

**Affidavit That An OUT-OF-STATE OR FOREIGN EMPLOYER Working In New York State Does Not Require Specific New York State Workers' Compensation And/Or Disability Benefits Insurance Coverage**  
(Incomplete forms will be returned – Please contact an attorney if you have any questions regarding this form.)

Because this is a sworn affidavit, employees of the Workers' Compensation Board cannot assist applicants in answering questions about this form.

**\*\*This form cannot be used to waive the workers' compensation rights or obligations of any party.\*\***

The applicant may use this Affidavit **ONLY** to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may **NOT** use this form to show either other businesses or those business' insurance carriers that such insurance is not required.

Please note: This statement must FIRST be notarized and THEN sent to be stamped as received by the New York State Workers' Compensation Board. This affidavit will not be accepted by government officials one year after the date stamped as received by the Workers' Compensation Board. Incomplete forms will be returned.

Applicant must EITHER fax or mail this completed form to the New York State Workers' Compensation Board at:

**Queens Enforcement Unit  
NYS Workers' Compensation Board  
168-46 91<sup>st</sup> Avenue  
Jamaica New York 11432  
Phone Number: 718-523-8367**

**Fax Number: 718-523-8446**

UPON RECEIPT OF A FULLY COMPLETED WC/DB-101 FORM, the Workers' Compensation Board will stamp this form as received and return it to you by either mail or fax within 5 business days. Please provide a copy (or the original, if required by the government entity) of this stamped form to the government entity from which you are requesting a permit, license or contract.

\_\_\_\_\_ **In the Application of (Business Name and Address)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

for a \_\_\_\_\_ permit/license/contract

State of \_\_\_\_\_ )  
 ) ss.:  
County of \_\_\_\_\_ )

**4** 1. \_\_\_\_\_ (applicant's name) being duly sworn, deposes and says:

1a) I am the \_\_\_\_\_ (position) with the above-named business, a/an \_\_\_\_\_ (nature of business—IE. Building contractor, health laboratory, thoroughbred trainer, etc). The telephone number of the business is (\_\_\_\_\_)\_\_\_\_\_. The Federal Employer Identification Number of the business (or the Social Security Number of the business owner) is \_\_\_\_\_. The New York State Unemployment Insurance Employer Registration Number (if any) of the business is \_\_\_\_\_. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this affidavit.

2. My personal address is \_\_\_\_\_ and my home telephone number is (\_\_\_\_\_)\_\_\_\_\_.

3. That the above named business is applying for a \_\_\_\_\_ (type of permit/ license/contract applying for) from \_\_\_\_\_ (governmental entity issuing the permit/ license/contract).

3a) {Optional -- Location of where work will be performed in New York State from \_\_\_\_\_ to \_\_\_\_\_ (dates necessary to complete work associated with permit/license/contract). The estimated dollar amount of project is \_\_\_\_\_.

4. That the above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE** for the following reason (to be eligible for exemption, applicant must be able to truthfully check either box 4a or 4b):

4a) the business is from outside of New York State, and wishes to use its foreign or other state's workers' compensation insurance policy to cover its employees while they are working in New York State. *To check this box, the applicant MUST have New York (NY) specifically listed on Item 3C on the Information Page of its workers' compensation insurance policy (Exception-3C coverage not required for contracts where ALL work is done outside of New York State), and MUST attach a certificate of insurance from its foreign or other State's workers' compensation insurance policy to this Affidavit (and listed the governmental entity issuing the permit/ license/contract as the Certificate Holder). Further, by checking box "4a" on this form, the applicant CERTIFIES that for the period covered by this exemption form the above business DOES NOT or WILL NOT meet any of the following four criteria (4aa. – 4ad.).*

4aa. has a physical location within New York State, nor

4ab. has more than \$50,000 in labor costs in a calendar year for employees working in New York State, nor

4ac. has one or more employees with a primary work location or hired within New York State, nor

4ad. has an employee or employees working in New York State more than 90 days in a calendar year.

**Applicants that meet any of the above four criteria (4aa. – 4ad.), CANNOT check "box 4a" on this form and CANNOT file this form for a workers' compensation exemption. PLEASE NOTE: Applicants that meet any of the above four criteria (4aa. – 4ad.), are REQUIRED to have a full New York State workers' compensation policy (NY listed under Item 3A on the Information Page of the insurance policy) and must file either a C-105.2 -- Certificate of Workers' Compensation Insurance OR a U-26.3, the State Insurance Fund's version of this form (the business' insurance carrier will send these forms to the government entity issuing the permit, license or contract upon the business' request) as proof of this coverage. [Applicants that DO NOT meet any of the above four criteria (4aa. – 4ad.) are NOT required to have NY listed under Item 3A on the Information Page of the insurance policy. Instead, the out-of-state employer's employees will be covered when working in New York by having NY listed in Item 3C on the Information Page of the workers' compensation insurance policy (the other-states section).]**

4b) All employees from the entity applying for the permit, license or contract are direct employees of a government entity outside of New York State and such employees are outside the jurisdiction of New York State workers' compensation coverage. (Applicant MUST attach a certificate of insurance from its foreign or other State's workers' compensation insurance policy to this Affidavit)

5. That the above named business is certifying that it is **NOT REQUIRED TO OBTAIN NEW YORK STATE DISABILITY BENEFITS INSURANCE COVERAGE** for the following reason (to be eligible for exemption, applicant must be able to truthfully check ONE of the boxes from 5a. through 5b.):

5a.) the business does not require disability benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

5b.) All employees from the entity applying for the permit, license or contract are direct employees of a government entity outside of New York State and such employees are outside the jurisdiction of New York disability benefits coverage.

6. By signing my name below, **I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this affidavit under the penalties of perjury.** I further affirm that I understand that any false statement, representation or concealment will subject me to **felony** criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. **I also hereby affirm that** if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named business will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed in item 3 on the front of this form.

\_\_\_\_\_  
(Applicant's Signature -- first and last name)

Sworn to before me this \_\_\_\_\_  
Day of \_\_\_\_\_, 20\_\_

\_\_\_\_\_  
Notary Public



NYS Workers' Compensation Board Received Stamp