Employment Development Department
State of California

APPLICATION TO PARTICIPATE IN A SMALL-BUSINESS THIRD-PARTY ADMINISTRATOR (SBTPA) ADMINISTERED VOLUNTARY PLAN FOR UNEMPLOYMENT COMPENSATION DISABILITY (UCD) BENEFITS

EMPLOYER INFORMATION

Items 1 through 14 to be completed by the employer:

1. Effective date of this voluntary plan: _____

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

3. Employer's legal name: _____

4. Other business name(s) used by the employer in California: _____

   _____

5. Employer's business address: _____

   City, State, Zip Code: _____

6. Nature of employer's business; for example, type of product manufactured or service provided:

   _____

   _____

7. Employee appointed to manage the administration of the voluntary plan:

   Name: _____

   Title: _____

   Address: _____

   City, State, Zip Code: _____

   Telephone: ( ) _____ E-mail address: _____

ELECTION INFORMATION

8. Total number of employees eligible to be covered by the voluntary plan:
   _____ as of _____.
   Number Date

9. Total number of employees who have consented, in writing or by electronic mail, to be covered by the voluntary plan: _____ as of _____ .
   Number Date

10. Election conducted between _____ and _____ .
    Date Date

REQUIRED DOCUMENTS

Items 11 through 14 must be submitted to the SBTPA with this application:

11. Copies of all informational documents distributed to your employees to secure their consent to the voluntary plan.

12. Copy of the SBTPA Self-Insured Voluntary Plan (SIVP) document previously approved by the Director of the EDD.

13. Copy of the statement of coverage, if one used, that was given to your employees.

14. Copy of the enrollment form used to secure your employees' consent to the plan; requesting their signature, date of consent, printed or typed name, and Social Security Number.

SBTPA INFORMATION

Items 15 through 17 to be completed by the SBTPA:

15. SBTPA Commercial Name: _____
    Address: _____
    City, State, Zip Code: _____
    Telephone: ( ) _____

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

17. SBTPA Voluntary Plan Number: _____ (this is the 6-digit number that the EDD assigned to the SBTPA granting it the authority to act as a third-party administrator to small businesses electing to provide voluntary plan coverage to their employees).

CERTIFICATION

By signing below, the employer and the SBTPA:

A. Submit this 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. Agree to operate the voluntary plan in conformity with the Code and Regulations and in accordance with the provisions of the SBTPA voluntary plan provisional document provided to the EDD Voluntary Plan Administration Unit.

C. Agree to pay any assessments which are levied in conformity with the Code and Regulations that directly relate to the voluntary plan.

D. Certify that all eligible employees were given the opportunity to elect or reject coverage under the plan and that a majority of the eligible employees consented, in writing or by electronic mail, to coverage under the plan.

E. Agree to offer the plan to all eligible new employees, and will maintain available for inspection by Department representatives the signed consents of all employees for a period of not less than five years.

F. Agree to post, upon request of the Director of the EDD, additional security in an amount determined by the Director to be adequate to pay this voluntary plan's obligations should the subaccount created by this application or the financial security provided by the SBTPA be inadequate to meet the obligations of this voluntary plan.

G. Agree to provide written notice to the Director of the EDD not less than 30 days prior to the date of withdrawal in the event that a decision is reached to terminate participation in the SBTPA voluntary plan.

H. Certify that the foregoing statements, including any accompanying statements, are to the best of our knowledge and belief true and correct.

Employer Certification

By _____
(Must be signed by Owner, Partner, or Officer if a Corporation)

_____
Print Name and Title

_____
Date

SBTPA Certification:

By _____
Authorized Representative

_____
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.