

**PPO – EMPLOYER AFFIRMATION A**

Mail, fax or email information to:

Division of Policy and Program Development  
(Attn: Mark Arunasalem)  
State of New York Workers' Compensation Board  
100 Broadway-Menands, Albany NY 12241  
Email: MCNetworks@wcb.ny.gov  
Fax: (518) 473-6379

In the Matter of Preferred Provider Organization Participation  
(**PPO Name:** \_\_\_\_\_)

By EMPLOYER (**Please enter name and address**)

**Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_  
\_\_\_\_\_

(Name of Employer Official), attests to the following:

1. I am the \_\_\_\_\_ of \_\_\_\_\_  
(Title) (Name of Employer)  
and I file this affirmation in accordance with Article 10-A of the Workers' Compensation Law and 12 NYCRR 325-8.2.

2. I attest that \_\_\_\_\_ has non-unionized employees.  
(Name of Employer)

**AND**

3. I attest that \_\_\_\_\_ has unionized employees.  
(Name of Employer)

Both non-unionized and unionized employees are participating in the Preferred Provider Organization ("PPO") program.

I am aware that no unionized employees may participate in the PPO program until such arrangement is collectively bargained with the recognized or exclusive bargaining representative of the covered employees. Such negotiation and consent must be evidenced in a notarized affirmation signed by the collective bargaining agent, agreeing to the selection of the PPO and setting forth the duration of the agreement.

\_\_\_\_\_  
Signature of Employer Official

\_\_\_\_\_  
(Type or print name of Employer Official)

Sworn to me this day of \_\_\_\_\_.

Notary Signature and Stamp