

**SMALL-BUSINESS THIRD-PARTY ADMINISTRATOR
VOLUNTARY PLAN APPLICATION PURSUANT TO AB 2778**

1. Effective date of this voluntary plan: _____

SMALL- BUSINESS THIRD-PARTY ADMINISTRATOR (SBTPA) INFORMATION

2. SBTPA Commercial Name: _____

Address: _____

City, State, Zip Code: _____

Telephone Number: () _____

3. SBTPA California Employer Account Number (EAN): _____ (this is the 8-digit number that the Employment Development Department (EDD) assigned when the company registered with EDD as a California employer).

SBTPA QUALIFICATIONS

4. The written terms and provisions of the SBTPA Self-Insured Voluntary Plan (SIVP) Document/Text must be approved by the Director of the EDD.

5. The SBTPA must maintain at least 1,000 California domiciled clients, 80 percent of whom have fewer than 20 employees. A current list of the company's California clients listing the legal names (include aka and dba names), 8-digit California EAN, complete address, phone number, number of employees, and FAX and e-mail addresses (if available) must be attached to this application.

6. The SBTPA must process payroll for its California domiciled clients. Client payroll will be processed at:

Name of Company (if different from SBTPA name): _____

Address: _____

City, State, Zip Code: _____

Telephone: () _____ E-mail address: _____

FAX: () _____

7. The SBTPA must offer workers' compensation insurance to its California domiciled employer clients through an affiliated California domiciled insurance company.

Name of Company (if different from SBTPA name): _____

California Company ID # (issued by the California Department of Insurance): _____

License/Certificate of Authority Status: _____

Date Authorized in California: _____

Address: _____

City, State, Zip Code: _____

Telephone: () _____ E-mail address: _____

FAX: () _____

SBTPA CONTACT INFORMATION

8. SBTPA representative appointed to manage the administration of the voluntary plan:

Name: _____
Title: _____
Address: _____
City, State, Zip Code: _____
Telephone: () _____ E-mail address: _____
FAX: () _____

9. SBTPA representative appointed to process disability claims:

Name: _____
Title: _____
Address: _____
City, State, Zip Code: _____
Telephone: () _____ E-mail address: _____
FAX: () _____

SECURITY DEPOSIT

10. Type of security that will be filed to secure the SBTPA voluntary plan:

- Guarantee Bond, DE 2544V
- Letter of Credit (based on the Model Letter of Credit provided by the EDD)
- Cash
- Bearer Bond(s)

NOTE: Do not send the security with this application. Instructions for sending the security will be provided to the individual identified above in Question #8 upon approval of the plan. If cash is being deposited, file the completed form, Agreement Regarding Deposit of Cash, DE 2545V, with this application. If a bearer bond(s) is being deposited, file the form, Agreement Regarding Deposit of Bearer Bond, DE 2545VB, with this application.

11. Estimated number of employers projected to participate in this SBTPA voluntary plan in the first year of operation: _____ employers.

12. Estimated number of employees to be covered under this SBTPA voluntary plan in the first year of operation: _____ employees; and their projected annual wages subject to the SDI taxable wage ceiling: \$ _____.

13. Withholding amount required of employees electing voluntary plan coverage: _____ % of \$ _____ ; check(✓), if none .

NOTE: Section 3254-1. (d), Title 22, California Code of Regulations provides that the employees' contributions for disability benefits (including amounts designated as premiums) will not exceed amounts greater than would be required if covered by the Disability Fund.

MASTER TRUST ACCOUNT

14. The Master Trust Account (MTA) has been or will be established at the following Federal Deposit Insurance Corporation (FDIC) Member Bank:

Bank Name: _____

Address: _____

City, State, Zip Code: _____

Subtrust accounts will be created for each employer that becomes a client of the SBTPA.

15. The SBTPA will secure additional funding in the event that an employer's trust monies are inadequate to meet the employer's voluntary plan obligations as follows:

NOTE: Section 3254, 1.(c)(2), California Unemployment Insurance Code (CUIC) requires the establishment of a master trust account that is administered by the SBTPA, but requires each individual employer that is a client of the SBTPA to have subtrust accounts that reflect each client's employees' specific plan contributions that are not commingled with any other client.

REQUIRED DOCUMENTS

Items 16 through 20 must be filed with this application:

16. Copies of all informational documents which will be distributed to your client employers and their employees to secure their consent for the voluntary plan.
17. Copy of the SBTPA SIVP document/text previously approved by the Director of the EDD.
18. Copy of the statement of coverage that will be given to all covered employees, if a statement of coverage has been developed and will be distributed in place of the SBTPA SIVP document/text.
19. Copy of enrollment form(s) used to secure the employees' consent to the plan; containing the signature, date of consent, printed or typed name, and the Social Security Number.
20. Copies of all service agreements/contracts and related fee schedules that your client employers will become subject to upon enlistment of your SBTPA services.

CERTIFICATION

By signing below:

- A. I am submitting an application for approval of a voluntary plan under the California Unemployment Insurance Code (hereinafter identified as "Code") and Title 22, California Code of Regulations (hereinafter identified as "Regulations").
- B. I agree to operate the voluntary plan in conformity with the written terms and provisions of the SBTPA SIVP document that was approved by the Director of the EDD and provided to the EDD Voluntary Plan Administration Unit.
- C. I agree to maintain the voluntary plan in effect for a period of not less than one year and, thereafter, continuously, unless the Director of the EDD finds that the SBTPA has given notice of withdrawal of the plan.
- D. I agree that all disability and family leave insurance claims and benefits arising out of this voluntary plan will be handled in accordance with the Code and Regulations.
- E. I agree to pay any assessments which are levied in conformity with the Code and Regulations.
- F. I agree to offer the plan to all eligible new employees, and will maintain available for inspection by EDD representatives the signed consents of all employees for a period of not less than five years.
- G. I agree to post, upon request of the Director of the EDD, security in an amount determined by the Director to be adequate to pay disability claims of my clients' employees should the client's subaccount or the financial security provided by my clients be inadequate to meet the obligations of this voluntary plan.
- H. I certify that the foregoing statements, including any accompanying statements, are to the best of my knowledge and belief true and correct.

By _____
(Must be signed by Owner, Partner, or Officer of the Corporation)

Print Name and Title

Date

Mail completed application to: EDD, Disability Insurance Branch
Voluntary Plan Administration Unit, MIC 29 VP
PO Box 826880
Sacramento CA 94280-0001

If you have questions or need assistance completing this form, please call (916) 653-6839.