Dear Policyholder:

It is a pleasure to welcome you as a new policyholder of the CIGNA Life Insurance Company of New York (CLICNY), a CIGNA Company. We are pleased to provide the coverage for your New York State (NYS) Disability Insurance program. For more information on your NYS Disability Benefits, please go to the Workers' Compensation (WC) Board website below:

http://www.wcb.ny.gov

Along with the master policy, the following forms are enclosed for the administration of the coverage:

1. Notice of Compliance, form #DB-120, to be posted conspicuously at the site of your place of business.

2. Certificate/Cancellation of Insurance, form #DB-820, filed with the government agency issuing a permit, license or contract. The DB-820 is always completed by the insurance carrier.

3. Statement of Rights – Disability Benefits Law, form DB-271S, issued by you to a disabled employee.

In addition to the above, the following forms are needed in the administration of the coverage and can be found on the WC Board website:

1. Tables of Statutory Employee Contributions, form #DB-791, which provides the contribution you may deduct from your employee's salary according to the computed premium. *****This only applies if your employee's are contributing to the plan.***

   The tables can be found at:

   http://www.wcb.ny.gov/content/main/forms/db791.pdf

2. Employee Identification Card, form #DB-125. This card must be issued to employees eligible for disability benefits upon termination from employment. It is not required to be issued to employees hired in accordance with an Employer's usual employment practice who are terminated prior to completing a period of employment of at least thirty (30) days.

The name, address and Unemployment Insurance (UI) number of the Employer must be typewritten or hand printed on each card issued. Supplies of the card can be found at:

http://www.wcb.ny.gov/content/main/forms/db125.pdf

Or by calling or writing directly to the:

Workers' Compensation Board, Disability Benefits Bureau
100 Broadway-Menands
Albany, NY 12241-0005
(800) 353-3092

3. Claim Form, form #DB-450.

The Claim form can be found at:

http://www.wcb.ny.gov/content/main/forms/db450.pdf

IMPORTANT. In the event of a claim, please provide your employee with a copy of the claim form. Instruct the employee to complete both sides of this form and to mail the completed form to the attention of the Group Claims Office at the address shown below. **It is important that you provide the employee with the address, as it is not included in the DB-450 form.**

CIGNA Disability Management Solutions
Paper Intake Team
12225 Greenville Ave., Suite #1000
Dallas, TX 75243

If the employee has questions related to the completion of the form, the employee may call:

CIGNA Disability Management Solutions
800-362-4462.

If you have any questions or if you need assistance, please contact your Account Manager or Account Service Representative.

Very truly yours,

Matthew G. Manders, President

CIGNA Life Insurance Company of New York

CIGNA Life Insurance Company of New York
140 East 45th Street, New York, New York 10017
A Stock Insurance Company

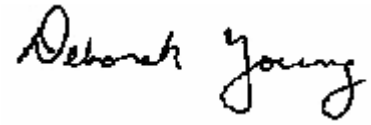
New York Disability Benefits Policy

POLICYHOLDER:	**Roku, Inc.**
POLICY NUMBER:	**NYD068228**
POLICY EFFECTIVE DATE:	**January 1, 2017**
POLICY ANNIVERSARY DATE:	**January 1 of each calendar year**

This is a contract between us, the CIGNA Life Insurance Company of New York, and you, the policyholder named above. In return for the payment of premiums as set forth in this policy, we agree to pay the benefits to which a covered employee is entitled as defined in the New York Regulations and referenced in this policy. We will only pay benefits if the employee becomes disabled while he is covered by this policy.

This policy shall take effect on the date shown above, at 12:01 a.m. standard time in the State of New York. It will stay in force as long as the premium is paid, until it is cancelled by you or us, in accordance with its provisions.

IN WITNESS WHEREOF, we have signed this policy at New York, New York.



Deborah Young, Corporate Secretary

Matthew G. Manders, President

DEFINITIONS

Covered Employees – As used in this policy, the term "covered employees" includes all employees eligible for coverage under New York Disability Benefits law except those specified in the Application attached to this policy. A person will not be covered by this policy during any period that he was not employed by you even though this policy is in force during that period.

New York Disability Benefits Law – As used in this policy, the term "New York Disability Benefits Law" means:

a) Article 9 of the Worker's Compensation Law of the State of New York; and
b) Any laws which (i) amend or supplement Article 9, and (ii) are in force or take effect while this policy is in force.

PREMIUMS

Amount of Premium – The premium rate is shown in the Application. The amount of premium shall be figured

(a) for employers with five or fewer Covered Employees, by multiplying the annual applicable to males by the number of male Covered Employees and the annual rate applicable to females by the number of female Covered Employees and then totalling; or
(b) for employers with more than five but fewer than 50 Covered Employees, by multiplying the quarterly rate per male employee by the number of male Covered Employees, the quarterly rate per female employee by the number of female Covered Employees and then totalling; or
(c) for employers with more than 50 Covered Employees, either (i) or (ii)

(i) by multiplying the applicable quarterly rate per $100.00 of wages by the total wages paid for the quarter, not to exceed the maximum for each Covered Employee specified in the New York Disability Benefits Law, or
(ii) by multiplying the quarterly rate per male employee by the number of male Covered Employees, the quarterly rate per female employee by the number of female Covered Employees and then totalling.

Premiums, calculated as described above, shall be payable annually, quarterly or monthly, as applicable. The first premium shall be due on or before the effective date of this policy. Renewal premiums shall be due on each policy anniversary if paid annually, or on the last day of each calendar quarter or month, if paid quarterly or monthly. A 31-day grace period applies to each premium after the first.

You shall figure the premium due and send this amount in full to us or to our authorized agent. You should also provide us with such information as we may require from your quarterly report to the Department of Labor.

Advance Premium – The advance premium is a deposit only. It shall be payable when the policy is delivered. It will be credited against the premium found to be due during the last calendar quarter (or part of a calendar quarter) that this policy is in force. If there is any excess, it will be returned to you.

Premiums Subject To Change – We may change the premium bases, rates, and rating plans:

a) as of each policy anniversary date; or
b) as of the effective date of any amendment to the New York Disability Benefits Law which affects our duties under this policy.

Any such change shall be made by an endorsement to this policy, which shall show the effective date of the change.

POLICY CANCELLATION

Cancellation of the Policy – Either you or we may cancel this policy at any time, by giving written notice to the other, and to the chairman of the Worker's Compensation Board of the State of New York. Notice shall be given to you either by delivering it to you or by sending it by registered mail to you at your last known place of business, and to the office of the chairman of the Worker's Compensation Board.

The notice shall set forth the date that the policy is to be cancelled; this date may not be less than 10 days after the date that the notice is furnished if the policy is cancelled for non-payment of premium, and not less than 30 days after the date that the notice is furnished if the policy is cancelled for any other reason. The policy will be cancelled as of the date set forth in the notice, as long as notice is provided as specified above; otherwise, at the end of the required notice period. However, if you obtain insurance with another carrier which takes effect before the date set forth in the notice, this policy will be cancelled as of the date that the other insurance takes effect.

Unearned Premiums – If this policy is cancelled, the earned premium will be figured, and the unearned premium (if any) will be returned to you. If we cancel this policy, or if you cancel this policy because you are retiring from business, then the earned premium shall be figured pro rata. If you cancel this policy for any other reason, then the earned premium shall be figured using the short rate table filed with the State of New York Insurance Department.

REQUIRED PROVISIONS

Notice and Jurisdiction – As between the covered employee and us, notice to you or knowledge by you of an injury or sickness suffered by the covered employee shall be deemed notice to us or knowledge by us, as the case may be; jurisdiction of you for the purposes of the New York Disability Benefits Law shall be jurisdiction of us; and we will in all things be bound by and subject to the orders, findings, or decisions made with regard to the payment of benefits under said law.

Enforcement by Chairman – The chairman of the Worker's Compensation Board of the State of New York shall have the right to enforce, in the name of the people of the State of New York for the benefit of the covered employee, our liability for the payment of the benefits provided by this policy, in whole or in part. He may file a separate application; or he may make us a party to the original application.

Multiple Liability – Payment in whole or in part of these benefits either by you or us shall be a bar to the recovery against the other of the amounts so paid.

Bankruptcy – We will not be relieved of any of our obligations under this policy, if you become bankrupt or insolvent.

Law Part of Policy – Each and every provision of the New York Disability Benefits Law shall be a part of this policy, as if it were written in this policy. Regardless of any provision of this policy, benefits shall be paid at least to the extent and in the manner required by, and subject to the terms of, said law.

Statutory Assessments – We will pay assessments levied on the total payroll of covered employees required by sections 214(2), 214(3), and 228 of the New York Disability Benefits Law.

Employee Contributions – If the total of contributions by employees for this coverage exceeds the total net premium for this policy, then the excess shall be applied for the sole benefit of employees, under rules of the chairman of the Worker's Compensation Board; or applied or disposed of as required by section 216 of the New York Disability Benefits Law.

If contributions are required by Covered Employees for this coverage, such contributions may not exceed 0.5% of the Covered Employee's wages, and not more than the maximum amount per week of $0.60 as permitted by the New York Disability Benefits Law.

GENERAL PROVISIONS

Notice of Disability – If you receive notice that a covered employee is disabled, you shall give written notice as soon as reasonable possible to us, or to an agent authorized by us. This notice should state your name; the policy number; the name and address of the covered employee; and any details of the time, place, and nature of the disability that are available to you. If a disability claim is made, you should give us notice right away, with full details of the claim. Nothing contained in any other section of this policy shall relieve you of the duty to give us notice set forth above.

Entire Agreement – By accepting this policy, you agree that the statements in the Application, which is attached to and made part of this policy, are your agreements with us; that these statements are representations and not warranties; and that this policy and the Application contains the entire agreement between you and us, or any of our agents, with respect to this insurance.

Changes – No change in this policy is valid unless it has been approved by one of our executive officers. This approval must be attached to or endorsed on this policy. No agent may change this policy or waive any provision. Notice to or knowledge by an agent or any other person shall not prevent us from enforcing any of our rights under the terms of this policy.

Records Maintained; Examination and Audit – You shall furnish us with all information which we may reasonably require with respect to the coverage provided by this policy. We may examine your records, which relate to this insurance at any time that this policy is in force, within 3 years after this policy is cancelled, or later if claims are still pending.

Assignment – No assignment of your interest under this policy shall bind us, until our consent has been endorsed on this policy.

Transaction Number: 6803539
Your submission was received for processing on 11/28/2016 at 5:40PM. It was submitted by user SLAWRENCE4.
It has been accepted and processed.

STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS LAW

CERTIFICATE/CANCELLATION OF INSURANCE
Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

Transaction Type: Initial **Transaction Effective Date:** 01/01/2017

A. INSURER/CARRIER	
1/2. INSURER/CARRIER NAME/CODE CIGNA LIFE INS CO OF NEW YORK - B089001	**6. TODAY'S DATE** 11/28/2016

B. CURRENT - EMPLOYER INFORMATION		
7. WCB EMPLOYER NUMBER	**8. NYS UIER NUMBER**	**9. EMPLOYER FEIN** 262087865
10. EMPLOYER'S NAME **Name:** Roku, Inc. **d/b/a:** **c/o:** **Attn:**		**13. LEGAL STATUS** Corporation (03)
11. ADDRESS **Line 1:** 45 West 34th St., Suite 808 **Line 2:**		**14. # OF EMPLOYEES**
12. CITY STATE ZIP CODE New York New York 10001 **COUNTRY** United States		**15. TELEPHONE NO.**

C. POLICY		
If policyholder is an Association, Union or Trustee for which form DB-820.3 is filed, do not complete item 18.		
16. POLICY NUMBER* NYD068228	**17. POLICY EFFECTIVE DATE** 01/01/2017	**18. POLICY FORM NUMBER***
19. WCB PLAN NUMBER (Only for Assoc., Union or Trustee with Form DB-801 on file.)		**20. ANNUAL PREMIUM AMOUNT**

F. POLICYHOLDER - If different from Employer
27. POLICYHOLDER NAME **Name:** **d/b/a:** **c/o:** **Attn:**
28. POLICYHOLDER ADDRESS **Line 1:** **Line 2:**
29. CITY STATE ZIP CODE COUNTRY
30. POLICYHOLDER FEIN

To be filed by Insurance Carrier on behalf of Employer to provide, through insurance, exactly statutory benefits, (Section 204) OR benefits under a plan accepted by the Chairman.

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

DB-820/829 rev. 5/01

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

NOTICE OF COMPLIANCE

DISABILITY BENEFITS LAW TO EMPLOYEES

1. If you are unable to work because of an illness or injury not work-related, you may be entitled to receive weekly benefits from your employer, or his or her insurance company, or from the Special Fund for Disability Benefits.

2. To claim benefits you must file a claim form,within 30 days from the first date of your disability, but in no event more than 26 weeks from such date.

3. Use one of the following claim forms:
   -If, when your disability begins, you are employed or are unemployed for four weeks or less, use claim Form DB-450, which you may obtain from your employer, his or her insurance carrier, your health provider, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board, and send it to your employer or the insurance carrier named below.
   -If, when your disability begins, you have been unemployed more than four weeks, use claim Form DB-300, which you may obtain from any Unemployment Insurance Office, your health provider, the Workers' Compensation Board's website (www.wcb.ny.gov) or any office of the Board. Send completed claim form to the Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANT:** Before filing your claim, your health provider must complete the "Health Care Provider's Statement" on the claim form, showing your period of disability.

4. You are entitled to be treated by any physician,chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. However, unlike workers' compensation, your medical bills will not be paid unless your employer and/or union provide for the payment of such bills under a Disability Benefits Plan or Agreement.

5. If you are ill or injured during the time you are receiving Unemployment Insurance Benefits, file a claim for Disability Benefits as soon as you sustain the injury or illness, by following the instructions outlined above.

6. If you are out of work in excess of seven days, your employer is required to send you a Disability Benefits Statement of Rights (Form DB-271S).

7. Other information about Disability Benefits may be obtained by writing or calling the nearest Workers' Compensation Board Office.

WORKERS' COMPENSATION BOARD OFFICES

Albany, 12241 - 100 Broadway-Menands - (866) 750-5157
Binghamton, 13901 - State Office Bldg. -44 Hawley St.- (866) 802-3604
Brooklyn, 11201 - 111 Livingston St.- Brooklyn - (800) 877-1373
Buffalo, 14203 - 295 Main Street, Suite 400 - (866) 211-0645
Hauppauge, 11788 - 220 Rabro Drive - Suite 100 - (866) 681-5354
Hempstead, 11550 - 175 Fulton Avenue - (866) 805-3630
New York, 10027 - 215 W.125th St. - Manhattan - (800) 877-1373
Peekskill, 10566 - 41 North Division St. - (866) 746-0552
Queens, 11432 - 168-46 91st Ave. - Jamaica - (800) 877-1373
Rochester, 14614 - 130 Main Street West - (866) 211-0644
Syracuse, 13203 - 935 James St.- (866) 802-3730

ESTADO DE NUEVA YORK
JUNTA DE COMPENSACION OBRERA

AVISO DE CUMPLIMIENTO

LEY DE BENEFICIOS POR INCAPACIDAD A LOS EMPLEADOS

1. Si usted no puede trabajar debido a enfermedad o lesión no relacionada con el trabajo, podría tener derecho a recibir beneficios semenales de su patrón o de la compañia de seguros de él/ella o del Fondo Especial para Beneficios por Incapacidad.

2. Para reclamar beneficios usted debe presentar una forma de reclamación, dentro de 30 dias a partir de la primera fecha de su incapacidad, pero en ningun caso más de 26 semanas de dicha fecha.

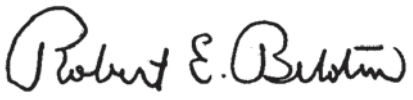
3. Use una de las siguientes formas de reclamación:
   -Si, cuando comience su incapacidad usted está empleado o ha estado desempleado por cuatro semanas o menos, use la forma de reclamación (Form DB-450), la cual puede obtener de su patrón o de la compañia de seguros de él/ella, o de su proveedor de cuidados de salud, o bien de cualquier oficina de la Junta de Compensación Obrera, y enviela a su patrón o a la compañia de seguros nombreda abajo.
   -Si cuando comience su incapacidad, usted ha estado desempleado más de cuatro semanas, use la forma de reclamación (Form DB-300), la cual puede obtener en cualquier Oficina de Seguro de Desempleo, de su proveedor de salud, o bien de cualquier oficina de la Junta de Compensación Obrera. Envie la forma de reclamación, debidamente terminada, a Workers' Compensation Board, Disability Benefits Bureau, Albany, New York 12241. **IMPORTANTE:** Antes de presentat usted su reclamación, es necesario que su proveedor de salud complete la declaracion del médico ("Health Care Provider's Statement") en la forma de relamacion, indicando el periodo de su incapacidad.

4. Usted tiene derecho a ser tratado por cualquier médico, quiropráctico, dentista, enfermera-partera, podiatra o psicólogo que usted elija. Pero, contrario ala compensación obrera, sus cuentas médicas no seran pagadas a menos que su patrón y/o Unión haga el pago de tales cuentas médicas bajo un Plan o Convenio de Beneficios por Incapacidad.

5. Si estuviera usted enfermo o lesionado durante el tiempo que esté recibiendo beneficios del Seguro de Desempleo, presente una reclamación para Beneficios por Incapacidad, siguiendo las instrucciones arriba descritas, tan pronto como sufra la lesión o la enfermedad.

6. Si usted está desempleado por mas de siete dias, su patrón está obligado a enviarle la Declaración de Derechos de Beneficios por Incapacidad (Form DB-271S).

7. Otras informaciones relativas a Beneficios por Incapacidad pueden obtenerse escribiendo o llamando ala oficina más cercana de la Junta de Compensación Obrera.



ROBERT E. BELOTEN
CHAIR/PRESIDENTE

www.wcb.ny.gov

Employers must post DB-120s so that all classes of their employees know who will pay their Disability Benefits.
Disability Benefits, when due, will be paid by (Los Beneficios por Incapacidad, cuando debidos, seran pagados por):

CIGNA LIFE INSURANCE COMPANY OF NEW YORK
2 Grand Central Tower, 10l E 45th St., 39th Fl.
New York, NY 10017-3144 Phone: 1-800-732-1603

Effective: From 01/01/2017 To 01/01/2019
(En Vigor Desde) (Hasta)
Policy No. NYD068228
(Poliza No.)

The benefits provided are (Los beneficios provistos son)

[X] Statutory	[ ] Under a Plan or Agreement

Class(es) of employees covered (Clase(s) de empleados amparados)

All Employees eligible under NY Disability Benefits Law.

Roku, Inc.

Name of employer (Nombre del Patron)

THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

LA JUNTA DE COMPENSACION OBRERA EMPLEA Y SIRVE A PERSONAS INCAPACITADAS SIN DISCRIMINAR.

DB-120 (1-11)

Prescribed by Chair
Workers' Compensation Board
State of New York

THIS NOTICE MUST BE POSTED CONSPICUOUSLY IN AND ABOUT THE EMPLOYER'S PLACE OR PLACES OF BUSINESS.

CIGNA Life Insurance Company of New York
140 East 45th Street, New York, New York 10017

Application for a New York Disability Benefits Policy **Policy No:** NYD68228

1. **Name of Employer** Roku, Inc.
2. **Address** 45 West 34th St., Suite 808, New York, NY 10001 **Phone No.** 408-740-5212
3. **Employer is** [✓] **Corporation** [ ] **Partnership** [ ] **Proprietorship** [ ] **Other**
4. **Name under which Employer conducts business, if different from (1) above** Not Applicable
5. **Name and Address of Policyholder, if different from (1) above** 150 Winchester Circle Los Gatos CA 95032 (Mailing Address: 130 Knowles Drive Suite D Los Gatos CA 95032)
6. **Send Premium Report Forms to** [ ] **Employer** [✓] **Policyholder** [ ] **Individual subsidiaries**
7. **Nature of Business** 5065 Electronic Parts and Equipment, Not Elsewhere Classified
8. **Have New York Disability Benefits been provided previously?** [✓] **Yes** [ ] **No**

   If yes, by whom? Unicare Life & Health Ins Co (277126GDBL)
9. **Current New York Unemployment Insurance Number** 51-36262 7
10. **Total number of employees eligible under New York Disability Benefits Law and who are to be covered by this policy?** 30 **consisting of** 17 **males and** 13 **females.**
11. **All employees eligible under New York Disability Benefits Law are to be covered by this policy except** Not Applicable
12. **Requested Policy Effective Date** 01/01/2017 **Policy Anniversary Date** 01/01
13. **Premiums shall be figured as follows:**
    a. **For employers with 1 to 5 eligible Employees**
       $_____ **per Male Employee** **Annual Premium** $_____
       $_____ **per Female Employee** **Annual Premium** $_____
    b. **For employers with 6 to 49 eligible employees**
       $ 39.60-Annual male ($3.30/mo) **per Male Employee** **Quarterly Premium** $ 168.30
       $ 84.12-Annual female ($7.01/mo) **per Female Employee** **Quarterly Premium** $ 273.39
    c. **For employers with more than 50 eligible Employees**
       (i) Quarterly Premium of $_____ **per** $100 **of the first** $_____ **of wages paid to each Covered Employee; or**
       (ii) $_____ **per Male Employee** **Quarterly Premium** $_____
       $_____ **per Female Employee** **Quarterly Premium** $_____.

Advance Premium $ 441.69

LZ-3D07a-DBL

Premiums shall be payable annually or quarterly, as applicable. The first premium shall be due on or before the effective date of the policy. Renewal premiums shall be due on each policy anniversary if paid annually, or on the last day of each calendar quarter, if paid quarterly. A 31-day grace period applies to each premium after the first. This policy may be cancelled, but not before written notice has been provided to the policyholder and the chairman of the Workers' Compensation Board of the State of New York, but not less than 10 days after the date notice is furnished if the policy is cancelled for non-payment of premium, and not less than 30 days after the date notice is furnished if the policy is cancelled for any other reason. All advance premiums are deposit only, shall be held without interest and shall be subject to final audit and adjustment at the end of the last premium period for which this policy remains in force. We reserve the right to change premium rates, as provided in the policy.

THE EMPLOYER NAMED ABOVE hereby (a) represents that it is an employer subject to the New York Disability Benefits Law and (b) applies to CIGNA Life Insurance Company of New York for a policy to provide the disability benefits prescribed by Section 204 of that law. The statements made in this application are true and correct to the best of the Employer's knowledge, information and belief.

The Employer understands and agrees that, under the New York Disability Benefits Law, covered employees may not contribute more than ½ of 1% of their wages paid on and after the effective date of the policy, not to exceed $ 00.60 per week, to the cost of this insurance.

The Employer understands that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim which contains any materially false information, or who conceals for the purpose of misleading, any fact material thereto, commits a fraudulent insurance act, which is a crime and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

In reliance on the above statements, a New York Disability Benefits Policy, with the same number as this application, shall be binding on the company as of 12:01 a.m. Eastern Standard Time on the Policy Effective Date shown above; only if this application and the premium due is received by the Company not more than 10 days after the Policy Effective Date.

Agent's/Broker's Code 007055 **Agent/Broker** Bret Goodman/Alliant Insurance Services

SS# or Federal ID# 33-0785439

Employer Roku, Inc. **By** Troy Fenner, VP Human Resources

Date Signed 11-22-16

signature and title of authorized representative of employer

Signed at 170 Knowles, Los Gatos, CA 95032
address

Industry Code 5065 **Class Code**_____

LZ-3D07a-DBL

For Home Office Use Only
Estimated Annual Premium 17606.76 Employee Contribution % 0
SIC 5065 Class 1
Underwriting Approval By Amy K. Guinan Date 11-23-2016

STATE OF NEW YORK
Andrew M. Cuomo, Governor

WORKERS' COMPENSATION BOARD
Robert E. Beloten, Chair

STATEMENT OF RIGHTS - DISABILITY BENEFITS LAW

IF YOU ARE UNABLE TO WORK BECAUSE OF A NON-OCCUPATIONAL ILLNESS OR INJURY, YOU MAY BE ENTITLED TO DISABILITY BENEFITS

1. Your employer is required by law to provide for the payment of Disability Benefits to his/her employees.
2. Statutory Disability Benefits are payable for any non-work related injury or illness (including disability due to pregnancy) beginning with the 8th consecutive day of disability. Benefits are payable for up to 26 weeks. Benefit payments are based on your average weekly wages for the eight weeks immediately prior to your disability, and are subject to the maximum allowable by the law in effect on the initial day of disability. Your employer or union may provide for different benefits which are at least as favorable as statutory benefits under an approved Disability Benefits Plan or Agreement.
3. TO CLAIM BENEFITS you should file written notice and proof of disability (Claim Form DB-450) with your employer or the insurance carrier named below within 30 days from the first day of your disability, or all or part of your claim may be rejected. In no event should you wait more than 26 weeks from that date to file a claim. You may obtain Form DB-450 from your employer, its insurance carrier, your health care provider or any office of the Workers' Compensation Board. (See addresses and telephone numbers below.) **Do not** assume that your employer has filed a claim on your behalf; **claim filing is your responsibility.**
4. You are entitled to be treated by any physician, chiropractor, dentist, nurse-midwife, podiatrist or psychologist of your choice. Unlike workers' compensation, your medical bills will **not** be paid by your employer or the insurance carrier, unless your employer and/or union provides for the payment of medical bills under an approved Disability Benefits Plan or Agreement.
5. Disability Benefits are to be paid **directly** to you by the insurance carrier, **not through your employer**, unless your employer is an approved self-insurer.
6. If your employer or the insurance carrier contends that you are not entitled to the payment of Disability Benefits, they are required to send you a Notice of Rejection, within 45 days of the filing of your claim, telling you the reasons benefits are not being paid. If you disagree with their rejection, you have a **legal right** to request a review of the rejection by the Workers' Compensation Board. **IMPORTANT:** If within 45 days of filing your claim you do not receive benefits and do not receive a Notice of Rejection (Form DB-451), promptly contact any office of the Workers' Compensation Board.
7. **If your disability is the result of an automobile accident** and you have filed a claim for no-fault benefits, you must also file a claim (Form DB-450) for disability benefits. **If you do not file for disability benefits, the no-fault insurer may reduce your no-fault payments. IMPORTANT**: In such cases, if you are not entitled to disability benefits, immediately advise the no-fault insurance carrier.
8. Your employer may not ask you to waive your right to disability benefits nor may your employer deduct more than 60 cents a week (unless the additional contribution is part of an approved plan) from your pay to contribute to the payment of disability benefits insurance premiums. **You cannot be discharged or discriminated against for filing a claim for disability benefits.**

IF YOU HAVE DIFFICULTY IN OBTAINING A CLAIM FORM OR NEED HELP IN FILLING IT OUT, OR IF YOU HAVE ANY OTHER QUESTIONS OR PROBLEMS ABOUT A NON-WORK RELATED INJURY OR ILLNESS, CONTACT ANY OFFICE OF THE WORKERS' COMPENSATION BOARD.

This information is a simplified presentation of your rights as required by Section 229 of the Disability Benefits Law. Your employer's disability benefits insurance carrier is:

CIGNA Life Insurance Company of New York
2 Grand Central Tower, 140 East 45th St., 39th Floor
New York, NY 10017-3144
Phone Number: 1-800-732-1603

ROBERT E. BELOTEN
CHAIR

100 Broadway Menands	StateOffice Building 44 Hawley Street	111 LivingstonSt. 22nd Floor	295 Main Street Suite 400	220 Rabro Drive Suite 100	175 FultonAvenue	215 W. 125th Street 3rd Floor	41 North Division St.	168-46 91st Ave. 3rd Floor	130 Main Street W.	935 James St.
ALBANY 12241	BINGHAMTON13901	BROOKLYN11201	BUFFALO 14203	HAUPPAUGE 11788	HEMPSTEAD11550	NEW YORK 10027	PEEKSKILL 10566	QUEENS 11432	ROCHESTER 14614	SYRACUSE 13203
(866) 750-5157	(866)802-3604	(800) 877-1373	(866) 211-0645	(866) 681-5354	(866) 805-3630	(800) 877-1373	(866) 746-0552	(800) 877-1373	(866) 211-0644	(866) 802-3730

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.
ESTE RESUMEN ESTA ESCRITO EN ESPANOL AL DORSO.

www.wcb.ny.gov

ESTADO DE NUEVA YORK
Andrew M. Cuomo, Gobernador

JUNTA DE COMPENSACION OBRERA
Robert E. Beloten, Presidente

DECLARACION DE DERECHOS - LEY DE BENEFICIOS POR INCAPACIDAD

SI USTED NO PUEDE TRABAJAR A CAUSA DE ENFERMEDAD O LESION NO RELACIONADA CON EL TRABAJO PUEDE TENER DERECHO A BENEFICIOS POR INCAPACIDAD

1. Su patrono está obligado por ley a proveer pagos de Beneficios por Incapacidad a sus empleados.

2. Beneficios por Incapacidad establecidos por ley son pagados por cualquier lesión o enfermedad no relacionada con el trabajo (incluyendo incapacidad debida a embarazo) comenzando a partir del octavo dia consecutivo de incapacidad. Los beneficios son pagados por 26 semanas. Los pagos de beneficios por incapacidad se basan en el promedio de su sueldo semanal durante las ocho semanas inmediatamente anteriores a su incapacidad y estan limitados al maximo permitido por ley el dia inicial de su incapacidad. Su patrono ó unión podran proveer en un plan o en un convenio beneficios diferentes que sean al menos tan favorables como los establecidos por ley.

3. PARA RECLAMAR BENEFICIOS **usted** deberá radicar una notificación y prueba de incapacidad (Formulario DB450) con su patrono ó con la compañia de seguros nombrada abajo dentro del plazo de 30 dias desde el primer dia de incapacidad o toda o parte de su reclamación podra ser rechazada. Bajo ninguna circunstancia usted debe esperar mas de 26 semanas desde esa fecha para radicar su reclamación. El formulario DB-450 lo puede conseguir a traves de su patrono, la compañia de seguros, el proveedor de servicios médicos o cualquier oficina de la Junta de Compensación Obrera.(Direcciones y telefonos mas abajo). **No** asuma que su patrono ha radicado la reclamación por usted. **La radicación de la reclamación es su responsabilidad.**

4. Usted tiene el derecho de ser atendido por cualquier médico, quiropractico, dentista, enfermera-partera, podiatra, o psicologo que usted seleccione. Contrario a como ocurre en compensación obrera sus cuentas médicas **no** seran pagadas por su patrono o su compañia de seguros a menos que el patrono y o la unión lo hayan dispuesto mediante un plan de beneficios o convenio.

5. Los beneficios por incapacidad le seran pagados a usted **directamente** por la compañia de seguros, **no a traves de su patrono,** salvo en los casos en que su patrono sea aprobado como auto asegurado.

6. Si su patrono ó la compañia de seguros reclama que usted no tiene derecho al pago de Beneficios por Incapacidad ellos tienen la obligación de enviarle un Aviso de Rechazo, dentro de los 45 dias siguientes ala radicación de su reclamación, explicandole las razones para no pagar los beneficios. Si usted no está de acuerdo con el rechazo, **tiene el derecho** de solicitar una revisión del mismo por la Junta de Compensación Obrera. **IMPORTANTE:** Si dentro del término de 45 dias de haber radicado su reclamación no recibe los beneficios ni tampoco recibe un Aviso de Rechazo (Formulario DB-451) comuniquese inmediatamente con cualquier oficina de la Junta de Compensación Obrera.

7. **Si su incapacidad es el resultado de un accidente automovilistico** y usted ha radicado una reclamación para beneficios por 'no-fault' tambien deberá radicar una reclamación (Formulario DB-450) para beneficios por incapacidad. **Si no radica reclamación para beneficios por incapacidad, la compañia de seguro podria reducir los pagos 'no fault' que le correspondan. IMPORTANTE:** en estos casos, si no tiene derecho a beneficios por incapacidad, avise inmediatamente a la compañia de seguros.

8. Su patrono no puede pedirle que renuncie a su derecho de recibir beneficios por incapacidad ni tampoco puede descontar mas de 60 centavos semanales (a menos que la contribución adicional sea parte de un acuerdo) de su paga para contribuir al pago de las primas de seguro para los beneficios por incapacidad. **Usted no puede ser despedido ni discriminado por radicar una reclamación de beneficios por incapacidad.**

SI TIENE DIFICULTAD EN CONSEGUIR UN FORMULARIO DE RECLAMACIÓN O NECESITA AYUDA PARA LLENARLO, O TIENE CUALQUIER OTRO PROBLEMA ACERCA DE UNA LESION O ENFERMEDAD NO RELACIONADA CON EL TRABAJO COMUNIQUESE CON CUALQUIER OFICINA DE LA JUNTA DE COMPENSACIÓN OBRERA.

Este es un breve resumen de sus derechos como lo requiere la Sección 229 de la Ley de Beneficios por Incapacidad. La compañia de seguro de su patrono para beneficios por incapacidad es:

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