New York State

Disability Insurance Enrollment Form

Learn more about this program at www.nysra.org

NEW YORK STATE RESTAURANT ASSOCIATION

Name of Corporation: _____

Restaurant Name/DBA: _____

Location Address: _____

Mailing Address (if different from above): _____

Effective Date of Coverage: _____

Current Insurance:

Disability Insurance Carrier: _____

Workers' Compensation Carrier: _____

Number of Employees: _____Males:_____ Females: _____

N.Y.S. Unemployment #: _____

Federal I.D. #: _____

Please check which benefits you are applying for (All rates are monthly rates per employee)

State Mandated Benefit:

☐ $2.70 (50% of salary up to $170 per/week)

Enriched Options

☐ 1 1/2 x State (50% of salary up to $225 pr/week) $3.90

☐ 2 x State (50% of salary up to $340 per/week) $5.00

☐ 3x State (50% of salary up to $510 per/week) $6.50

Do your employees currently contribute? ☐ Yes ☐ No

Contact: _____ Title: _____

Signature: _____

Phone: _____ Fax: _____

Administrated by: New York State Restaurant Services
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