STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY AND PAID FAMILY LEAVE BENEFITS LAW
CERTIFICATE/CANCELLATION OF INSURANCE

Filed on behalf of Employer in compliance with Article 9 of the Workers' Compensation Law

[X] Initial [ ] Cancellation [ ] Reinstatement [ ] Supersedes Transaction Effective Date 1/1/2022

A. INSURER

1. INSURER NAME	2. INSURER CODE	3. INSURER PHONE #
MUTUAL OF OMAHA INSURANCE COMPANY	B110005	914-591-7111

4. CONTACT NAME	5. TITLE	6. DATE
Hana Rubin	Disability Administrator	1/12/2022

B. CURRENT EMPLOYER INFORMATION

7. WCB EMPLOYER NUMBER	8. NYS UIER NUMBER	9. EMPLOYER FEIN
		95-3950647

10. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA) SONSRAY, INC.	13. LEGAL STATUS (SEE BACK OF FORM) 3
11. EMPLOYER STREET ADDRESS 23935 MADISON STREET	14. NUMBER (#) OF EMPLOYEES 17
12. EMPLOYER CITY, STATE and ZIP CODE TORRANCE, CA 90505	15. EMPLOYER PHONE # (323)319-1900

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	17. POLICY EFFECTIVE DATE	18. POLICY FORM NUMBER *
GMNY6X008L04-0001	1/1/2022	DBL-100

19. WCB PLAN NUMBER (Only for Association, Union or Trustee with Form DB-801 on file.)	20. PREMIUM AMOUNT

D. REASONS FOR CANCELLATION

[ ] Non-Payment of Premium
[ ] Not Subject/ No Eligible Employees
[ ] Out of Business
[ ] Seasonal

[ ] Other :
Date : ______________
Date : ______________
Date: ______________

DATE CANCELLATION OR TERMINATION SENT TO EMPLOYER :

E. Complete if SUPERSEDES box is checked at top of form		F. POLICYHOLDER if different from Employer
21. EMPLOYER'S LEGAL NAME, INCLUDING (DBA/AKA/TA)		27. POLICYHOLDER NAME
22. EMPLOYER'S STREET ADDRESS		28. POLICYHOLDER ADDRESS
23. CITY, STATE and ZIP CODE		29. CITY, STATE and ZIP CODE
24. EMPLOYER FEIN	25. POLICY EFFECTIVE DATE	30. POLICYHOLDER FEIN
26. POLICY NUMBER		

G. 1. The policy covers Employer's employees as follows:

a. The policy provides coverage for:
[X] Both disability and paid family leave benefits
[ ] Disability benefits only
[ ] Paid Family leave benefits only

b. The policy covers the following class or classes of employees
[X] All employees
[ ] Only the class or classes of employees listed here:
____
____

2. The Employee contributions required and benefits insured are:
[X] The same in all respects as under Section 204 and not in excess of those authorized under Section 209.
[ ] As described in attached supplement, Form DB-820-.1
[ ] As described in Employers Application for Acceptance of a Plan, Form DB-800, filed with and accepted by the Chair
[ ] As described in Certificate of Insurance, Form DB-820.3, filed on behalf of the Association. Union or Trustees (policyholders) on ____________ or amended Form DB-820.3 filed thereafter.

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 Chair