GENERAL ADMINISTRATION DIVISION
REPORT NO. 5

OGDENSBURG CITY SCHOOL DISTRICT
OGDENSBURG, NEW YORK

SUBJECT: Resolution to Approve a Change to an Existing Aflac New York Payroll Account

DATE: February 22, 2016

REASON FOR BOARD CONSIDERATION:

The Board of Education must approve all agreements with regard to the District Employees Payroll Accounts.

FACTS AND ANALYSIS:

A district employee has requested the Board of Education approve a request to add short- term disability coverage to an existing Aflac New York Payroll Account.

RECOMMENDED ACTION:

Moved by _____ and supported by _____ that, having the approval of the Superintendent of Schools, the Board of Education of the Ogdensburg City School District does hereby approve the addition of short-term disability coverage to an existing Aflac New York Payroll Account, as per the attached documentation, this 22nd day of February, 2016.

APPROVED FOR PRESENTATION TO THE BOARD:

Superintendent

TMV/alf
Attachment

Account Name: Ogdensburg City School

Tax ID: 160876164 Group No.: N4067 Writing No.: 56178

Payroll Account Acknowledgment

All applicable sections must be completed for processing.

INSTRUCTIONS

- ALL accounts must complete Section 8, Authorization and Signatures.
- Accounts establishing or modifying a Wingspan℠ cafeteria plan must complete Section 5.
- Accounts with another carrier's cafeteria plan must complete Section 7.
- Broker Information must be completed in Sections 9 and 10.
- Fax the completed form to 1-888-627-2469.

1. GENERAL ACCOUNT INFORMATION

☐ **New Aflac New York Payroll Account**

☒ **Changes to an Existing Aflac New York Payroll Account** **Group Number:** N4067

☐ **Split or Transferred Account** **Transferring From Account:** _____

Will new split account be affiliated with an existing Aflac New York account? ☐ Yes, Account: _____ ☐ No

Does this account have multiple locations, each requiring an invoice? ☐ Yes ☐ No

Are there any existing policies to place on this account? ☐ Yes ☐ No (If yes, list the policies on a separate page and send it with the completed Payroll Account Acknowledgment form to the Aflac New York Home Office.)

Name of Account:

Type of Business: | Tax ID No.: | SIC Internet Request No.:

Affiliate/Subsidiary of *(if applicable)*: | Master Account No.:

Mailing Address:

City: | State: | Zip:

Location Address: ☐ *Check if same as mailing address (P.O. Box is not acceptable).*

City: | State: | Zip: | Phone: | Fax *(if applicable)*:

Total Employees: _____ Total Benefits-Eligible Employees: _____ Total Benefits-Eligible W-2 Employees: _____

Total benefits-eligible 1099 Workers: _____

Will benefits-eligible 1099 workers be applying for coverage? ☐ Yes ☐ No

Is this a leasing company or staffing agency? ☐ Yes ☐ No

If yes, will the temporary/leased employees be applying for coverage? ☐ Yes ☐ No

Account Website Address *(if applicable)*:

Enrollment Period: What is the length of the enrollment period? _____ (Options are 30, 60, or 90 days.)

Will the enrollment period exceed 90 days? ☐ Yes ☐ No

If yes, has this been approved by Sales Support? ☐ Yes ☐ No

Is there an established Aflac account? ☐ Yes ☐ No If yes, provide the name and group number:

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

4. INFORMATION CONCERNING TAX STATUS OF DISABILITY INSURANCE BENEFIT PAYMENTS

If disability coverage is funded by employer contributions, pre-tax employee contributions, or a combination of these two, then the disability benefits an employee receives upon becoming disabled will be includible in the employee's income and are fully taxable when paid. In addition, FICA taxes must be withheld and paid on all such benefits during the first six months after the disability begins. Where, as noted below, coverage is funded by employer contributions or employee pre-tax contributions, Aflac New York will notify the employer of the amount of disability benefits to be paid. Aflac New York will withhold the employee's portion of FICA taxes and will deposit such taxes with the government as required by the Internal Revenue Code. **The employer will be required to submit the employer's portion of applicable FICA and FUTA taxes, and report the benefit payments on its Form 941 and the employee's Form W-2.**

Employer authorizes disability coverage to be included as part of this agreement: ☒ Yes ☐ No

NOTE: At least one disability type must be marked if the question above is checked "Yes".

All the remaining questions in the section below must be answered if disability is being offered.

- **Authorized disability coverage types:** ☐ Accident/Disability ☒ Short-Term Disability ☐ Off-the-job
- **Authorized riders:** ☒ Off-the-job ☒ On-the-job ☒ Sickness ☐ Spouse

Will any portion of disability premiums be funded by employer contributions? ☐ Yes ☒ No

NOTE: New York State does not allow employer funded contributions for disability.

If yes, please provide percent: _____% **OR** flat dollar amount: $ _____

Percent or dollar amount must be a whole number, such as "50%" or "$10".

Will any portion of disability premiums be funded by pre-tax employee contributions? ☐ Yes ☒ No

This employer is a government employer exempt from FICA or a portion of FICA. ☐ Yes ☒ No

Employees of this employer are eligible for RRTA (Railroad Retirement Tax). ☐ Yes ☒ No

NOTE: Disability caused by or under certain circumstances will not be covered. Refer to each policy to determine specific coverage, exclusions, and limitations.

5. WINGSPAN℠ CAFETERIA PLAN

Please consult with employer's cafeteria plan contact to ensure accurate completion of the next section.

☐ **New Wingspan℠ Cafeteria Plan**

☐ **Wingspan℠ Cafeteria Plan Change Request**

☐ **Requesting Additional Payroll Account Number for Existing Wingspan℠ Cafeteria Plan**

Plan/Company Name:	Tax ID:

Plan Type: ***What type of cafeteria plan will this be? (FSA = Flexible Spending Account)***

☐ Premium Only – no FSAs ☐ Self-Administered with FSAs (employer processes FSA claims)

Plan Year: What are the dates of this plan?

Plan Start Date: ____/____/____ Plan End Date: ____/____/____

Plan Sponsor/Legal Representative: ***List the plan sponsor and legal representative for this cafeteria plan.***

Plan Sponsor/Principal Contact:	Email address:
Phone:	Fax:
Legal Representative's Name:	Title:

Account Name: _____

Tax ID: _____ Group No.: _____ Writing No.: _____

8. AUTHORIZATION AND SIGNATURES – EMPLOYER

Aflac New York assures you that you will be reimbursed without question for premium you advance for any employee who terminates after the premium is remitted but before payroll deductions commence. Aflac New York also agrees to hold you harmless from any claims against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employees, except where caused by misconduct or negligence committed by you or any of your employees or violations of your responsibilities under state or federal laws.

The employer agrees to provide Aflac New York (and its agents) with certain personally identifiable information (including but not limited to compensation, Social Security numbers, addresses, etc.) regarding its officers and employees for Aflac New York (and its agents) to use in the administration of employer's cafeteria (including health and dependent care FSA) plan, and Aflac New York products and services.

Aflac New York is authorized to offer this insurance program to our officers and employees. I understand that all applicants must qualify for coverage based on each product's underwriting requirements and that payments for such coverage will be deducted from wages and remitted by my organization to Aflac New York .

The paragraph below only applies if establishing a Wingspan℠ cafeteria plan:

The employer plans to establish/amend a flexible benefits plan in accordance with Section 125 of the Internal Revenue Code. The employer acknowledges that neither Aflac New York nor its agents are providing legal or tax advice, nor serving as the plan administrator or a plan fiduciary under the plan. The employer shall be the sole party responsible for establishment of the plan under applicable law. Aflac New York shall have no power or authority to waive, alter, breach, or modify any terms and conditions of the plan. The employer shall retain all responsibility and liability for the plan, except as may otherwise be specifically agreed to in writing by an officer of Aflac New York. The plan sponsor/ administrator should consult its own tax advisor regarding the plan and any changes to the plan. The employer acknowledges receipt of the Summary of Plan Sponsor Responsibilities and agrees to fulfill its responsibilities as stated therein.

Authorizing Officer's Name/Title *(please print)*: ☐ **Mr.** ☐ **Ms.**

Authorizing Officer's Email Address:

Authorizing Officer's Signature: **Date:**

Eric Wehr
Agent
An Independent Agent Representing Aflac

1521 County Route 25
Canton, NY 13617
315.323.2185 cell
eric_wehr@us.aflac.com
aflac.com

Page: 1 Document Name: untitled

04/15/99 E S T A B L I S H N E W G R O U P S 09:
CGMON002 E03
*** NEXT GROUP NO IS N3363 TOTAL GRPS LEFT 6636
TO ESTABLISH A NEW GROUP ENTER ALL REQUIRED DATA N4047 GROUP NO: N

NAME: Ogdensburg City.... NBR EMP: 315 TEL: 3153933913 SPC FLG: J
BILL: School District.... CUR PLN YR ST: 1/1/00 12/31/00 ENR PER: 0
ADDR: ..... 125 START: 1/1/00 TAX ID NUMBER: 14 D8160104
: 1100 State St..... -PRINCIPAL CONTACT / PAYROLL CLERK-
: ..... James Chadwick.....
CITY: Ogdensburg STATE: NY ZIP: 13669 DELAYED BILLING DATE: 1/15/00

GROUP CATEGORY	: P	GROUP MODE	: 01
INDUSTRY CODE	: 19	GEOGRAPHICAL CODE	: 10306
INIT PREM CODE	: C	HANDLING CODE	:
START DATE	: 01/2000	MODE DUE DATE	: 2/15/00
ORIG AGENT	:	LIFECARE TRUST	: .
DURATION	: ..	NUMBER OF MONTHS	:
PERIODS	: ..	COMPANY CODE	: 01
LIFECARE EFF DATE	:	NEGATIVE ACCT CODE	: 8
SPECIFICATION CODE	: C	TYPE PAYROLL NUMBER	: .
NO OF DIGITS	: .	DEPARTMENT NO FLAG	: .
ZERO FILL POSITION	: .	GMS EFFECTIVE DATE	: .....
WAIT PERIOD CODE	: .	W PERIOD START/END	: ..... / .....
SPLIT GROUP TYPE	: .	OLD GROUP NO	: .....
SPLIT EFFECTIVE DT	:	SPLIT GROUP CLERK	: .....
SPLIT GROUP DATE	:	BILL CODE	: 4
BROKER NUMBER/LEVEL	: ..... / ..	BROKER START/END DT	: ..... / .....

GRP TYPE: 1 MST ACCT: ..... DUE DAY: 27 1/2 BILL DAY: 00/00
OCC: A ABI: 8211030 CONTRIBUTION - CONTROL: 0 RULE: 0 AMT/PCT: .....

ADDRESS: 1100 State St..... BUSINESS ALLIANCE...:
: ..... MEDICARE ONLY.....:
: ..... CONVALESNT CARE ONLY:
: ..... BANK TRANSIT NO: .....
CITY : Ogdensburg..... PREMIUM CTRL IND....:
STATE : NY ZIP : 13669 M0135: 4 OJR: . DRAFT ORIGIN IND....:

REMARKS
10/13/99 - Group Est. SR
.....
.....
** ENTER X TO RETURN TO MASTER MENU--> .

Waiting for 04306 ~~[illegible]~~ Lisence to be renewed.
Let David know that he needs an exception for longer enrollment!

Date: 4/15/99 Time: 09:36:20 AM

NEW PAYROLL GROUP SUBMISSION

GROUP NAME: Ogdensburg City School District

INDUSTRY CODE/SIC: A / 821103

GEOGRAPHICAL CODE: 10306

EXCEPTIONS: NONE

DATE: 7/29/99 **BY** LM

LM 9/16/99

LM 9/4/99

* Needs more than 1 app - need 2 different apps w/ 2 diff. applicants

David Howe
315 393 8849

American Family Life Assurance Company of New York (AFLAC New York)
One Marcus Blvd., Albany, New York 12205
Toll-Free 1-800-366-3436
Insurance Program Acknowledgment Payroll Deduction

821103 A

AFLAC New York is authorized to offer this insurance program to our officers and employees. I understand that payments will be deducted from wages and remitted by my organization to AFLAC New York.

Name of Account: Ogdensburg City School District
Type of Business: Educational Institution **Tax ID#:** 16-0876164
Payroll Clerk or Contact Person: (X) Mr. ( ) Ms. James Chadwick **Best time to contact:**

Mailing Address: 1100 State St. **Location Address:** same
City: Ogdensburg **City:**
State: NY **Zip:** 13669 **State:** **Zip:**
Telephone #: 315/393-7912 **Fax #:** 315/394-7298 **# of Employees:** 315

An Employer Authorization to include Disability Insurance [( ) is (X) is not] part of this agreement.

Authorizing Officer's Name/Title: (X) Mr. ( ) Ms. James J. Chadwick/Business Mngr.
Authorizing Officer's Signature: James J. Chadwick **Date:** 7/23/99
May we use your name as a reference? ( ) No (X) Yes

Note: AFLAC New York assures you that if you advance the first premium, you will suffer no loss of the amount advanced for any employee who terminates before you can deduct the premium. In this event, we will reimburse you without question. AFLAC New York also agrees to hold you harmless from any claims arising against you due to any disagreements between your employees and our company with respect to the coverage provided under our insurance policies issued to your employee except for any misconduct or negligence committed by you or any of your employees.

FOR AGENT'S USE ONLY

Is this a Cafeteria Plan? ( ) No (X) Yes **If yes, plan start/end date:** 1/1 / 12/31
Is this a Flex One Plan?** (X) No ( ) Yes **If yes, plan start/end date:** /

Enrollment period: ( ) 30 days ( ) 60 days ( ) 90 days (X) Other: 120 Days
Is this benefit paid by the employer? (X) No ( ) Yes If yes, percent (%):

Date of 1st invoice: 2/15 **Date of 1st Payroll deduction:** 1/14/00 **# of deductions:**

Billing Frequency:
(X) Monthly {12 invoices} ( ) 8-month {8 invoices}*
( ) Quarterly {4 invoices} ( ) 9-month {9 invoices}*
( ) Semiannual {2 invoices} ( )10-month {10 invoices}*
( ) Annual {1 invoice} *Indicate no invoice months:

If one of the above is checked, you must indicate the 1st or the 15th for invoice due date: ( ) 1st (X) 15th
( ) Weekly {52 invoices} ( ) Semimonthly {24 invoices}
( ) 14-day {26 invoices} ( ) 28-day {13 invoices}

Billing Options: (X) Paper Invoice ( ) Magnetic Tape {Cartridge, Diskette} ( ) Other
Circle One

Billing Format: ( ) Social Security # ( ) Department # (X) Alphabetic ( ) Employee #

Payment Options: (X) Paper Invoice ( ) Magnetic Tape {Cartridge, Diskette}
( ) Wire Transfer ( ) ACH

1. **Premium Deduction Authorization Forms have been/will be given to account on** 12/20/99 **(date).**
2. **Contract Status:** ( ) Agency ( ) Non-Soliciting Broker (NSB) ( ) Other
   If Agency or NSB is checked, Broker Name: Broker #: Level:
3. **Geographical Code:** 10306 **Master Account #:** (if applicable)

I acknowledge that AFLAC New York has the sole and absolute right to determine who shall solicit and service payroll deduction accounts, and AFLAC New York may reassign any account for servicing and designate who may solicit applications from persons in the account.

Agent's Signature: **Resident State:** NY
Writing #: 04306 **Sit. Code:** 0 **Date:** 7/23/99

Form NY-0135R NY0135R.1
R(12/97)

AFLAC
NEW YORK

October 26, 1999

Ogdensburg City School District
1100 State Street
Ogdensburg NY 13669

Re: Account # N4067

Dear Payroll Account Administrator:

Welcome to AFLAC New York! We appreciate your business and look forward to serving you. To assist you in administering AFLAC New York's insurance plans, we are enclosing a resource guide. The guide will assist you in answering employee questions.

Thank you for helping your group members choose AFLAC New York's protection. AFLAC New York is committed to providing you and your employees with quality customer service.

If we may help you in the future or if you have any questions, please do not hesitate to contact us at (800) 366-3436. Our customer service specialists are here to assist you Monday through Friday from 9 a.m. to 5 p.m. Eastern Time.

Client Services and Administration

American Family Life Assurance Company of New York
One Marcus Boulevard • Albany, New York 12205
(518) 438-0764 • FAX (518) 438-0896