

Important: If you have not notified NBL of the amount of benefit subject to tax, this form must be completed and returned to NBL.

FICA WITHHOLDING – NY DISABILITY BENEFITS LAW (DBL) INSURANCE

Employers may require their employees to contribute to the cost of DBL premiums by withholding 1/2 of 1% of weekly wages up to \$.60 per week. If you take a contribution from your employees, only the ratio of the employer contribution to the total premium paid is the portion of benefit that is subject to FICA tax withholding. **Incorrect FICA withholding may reduce the DBL benefit your employee receives as well as overstate your firm's tax liability.** If you take different contributions from different classes of employees, you must do a calculation for each class. To assure proper withholding, please complete this form and return it to National Benefit Life Insurance Company. We urge you to consult with your accountant, tax advisor or the IRS with any questions regarding your tax liability.

FICA Withholding Worksheet- Guidelines

Do you take a contribution from your employees?

Check one:

- No** → skip **Step 1** and **Step 2**, sign form and return to NBL.
- Yes** → continue with **Step 1** and **Step 2**, sign form and return to NBL.

Step 1: Determine the premium paid to your DBL carrier(s) for each of the past three calendar years. Enter these amounts in **(A) PREMIUM PAID**. If coverage was in effect fewer than 3 years, use the cost for the policy years in effect or, if in effect less than 1 year, a reasonable estimate of the cost for the first policy year. If NBL was the carrier for all 3 years, leave blank and we will determine the premium.

Step 2: Determine contributions withheld from your employees for the same period. Enter these amounts in **(B) EMPLOYEE CONTRIBUTIONS**.

Using the guidelines above, complete the worksheet below. To ensure proper tax withholding, please return form within 10 days of receipt.

| Indicate the years for which this report is being completed <input type="checkbox"/> | Policy Year Ending | Policy Year Ending | Policy Year Ending | |
|--|--------------------|--------------------|--------------------|----------|
| | 20_____ | 20_____ | 20_____ | |
| (A) PREMIUM PAID | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| (B) EMPLOYEE CONTRIBUTIONS | \$ _____ | \$ _____ | \$ _____ | \$ _____ |
| DO NOT COMPLETE SHADED AREAS | | | | \$ _____ |
| | | | | % |

POLICYHOLDER NAME _____ POLICY# 8-910-_____

TAX ID # _ _ _ _ - _ _ _ _ _

New York Registration ER # _ _ _ - _ _ _ _ _

Signature _____ Telephone _____ Date _____

MAIL OR FAX COMPLETED FORM TO: NATIONAL BENEFIT LIFE, State Disability Plans,
One Court Square, Long Island City, NY 11120-0001
FAX: (800) 584-9370