STATE OF NEW YORK WORKERS' COMPENSATION BOARD

DISABILITY BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE

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

☑ **Initial** ☐ **Cancellation** ☐ **Reinstatement** ☐ **Supersedes** **Transaction Effective Date:** 10/1/2014

A. INSURER/CARRIER

1. INSURER/CARRIER NAME	2. INSURER/CARRIER CODE	3. INSURER/CARRIER TELEPHONE NO.
HARTFORD LIFE & ACCIDENT INSURANCE CO.	B488759	(800) 454-7020
4. CONTACT NAME	5. TITLE	6. TODAY'S DATE
JILL GRANT	MANAGER	8/31/2014

B. CURRENT – EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
	PENDING	331005840
10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		13. LEGAL STATUS (see back of form)
SUSQUEHANNA EYE CARE PLLC DBA SACCO EYE GROUP		03
11. ADDRESS		14. # OF EMPLOYEES
400 PLAZA DRIVE SUITE B		14
12. CITY / STATE / ZIP CODE		15. TELEPHONE NO.
VESTAL / NY / 13850		607-798-1987

C. POLICY

*** If policyholder is an Association, Union or Trustee for which Form DB-820.3 is filed, do not complete items 16 and 18**

16. POLICY NUMBER*	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER*
LNY642212001	1/1/2013	P1114724(A)DBL
19. WCB PLAN NUMBER (Only for Assoc. Union or Trustee with Form DB-801 on file)		20. PREMIUM AMOUNT
		0

D. REASONS FOR CANCELLATION

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

CANCELLATION OR TERMINATION SENT TO EMPLOYER — DATE:

E. Complete if SUPERSEDES box is checked at top of form.		**F. POLICYHOLDER – If different from Employer**
21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		27. POLICYHOLDER NAME
22. ADDRESS		28. POLICYHOLDER ADDRESS
23. CITY / STATE / ZIP CODE		29. CITY / STATE / ZIP CODE
24. EMPLOYER FEIN	25. POLICY EFFECTIVE DATE	30. POLICYHOLDER FEIN
26. POLICY NUMBER		

G. 1. The POLICY COVERS Employer's employees as follows :

a. ☒ All employees eligible under the New York State Disability Benefits Law.
b. ☐ All employees eligible under the New York State Disability Benefits Law except those classes of employees eligible to receive benefits under another policy or plan accepted by the Chair.
c. ☐ Only the following class or classes of employees:

2. The employee contributions required and benefits insured are:

a. ☒ The same in all respects as under Section 204 and not in excess of those authorized under Section 209.
b. ☐ As described in the attached supplement, Form DB820.1.
c. ☐ As described in Employer's Application for Acceptance of a Plan, Form DB800, Filed with and accepted by the Chair.
d. ☐ As described in Certificate of Insurance, Form DB820.3, filed on behalf of the Association, Union or Trustees (policyholders) on _____ (DATE) or amended Form DB820.3 filed thereafter.

To be filed by insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204) OR benefit under a plan accepted by the Chairman

THE WORKER'S COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

DB820/829 rev. 5/01