child, the required information to be included in the certification is contained in the PFL-2 form available on the New York State Paid Family Leave website or from ShelterPoint Life.

(3) Certification of a Serious Health Condition.

(a) It is the employee's responsibility to obtain a medical certification from a health care provider and to provide ShelterPoint Life with the complete and sufficient certification for PFL taken due to the serious health condition of a family member. Failure to provide the certification may result in the denial of PFL benefits.

(b) The required information to be included in the certification from the health care provider is contained in the PFL-4 form available on the New York State Paid Family Leave website or from ShelterPoint Life.

(4) Certification Relating to a Qualifying Military Exigency.

(a) It is the employee's responsibility to submit a certification for PFL taken due to a qualifying military exigency. The information to be included in the certification is contained in the PFL-5 form on the New York State Paid Family Leave website or from ShelterPoint Life.

(b) ShelterPoint Life may require the employee to provide a copy of the military member's active duty orders or other documentation issued by the military which indicates that the military member is on active duty or called to active duty status, and the dates of the military member's active duty service.

(c) If the qualifying military exigency involves rest and recuperation leave, the employee must provide a copy of the military member's rest and recuperation orders, or other documentation issued by the military which indicates that the military member has been granted rest and recuperation leave and the dates of the military member's rest and recuperation leave.

(d) ShelterPoint Life may independently verify the employee's appointments with third parties and may verify the military member's active duty status.

VI. Payment of Benefits

A. The first payment of benefits shall be paid within 18 days of receipt of a completed request for PFL with the necessary certification or proof of claim documentation. Thereafter, PFL benefits shall be paid biweekly. In the event a completed request for PFL is received more than 18 days before

the occurrence of a qualifying event, ShelterPoint Life shall send payment to the employee within five days following the qualifying event.

B. Payment of PFL benefits may be made in the same manner as the employee is paid wages from the employer (such as debit card, direct deposit, or check).

C. Payment Options. If ShelterPoint Life offers a choice of method of payment, ShelterPoint Life will contact the employee upon the receipt of the request for PFL and may require the employee to choose between debit card or direct deposit as the method of payment, unless the employee certifies the need for payment by check. If the employee fails to choose a method of payment, ShelterPoint Life may elect to make payment using either a debit card or a check. The employee may elect at a later time to change the default method of payment.

D. If ShelterPoint Life provides for payment methods in addition to a check, ShelterPoint Life must provide employees with written notice that meets the requirements of 12 NYCRR 380-5.6(e).

VII. Employee Use of Accruals and Employer Request for Reimbursement

Where an employer provides an option to employees to charge all or part of unused accruals or other paid time off to receive full salary during the period of family leave and the employee exercises that option, and the employee does not file a request for PFL benefits with ShelterPoint Life, the employer may request reimbursement from PFL benefits due by filing its claim for reimbursement with ShelterPoint Life in accordance with Workers' Compensation Law §205(2)(c).

VIII. Dispute Resolution

A. Informal Resolution. The employee and ShelterPoint Life shall make every effort to informally resolve a denial of PFL benefits.

B. Arbitration. In the event an informal resolution is unsuccessful, any party may seek a formal resolution through arbitration. Any claim-related dispute, including eligibility, benefit rate, and duration of family leave, is subject to arbitration pursuant to procedures promulgated or approved by the Chair of the Workers' Compensation Board. Awards are made in writing and are final and binding on the parties in the case subject to Article 75 of the Civil Practice Law and Rules.

IX. Exclusions and Limitations

(1) Prohibition on concurrent payments. DBL and PFL benefits are not payable concurrently.

(2) No employee shall be entitled to PFL benefits:

(a) For any disability occasioned by the willful intention of the employee to bring about injury to or the sickness of himself or another, or resulting from any injury or sickness sustained in the perpetration by the employee of an illegal act;

(b) For any day of PFL during which the employee performed work for the employer for remuneration or profit;

(c) For any family leave commencing before the employee becomes eligible for PFL benefits.

(3) A sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person who elects coverage under Article 9 of the WCL shall be subject to a waiting period of 2 years from the effective date of this rider before PFL benefits are payable. During the 2 year waiting period, premium contributions for PFL coverage shall be payable.

X. Renewal/Cancellation/Termination

The renewal/cancellation/termination provision of the DBL policy shall apply to this PFL rider. The benefits contained within this PFL rider shall renew or cancel/terminate on the same renewal date or cancellation/termination date as the DBL policy.

XI. Discontinuance

If ShelterPoint Life elects to discontinue all DBL/PFL policies in one or more group sizes (small, medium, large), ShelterPoint Life will provide written notification of the proposed discontinuance to the Superintendent, in accordance with 11 NYCRR 363.6(l) and (m), at least 90 days prior to the date of discontinuance of the coverage. This notification shall be in addition to the notification to the employer required in the underlying DBL policy.

David G. Melman
Chief Legal Officer

Richard A. White
Chief Executive Officer

SHELTERPOINT

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

ENRICHED BENEFITS RIDER
Additional Excess Disability Benefits Coverage Only

Effective 09/01/2006, Policy Number DBL208356, to which this Rider is attached, is hereby amended by adding the following:

Enriched Benefits: Increased disability benefits are provided to all covered employees upon proof of disability pursuant to policy provisions as follows:

50% of the employee's current salary up to a maximum benefit of 1.50 times the statutory disability benefits law weekly benefit for the earlier of duration of the disability or 26 weeks. The enriched benefit includes the statutory benefit available to the insured employee pursuant to the requirements of the New York State Disability Benefits Law and Paid Family Leave Law.

This Enriched Benefits Rider increases disability benefits only and does not affect the policy's Paid Family Leave benefit, if any.

All other terms and conditions of the policy remain the same.

David G. Melman
Chief Legal Officer

Richard A. White
Chief Executive Officer

SHELTERPOINT
Master Application

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

NYS Disability Benefits (DBL) and Paid Family Leave Benefits (PFL) Application Including Optional Benefits

This application becomes part of the DBL policy.

Full Legal Business Name (as filed with the NY State Department of Labor)

REDDING HUNTER INC

Business Address	Mailing Address (if not the same)		
Same as Mailing Address.	1089 STARR ROAD		
City	**State**	**Zip**	
City	**State**	**Zip**	
CORTLAND	NY	13045	

Applicant E-mail	Applicant Phone	Attention/Care of
	607-753-3331	

Applicant Website Address

Legal Entity Type (Choose one)

☐ Sole Proprietor ☐ Partnership ☐ Corporation ☐ Association ☐ Limited Partner (LP) ☐ Joint Venture (JV)
☐ Limited Liability Co. (LLC) ☐ Trust or Estate ☐ Executor or Trustee ☐ Limited Liability Partnership (LLP or LLLP) ☐ Other

A sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person who elects PFL coverage under Article 9 of the WCL shall be subject to a waiting period of 2 years before PFL benefits are payable if coverage is initially elected after January 1, 2018 or, if later, more than 26 weeks after the employer first becomes a sole proprietor, a member of a limited liability company, a member of a limited liability partnership, or other self-employed person.

If Business Entity is a Proprietorship, Limited Liability Company or Limited Liability Partnership, provide the date the Business Entity was established:_____

Nature of Business	SIC Code	Public Employer	Federal ID #	Unemployment Insurance #
	3999	☐ Yes ☐ No	150583652	

Requested Effective Date	Current Workers' Compensation Carrier	Current DBL Carrier
01/01/2004		

COVERED EMPLOYEES

Do you wish to cover out-of-state employees for DBL? ☐ Yes ☒ No
PFL coverage is not available for employees in states/territories other than New York State.

If Yes, list states:

Coverage not available for employees in states/territories with mandated Temporary Disability Insurance.

All employees, pursuant to New York Disability and Paid Family Leave Benefits Law, Article 9, Section 204, are covered:
☒ Yes ☐ No If NO is checked, please list excluded classes of employees
None

EMPLOYEE CONTRIBUTION

DBL ☐ Noncontributory ☒ Contributory

Number of Covered Males	28
Number of Covered Females	15
Total Employees	43

Type of Organization	Coverage Includes	Voluntary Coverage: List additional Class(es) of Employees to be included.
☐ Profit	☐ Teachers	
☐ Non-Profit	☐ Clergy	

Voluntary coverage requires form DB135 or DB136 , PFL-135 or PFL-136 to be submitted with application unless form is currently on file with the New York State Workers' Compensation Board

Proprietors: If Business Entity is a Proprietorship, list Names of Proprietors below.			

Additional Entities/Locations to be covered (as filed with the NY State Department of Labor)			
Name	**None**		
Address			
Federal ID #		Unemployment Insurance #	
Name			
Address			
Federal ID #		Unemployment Insurance #	

**** If the number of additional entities exceeds space provided above, attach all additional information required on a separate piece of paper.****

DBL and PFL Benefits – Please select ONE from options below.		**Optional Riders -** Please select from options below.	
Statutory DBL with PFL Benefits ☐ 1x Statutory DBL Benefit	**Enhanced DBL Benefits** ☒ 1.5x Enriched DBL Benefit ☐ 2x Enriched DBL Benefit ☐ 3x Enriched DBL Benefit ☐ 4x Enriched DBL Benefit ☐ 5x Enriched DBL Benefit	**In-Hospital Rider** ☐ Selected	**AD&D Benefit Rider** ☐ $50,000 ☐ $100,000
All DBL benefit options include statutory PFL benefits			

Optional BaseLine Benefits – Please select from policy options below.			**Optional Non-Insurance Benefits**
Term Life ☐ $ 15,000 Benefit		**Hospital Cash** ☐	☐ **Employer & Employee Assistance Program** ☐ **Nurse Helpline**

Billing Options – Make one selection from the options below.

☐ **Annual Billing**
Minimum DBL Premium is $125.00 annually.

Minimum DBL Premium is $35.00 per quarter. A quarterly installment fee may apply to quarterly billed cases. 11 or more lives required

☒ **Quarterly Billing**

☐ **Quarterly Billing – DBL based on covered payroll**

Monthly Covered Payroll applicable to Females $_____

Monthly Covered Payroll applicable to Males $_____

Total Monthly Covered Payroll $_____

Authorization

The applicant declares that, to the best of his/her knowledge and belief, the statements and answers to the questions in this application are correct and true.

No one except the Chief Executive Officer, a Vice President or the Secretary of SHELTERPOINT LIFE INSURANCE COMPANY may make or modify any contract on behalf of SHELTERPOINT LIFE INSURANCE COMPANY. Any change or amendment to the policy shall be signed by ShelterPoint Life and the policyholder.

NOTICE (Does not apply to life insurance): Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information, or conceals for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime, and shall also be subject to a civil penalty not to exceed $5,000 and the stated value of the claim for each such violation.

Applicant: Date_____ Name _____ Signature_____

Producer: Date_____ Name _____ Signature_____

Agency Name JAQUIN & CO INC Agency # 0000-8415

Agency Address 1524 WEST FAYETTE STREET SYRACUSE,NY 13204 Phone # 315-473-9623

Policy #: **D208356**	Effective: **01/01/2004**	Male Rate: **2.45**	Female Rate: **5.25**	Payroll Rate: **0.0000**

STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

DB-820/829 07-17

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

☒ Initial ☐ Cancellation ☐ Reinstatement ☐ Supersedes **Transaction Effective Date:** 01/01/2004

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
Shelterpoint Life Insurance Company	B069508	(516) 829-8100

4. CONTACT NAME	5. TITLE	6. DATE
Customer Service Department	Customer Service Representative	07/25/2023

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
871320		150583652

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	13. LEGAL STATUS (SEE BACK OF FORM)
REDDING HUNTER INC	
11. EMPLOYER STREET ADDRESS	**14. NUMBER (#) OF EMPLOYEES**
1089 STARR ROAD	43
12. EMPLOYER CITY, STATE and ZIP CODE	**15. EMPLOYER PHONE #**
CORTLAND, NY 13045	---

C. POLICY * If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete item 18.

16. POLICY NUMBER	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
DBL208356	01/01/2004	SPL DBL1114

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT
--	$ 0.00

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: _____

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

21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)	
22. EMPLOYER'S STREET ADDRESS	
23. CITY, STATE and ZIP CODE	
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 and ZIP CODE
30. POLICYHOLDER FEIN

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

a. The policy provides coverage for:

☒ Both disability and paid family leave benefits

☐ Disability benefits only

☐ Paid family leave benefits only

b. The policy covers the following class or classes of employees:

☒ All employees

☐ Only the class or classes of employees listed here:

_____

_____

2. The employee contributions required and benefits insured are:

☒ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.

☐ As described in attached supplement, Form DB-820.1

☐ As described in Employer's Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair.

☐ As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ or amended Form DB-820.3 filed thereafter.

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 Chair.

NEW YORK STATE | Workers' Compensation Board

STATEMENT OF RIGHTS
NEW YORK STATE DISABILITY BENEFITS

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of disability benefits to his/her employees.

2. Statutory disability benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. The total amount of combined paid family and disability leave an employee may take in a 52 consecutive week period may not exceed 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.

3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or by contacting the Workers' Compensation Board. (See address and telephone number below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**

4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.

5. Disability benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.

6. **If your employer or the insurance carrier contends that you are not entitled to the payment of disability benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact the Workers' Compensation Board at the telephone number below.

7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.

8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's disability benefits insurance carrier is:

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste 475
Garden City, NY 11530
Phone: 800-365-4999

Prescribed by the Chair,
Workers' Compensation Board

NEW YORK STATE | Workers' Compensation Board

DECLARACIÓN DE DERECHOS
BENEFICIOS POR DISCAPACIDAD DEL ESTADO DE NUEVA YORK

SI USTED NO PUEDE TRABAJAR POR CAUSA DE UNA ENFERMEDAD O LESIÓN NO-OCUPACIONAL, USTED PODRÍA TENER DERECHO A BENEFICIOS POR DISCAPACIDAD

1. Por ley, su empleador debe facilitarle el pago de beneficios por discapacidad a sus empleados.

2. Las prestaciones estatutarias por discapacidad son pagaderas para cualquier lesión o enfermedad no-ocupacional relacionada (incluyendo discapacidad por embarazo) comenzando al 8vo día consecutivo de discapacidad. Los beneficios son pagaderos por hasta 26 semanas. La cantidad total de pago combinado por licencia por discapacidad o familiar que un empleado puede recibir dentro de un periodo de 52 semanas consecutivas no puede exceder las 26 semanas. Los pagos por beneficios se basan en su salario semanal promedio de las ocho semanas inmediatamente antes de su discapacidad, y están sujetos al máximo permitido por la ley vigente en el primer día de la discapacidad. Su empleador o sindicato puede ofrecer diferentes beneficios que sean por los menos igual de favorables que los beneficios estatutarios bajo un Plan o Acuerdo de Beneficios por Discapacidad.

3. PARA RECLAMAR BENEFICIOS usted debe someter una notificación por escrito y prueba de discapacidad (Formulario de reclamos DB-450) a su empleador o proveedor de seguros indicado a continuación dentro de los 30 días después del primer día de su discapacidad. En ningún caso usted debe esperar más de 26 semanas después de esa fecha para someter un reclamo. Usted puede obtener un Formulario DB-450 con su empleador, su proveedor de seguros, su proveedor de cuidados de salud o contactando la Junta de Compensación Laboral. (Vea la dirección y número de teléfono indicados a continuación.) **No asuma** que su empleador ha sometido un reclamo de parte suya; **someter el reclamo es su responsabilidad**.

4. Usted tiene derecho a ser tratado por cualquier médico, quiropráctico, dentistas, enfermera-partera, podólogo o psicólogo de su preferencia. A diferencia de la compensación de empleados, sus facturas médicas **no** serán pagadas por su empleador o proveedor de seguros, a menos que su empleador y/o sindicato provea el pago de facturas médicas bajo un Plan o Acuerdo de Beneficios por Discapacidad aprobado.

5. Los beneficios por discapacidad serán pagados directamente a usted por el proveedor de seguros, **no a través de su empleador**, a menos que su empleador sea un asegurador aprobado.

6. **Si su empleador o proveedor de seguros le disputa que usted no tiene derecho al pago de beneficios por discapacidad, ellos deben enviarle una Notificación de Rechazo, dentro de 45 después de haber sometido su reclamo, informándole las razones por las cuales los beneficios no se les están pagando. Si usted no está de acuerdo con su rechazo, usted tiene el derecho legal** de solicitar una revisión del rechazo ante la Junta de Compensación Laboral. **IMPORTANTE:** Si usted no ha recibido beneficios dentro de 45 días después de haber sometido su reclamo y no recibe una Notificación de Rechazo (Formulario DB-451), contacte rápidamente a la Junta de Compensación Laboral llamado al siguiente número de teléfono.

7. Si su discapacidad es el resultado de un accidente automovilístico y usted ha sometido un reclamo para beneficios por no-culpa, usted debe también someter un reclamo (Formulario DB-450) para beneficios por discapacidad. **Si usted no solicita los beneficios por discapacidad, el asegurador por no-culpa puede reducir sus pagos de no-culpa. IMPORTANTE**: En tale casos, si usted no tiene derecho a beneficios por discapacidad, notifique inmediatamente a su proveedor de seguros de no-culpa.

8. Su empleador no le puede pedir que renuncie a su derecho de beneficios por discapacidad ni tampoco puede deducirle más de 60 centavos a la semana (a menos que la contribución adicional sea parte de un plan aprobado) de su salario para contribuir al pago de primas de seguros de beneficios por discapacidad. **Usted no puede ser despedido ni discriminado por someter un reclamo para beneficios por discapacidad.**

SI TIENE ALGUNA DIFICULTAD PARA OBTENER UN FORMULARIO DE RECLAMO O NECESITA AYUDA PARA LLENARLO, O SI TIENE CUALQUIER OTRA PREGUNTA O DUDA ACERCA DE UNA ENFERMEDAD O LESIÓN NO-OCUPACIONAL RELACIONADA, CONTACTE A CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN LABORAL.

Esta información es una presentación resumida de sus derechos según las provisiones de la Sección 229 de la Ley de Beneficios de Baja Familiar Remunerada e Discapacidad. El proveedor de seguros de beneficios por discapacidad de su empleador es:

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste 475
Garden City, NY 11530
Phone: 800-365-4999

Estipulado por el Presidente,
Junta de Compensación Laboral

Paid Family Leave
STATEMENT OF RIGHTS

NEW YORK STATE | Paid Family Leave

If you need to take time off from work to care for a family member, you may be entitled to Paid Family Leave benefits.

Paid Family Leave is employee-funded insurance that provides eligible employees job-protected, paid time off to:

- **BOND** with a newly born, adopted or fostered child;
- **CARE** for a family member with a serious health condition (see **paidfamilyleave.ny.gov** for eligible family members); or
- **ASSIST** loved ones when a spouse, domestic partner, child or parent is deployed abroad on active military service.

Paid Family Leave may also be available for use in situations when you or your minor dependent child are under an order of quarantine or isolation due to COVID-19. See **PaidFamilyLeave.ny.gov/COVID19** for full details.

Eligibility:

- If you have a regular work schedule of 20 or more hours per week, you are eligible after 26 consecutive weeks of employment with your employer.
- If you have a regular work schedule of less than 20 hours per week, you are eligible after working for your employer for 175 days, which do not need to be consecutive.

Citizenship or immigration status is not a factor in your eligibility.

Benefits:

You can take up to 12 weeks of Paid Family Leave and receive 67% of your average weekly wage, capped at 67% of the New York State Average Weekly Wage. Generally, your average weekly wage is the average of your last eight weeks of pay prior to starting Paid Family Leave. Leave can be taken all at once or intermittently, but must be in full-day increments.

Rights and Protections:

- **Job protection**: Return to the same or comparable job after you take leave.
- You keep your **health insurance** while on leave (you may have to continue paying your portion of the premium costs, if any).
- Your employer is **prohibited from discriminating or retaliating** against you for requesting or taking Paid Family Leave.

Disputes:

If your Paid Family Leave claim is denied, you may request to have the denial reviewed by a neutral arbitrator. The insurance carrier listed below will provide you with information about requesting arbitration.

Discrimination Complaints:

If your employer terminates your employment, reduces your pay and/or benefits, or disciplines you in any way as a result of you requesting or taking Paid Family Leave, you may request to be reinstated by taking these steps:

1. Complete the *Formal Request for Reinstatement Regarding Paid Family Leave (Form PFL-DC-119)*.
2. Send your completed form to your employer and a copy of the completed form to: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. If your employer does not reinstate you or take other corrective action within 30 days, you may file a discrimination complaint with the Workers' Compensation Board using the *Paid Family Leave Discrimination/Retaliation Complaint (Form PFL-DC-120)*. The Workers' Compensation Board will assemble your case and schedule a hearing.
4. There are other state and federal laws that protect employees from discrimination. Additional information is available at **PaidFamilyLeave.ny.gov**.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the *Request for Paid Family Leave (Form PFL-1)* to your employer.
3. You must submit your completed request package to your employer's insurance carrier within 30 days after the start of your leave to avoid losing benefits.
4. In most cases, the insurance carrier must pay or deny benefits within 18 calendar days of receiving your completed request or your first day of leave, whichever is later.

You may obtain all forms from your employer, their insurance carrier listed below, or online at **PaidFamilyLeave.ny.gov/Forms**.

For more information, forms and instructions, visit PaidFamilyLeave.ny.gov or call the PFL Helpline (844)-337-6303

This information is a simplified presentation of your rights as required by Section 229 of the Disability and Paid Family Leave Benefits Law. Your employer's Paid Family Leave benefits insurance carrier is: **SHELTERPOINT LIFE INSURANCE COMPANY**
address: 1225 FRANKLIN AVE- STE 475; GARDEN CITY, NY 11530
web: www.shelterpoint.com **phone:** 1-800-365-4999

PRESCRIBED BY THE CHAIR,
WORKERS' COMPENSATION BOARD
NYS Paid Family Leave
PO Box 9030, Endicott NY 13761

Licencia Familiar Paga
DECLARACIÓN DE DERECHOS

NEW YORK STATE | Paid Family Leave

Si necesita tomarse tiempo libre del trabajo para cuidar a un familiar, quizás tenga derecho a beneficios de Licencia Familiar Paga.

La Licencia Familiar Paga (Paid Family Leave, PFL) es un seguro financiado por el empleado que brinda a los empleados elegibles tiempo libre pago con el empleo protegido para:

- **FORMAR LAZOS AFECTIVOS** con un recién nacido, un hijo adoptado o de cuidado temporal;
- **CUIDAR** a un miembro de la familia con una condición de salud grave (consulte paidfamilyleave.ny.gov para conocer a los miembros de la familia elegibles); o
- **AYUDAR** a sus seres queridos cuando un cónyuge, una pareja doméstica, un hijo o un padre es enviado al exterior para desempeñarse en el servicio militar activo.

La Licencia Familiar Paga también podría estar disponible para su uso en situaciones en las que usted o su hijo menor de edad dependiente se encuentran bajo una orden de cuarentena o aislamiento debido al COVID-19. Para ver detalles completos, visite PaidFamilyLeave.ny.gov/COVID19.

Elegibilidad:

- Si cuenta con un cronograma de trabajo regular de 20 horas o más por semana es elegibles después de 26 semanas consecutivas de empleo con su empleador.
- Si cuenta con un cronograma de trabajo regular de menos de 20 horas por semana, es elegible después de trabajar para su empleador 175 días, no necesariamente consecutivos.

La condición de inmigración o ciudadanía no es un factor en su elegibilidad.

Beneficios:

Puede pedir hasta 12 semanas de Licencia Familiar Paga y recibir el 67% de su salario semanal promedio, limitado al 67% del Salario Semanal Promedio del Estado de Nueva York. En general, su salario semanal promedio es el promedio de las últimas ocho semanas de su paga antes de comenzar la Licencia Familiar Paga. Puede tomar el permiso completo de una sola vez o de forma intermitente, pero debe ser en incrementos de días completos.

Derechos y protecciones:

- **Protección del puesto de empleo:** Regrese al mismo puesto de empleo, o un puesto comparable, después de tomarse la licencia.
- Usted conserva su **seguro médico** mientras está de licencia (quizás deba seguir pagando su parte de la prima, si la hubiera).
- Su empleador tiene **prohibido discriminarlo o tomar represalias** contra usted por solicitar o tomar una Licencia Familiar Paga.

Disputas:

Si su solicitud de Licencia Familiar Paga es rechazada, puede solicitar que un árbitro neutral revise el rechazo. La compañía de seguros que se indica más adelante le brindará información sobre cómo solicitar el arbitraje.

Quejas por discriminación:

Si su empleador lo despide, reduce su paga o sus beneficios, o lo sanciona de cualquier manera como resultado de su solicitud o toma de una Licencia Familiar Paga, puede solicitar su reincorporación siguiendo estos pasos:

1. Complete la ***Solicitud formal de reincorporación con respecto a la Licencia Familiar Paga (Formulario PFL-DC-119)***.
2. Envíe su formulario completado a su empleador y una copia del formulario completado a: Paid Family Leave, P.O. Box 9030, Endicott, NY 13761-9030
3. Si su empleador no lo reincorpora o toma otras acciones correctivas dentro de los 30 días, puede presentar una queja por discriminación ante la Junta de Compensación Obrera usando el formulario de ***Queja por Discriminación/Represalias por Licencia Familiar Paga (Formulario PFL-DC-120)***. La Junta de Compensación Obrera armará su caso y programará una audiencia.
4. Hay otras leyes federales y estatales que protegen a los empleados contra la discriminación. Encontrará más información disponible en PaidFamilyLeave.ny.gov.

Proceso de solicitud de una Licencia Familiar Paga:

1. Notifique a su empleador al menos 30 días por adelantado, si la necesidad de tomarse licencia es previsible, o lo antes posible de lo contrario.
2. Complete y presente la ***Solicitud de Licencia Familiar Paga (Formulario PFL-1)*** a su empleador.
3. Debe enviar su paquete de solicitud completo a la compañía de seguros de su empleador dentro de los 30 días posteriores al comienzo de su permiso para evitar perder los beneficios.
4. En la mayoría de los casos, la compañía de seguros debe pagar o denegar los beneficios dentro de los 18 días calendario posteriores a la recepción de su solicitud completada o en su primer día de licencia; lo que ocurra después.

Puede obtener todos los formularios de su empleador, su compañía de seguros que se indica más adelante, o por internet ingresando a PaidFamilyLeave.ny.gov/Forms.

Para más información, formularios e instrucciones, visite PaidFamilyLeave.ny.gov o llame a la Línea de Ayuda de PFL al (844)-337-6303

Esta información es una presentación simplificada de sus derechos según lo requiere el Artículo 229 de la Ley de beneficios de Licencia Familiar Paga y Discapacidad. La compañía de seguros de beneficios Licencia Familiar Paga de su empleador es: **SHELTERPOINT LIFE INSURANCE COMPANY, 1225 Franklin Ave., STE 475, Garden City, NY 11530, phone: 800-365-4999**

ESTABLECIDO POR LA PRESIDENCIA,
JUNTA DE COMPENSACIÓN OBRERA
NYS Paid Family Leave
PO Box 9030, Endicott NY 13761

ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste. 475
Garden City, NY 11530
Fax: 516.504.6412 (main) | 516.504.6436 (service) | 516.504.6414 (claims)
Phone: 800.365.4999 (516.829.8100)
www.shelterpoint.com

PRIVACY POLICY

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

ShelterPoint Life Insurance Company (ShelterPoint Life) maintains confidential policyholder and individual insured files. In compliance with state and federal law, protected health information may be collected and/or released to assist ShelterPoint Life in underwriting or claims processing activities or pursuant to an order from a court of competent jurisdiction.

Insureds may access personal information (except when access is prohibited by law) by contacting:

Customer Service
ShelterPoint Life Insurance Company
1225 Franklin Avenue, Ste 475
Garden City, New York 11530

Telephone: (516) 829-8100 or (800) 365-4999
Fax: (516) 504-6412
E-mail: customerservice@shelterpoint.com

If there is a change in your personal information, you should notify ShelterPoint Life Customer Services. ShelterPoint Life may amend its privacy policy and/or our notice as necessary. You may obtain a copy of ShelterPoint Life's current privacy policy by contacting ShelterPoint Life Privacy Officer in the Legal Department.

SHELTERPOINT LIFE'S POLICIES AND PRACTICES PROTECT YOUR PERSONAL INFORMATION

In general, ShelterPoint Life does not release any protected health information or other confidential information unless you provide a signed release authorization valid for two years. Protected health information (PHI) is individually identifiable health information related to your physical or mental health or condition, health care services provided to you or payments made for your care. PHI may be released to a plan sponsor or policyholder for policy administration purposes without a signed authorization, unless notice is received, in writing, relating to domestic violence pursuant to NY CLS Ins § 2612. Specifically, New York Insurance Law provides that if any person covered by an insurance policy delivers to the insurer a valid order of protection against the policyholder or other person covered by the policy, then the insurer is prohibited for the duration of the order from disclosing to the policyholder or other person the address and telephone number of the insured, or of any person or entity providing covered services to the insured. If a child is a covered person, then the right established by this section may be asserted by the child's parent or guardian. The New York Insurance Law also requires a health insurer to accommodate a reasonable request made by a person covered by an insurance policy or contract to receive communications of claim-related information by alternative means or at alternative locations if the person clearly states that disclosure of the information could endanger the person. If a child is the covered person, then this right may be asserted by the child's parent or guardian. PHI may be released to a treating physician or to permit ShelterPoint Life to process a claim. PHI may be exchanged with third parties responsible for payment of related charges.

PERSONAL HEALTH INFORMATION: ShelterPoint Life collects and uses personal information in connection with underwriting functions, policy application review, policy administration and claims processing. Where permitted by law, ShelterPoint Life collects information from licensed insurance brokers and agents in connection with the sale of its products. Information may be exchanged with your medical provider to permit ShelterPoint Life to process your claim. Information may be provided to your plan administrator to assist it in seeking policy amendments, modifications or improvements or to permit it to process claim requests.

INFORMATION SECURITY: ShelterPoint Life **does not release** any information about any insured or claimant without a current authorization signed by the insured, except as permitted by law. ShelterPoint Life maintains all policyholder and insured records in confidential, secure locations.

SHELTERPOINT LIFE INSURANCE COMPANY

REDDING HUNTER INC

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

New York State Disability Benefits

Disability Benefits For 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, his or her insurance carrier, 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. Complete claim form DB-450 (Notice and Proof of Claim for Disability Benefits)
   You may obtain the form from your employer, his or her insurance carrier, your health provider, any Unemployment Insurance Office, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board.
   IMPORTANT: Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the form showing your period of disability.
   - If you are employed, or have been unemployed for four weeks or less when your disability begins, send the completed form to your employer or the insurance carrier named below.
   - If you have been unemployed more than four weeks when your disability begins, send the completed form to the Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
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 provide 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-271S).
7. You may not take disability benefits at the same time as paid family leave benefits. The total amount of disability and paid family leave in a 52 week period cannot exceed 26 weeks.
8. Other information about disability benefits may be obtained by writing or calling the Workers' Compensation Board.

SHELTERPOINT LIFE INSURANCE COMPANY
1225 FRANKLIN AVENUE, STE 475
GARDEN CITY, NY 11530

PHONE: 800-365-4999

Policy #: **DBL208356** Effective From: **01/01/2023** To: **12/31/2023**

☐ Statutory ☒ Under a Plan or Agreement

Class(es) of Employees Covered:

All Employees Eligible Under New York State Disability Benefits Law

NYS Workers' Compensation Board
Customer Service: (877) 632-4996
www.wcb.ny.gov

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.
Employers must post DB-120 so that all classes of their employees know who will pay their benefits.

SHELTERPOINT LIFE INSURANCE COMPANY

REDDING HUNTER INC

ESTADO DE NUEVA YORK

JUNTA DE COMPENSACIÓN DE LOS TRABAJADORES

AVISO DE CUMPLIMIENTO

Beneficios por discapacidad del estado de Nueva York

Beneficios por discapacidad para empleados

1. Si usted no puede trabajar por una enfermedad o lesión, que no se relaciona con el trabajo, es posible que tenga derecho a recibir beneficios semanales de su empleador, de su compañía aseguradora o del Fondo Especial para Beneficios por Discapacidad.
2. Para reclamar los beneficios, debe presentar un formulario de reclamo dentro de un período de 30 días desde la primera fecha de su discapacidad, pero, en ningún caso, más de 26 semanas después de dicha fecha.
3. Complete el formulario de reclamo DB-450 (Aviso y constancia de reclamo de beneficios por discapacidad)
   Puede obtener el formulario de su empleador, su compañía aseguradora, su proveedor de atención médica, cualquier oficina de Seguro por Desempleo, el sitio web de la Junta de Compensación de los Trabajadores (www.wcb.ny.gov) o cualquier oficina de la Junta.
   IMPORTANTE: Antes de presentar su reclamo, su proveedor de atención médica debe completar la "Declaración del proveedor de atención médica" en el formulario donde se indica su período de discapacidad.
   - Si usted tiene un empleo, o ha estado desempleado durante cuatro semanas o menos cuando comienza su discapacidad, envíe el formulario completo a su empleador o a la compañía aseguradora que se indica a continuación.
   - Si ha estado desempleado durante más de cuatro semanas cuando comienza su discapacidad, envíe el formulario completo a Workers' Compensation Board, Disability Benefits Bureau, 328 State Street, Schenectady, New York 12305.
4. Tiene derecho a recibir el tratamiento de un médico, quiropráctico, dentista, enfermero obstétrico, podólogo o psicólogo de su elección. Sin embargo, a diferencia de la compensación de los trabajadores, sus cuentas médicas no se pagarán, a menos que su empleador o el sindicato respondan por el pago de dichas cuentas en virtud del acuerdo o plan de beneficios por discapacidad.
5. Si está enfermo o lesionado durante el período durante el que recibe los beneficios del seguro por desempleo, presente un reclamo por los beneficios por discapacidad siempre y cuando siga teniendo dicha lesión o enfermedad, siguiendo las instrucciones indicadas anteriormente.
6. Si no se presenta a trabajar durante más de siete días, su empleador debe enviarle una Declaración de derechos de beneficios por discapacidad (Formulario DB-271S).
7. Puede no aceptar los beneficios por discapacidad al mismo tiempo que los beneficios por licencia con goce de sueldo para asuntos familiares. El tiempo total de licencia con goce de sueldo para asuntos familiares y por discapacidad en un período de 52 semanas no puede superar las 26 semanas.
8. Puede obtener más información sobre los beneficios por discapacidad escribiendo o llamando a la Junta de Compensación de los Trabajadores.

INGRESE EL NOMBRE, LA DIRECCIÓN Y EL NÚMERO DE TELÉFONO DE LA ASEGURADORA O DE LA OFICINA PRINCIPAL DE UNA AUTOASEGURADORA AUTORIZADA DE NUEVA YORK

Póliza Nº: **DBL208356** Fecha de entrada en vigencia: **01/01/2023** Hasta: **12/31/2023**

☐ Conforme a la ley ☒ Conforme a un plan o un acuerdo

Categoría(s) de empleados cubiertos:

All Employees Eligible Under New York State Disability Benefits Law

Junta de Compensación de los Trabajadores del Estado de Nueva York (NYS Workers' Compensation Board)
Atención al cliente: (877) 632-4996
www.wcb.ny.gov

ESTIPULADO POR EL PRESIDENTE DE LA JUNTA DE COMPENSACIÓN DE LOS TRABAJADORES (WORKERS' COMPENSATION BOARD)
ESTE AVISO DEBE SER PUBLICADO VISIBLEMENTE EN LOS ESTABLECIMIENTOS DE LOS EMPLEADORES Y EN LOS ALREDEDORES.
Los empleadores deben publicar el formulario DB-120 para que todas las categorías de empleados sepan quién pagará sus beneficios.

Paid Family Leave
NOTICE OF COMPLIANCE

NEW YORK STATE | Paid Family Leave

Paid Family Leave insurance coverage provided by: SHELTERPOINT LIFE INSURANCE COMPANY

Covering employees of: REDDING HUNTER INC
INSERT EMPLOYER NAME HERE

Paid Family Leave is employee-funded insurance that provides eligible employees job-protected, paid time off to:

- **BOND** with a newly born, adopted, or fostered child;
- **CARE** for a family member with a serious health condition (see **paidfamilyleave.ny.gov** for eligible family members); or
- **ASSIST** loved ones when a spouse, domestic partner, child, or parent is deployed abroad on active military service.

Paid Family Leave may also be available for use in situations when you or your minor dependent child are under an order of quarantine or isolation due to COVID-19. See **PaidFamilyLeave.ny.gov/COVID19** for full details.

Paid Family Leave Request Process:

1. Notify your employer at least 30 days in advance, if foreseeable, or as soon as possible.
2. Complete and submit the *Request for Paid Family Leave (Form PFL-1)* to your employer.
3. Complete and attach the additional documentation as instructed on the request form and submit to your employer's insurance carrier listed below. Submit within 30 days after the start of your leave to avoid losing benefits.

You may obtain all forms from your employer, their insurance carrier listed below, or online at **PaidFamilyLeave.ny.gov/Forms**.

Employers should NEVER discriminate or retaliate against anyone who requests or takes Paid Family Leave

INSURER OR AUTHORIZED NEW YORK SELF-INSURER INFORMATION

Name: SHELTERPOINT LIFE INSURANCE COMPANY **Telephone:** 800-365-4999

Address: 1225 FRANKLIN AVENUE, STE 475, GARDEN CITY NY 11530

Policy #: DBL208356 **Effective date from:** 01/01/2023 **to** 12/31/2023

☒ **Statutory** ☐ **Under a plan or agreement**

Class(es) of employees covered: All Employees Eligible Under New York State Disability Benefits Law

For more information, visit **PaidFamilyLeave.ny.gov** or call **(844) 337-6303**

PRESCRIBED BY THE CHAIR, WORKERS' COMPENSATION BOARD
THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

Permiso Familiar Pagado
AVISO DE CUMPLIMIENTO

NEW YORK STATE | Paid Family Leave

Cobertura de seguro de Permiso Familiar Pagado provisto por: SHELTERPOINT LIFE INSURANCE COMPANY

Cubre a los empleados de: REDDING HUNTER INC

INSERTAR AQUÍ EL NOMBRE DEL EMPLEADOR

El Permiso Familiar Pagado (Paid Family Leave, PFL) es un seguro financiado por el empleado que brinda a los empleados elegibles tiempo libre pago con el empleo protegido para:

- **FORMAR LAZOS AFECTIVOS** con un recién nacido, un hijo adoptado o de cuidado temporal;
- **CUIDAR** de un miembro de la familia con una condición médica grave (ver paidfamilyleave.ny.gov para detalle de los familiares elegibles); o
- **AYUDAR** a sus seres queridos cuando un cónyuge, una pareja doméstica, un hijo o un padre es enviado al exterior para desempeñarse en el servicio militar activo.

El Permiso Familiar Pagado también podría estar disponible para su uso en situaciones en las que usted o su hijo menor de edad dependiente se encuentran bajo una orden de cuarentena o aislamiento debido al COVID-19. Para ver detalles completos, visite PaidFamilyLeave.ny.gov/COVID19.

Proceso de solicitud de un Permiso Familiar Pagado:

1. Notifique a su empleador al menos 30 días por adelantado, si la necesidad de tomarse licencia es previsible, o de lo contrario, lo antes posible.
2. Complete y presente la *Solicitud de Permiso Familiar Pagado (Formulario PFL-1)* a su empleador.
3. Complete y adjunte la documentación adicional según se indique en el formulario de solicitud y preséntela a la compañía de seguros de su empleador indicada más abajo. Preséntelo dentro de los 30 días posteriores al inicio de su permiso para evitar perder los beneficios.

Puede obtener todos los formularios de su empleador, su compañía de seguros que se indica más abajo, o por internet ingresando a PaidFamilyLeave.ny.gov/Forms.

Los empleadores NUNCA deben discriminar o tomar represalias en contra los empleados por solicitar o tomar un Permiso Familiar Pagado

INFORMACIÓN DE ASEGURADORA O AUTOASEGURADO AUTORIZADO DE NUEVA YORK

Nombre: SHELTERPOINT LIFE INSURANCE COMPANY **Teléfono:** 800-365-4999

Dirección: 1225 FRANKLIN AVENUE, STE 475, GARDEN CITY NY 11530

Póliza N.º: DBL208356 **Fecha de vigencia desde:** 01/01/2023 **hasta** 12/31/2023

☒ Legal ☐ Conforme a un plan o acuerdo

Clase(s) de empleados cubiertos: All Employees Eligible Under New York State Disability Benefits Law

Para obtener más información, visite PaidFamilyLeave.ny.gov **o llame al (844) 337-6303.**

DISPUESTO POR EL PRESIDENTE, JUNTA DE COMPENSACIÓN OBRERA
ESTE AVISO DEBE PUBLICARSE EN UN LUGAR VISIBLE EN EL LUGAR O LUGARES DE NEGOCIOS DEL EMPLEADOR Y EN SUS ALREDEDORES.