# 2024 Small Employer Premium Opt-in Form

**Use this form to opt in to paying the employer share of the Paid Leave premium for your small business. This form must be completed and submitted by March 1, 2024.**

- If you are an employer with less than 50 employees, you are not required to pay the employer share of the Paid Leave premium. However, you may choose to contribute to the program by opting in to pay the employer share of the premium on an annual basis.
- By submitting this form, you are authorizing the Employment Security Department to assess the full employer premium rate on the wages you report for each quarter of 2024. The employer share of the premium will be calculated during quarterly wage and hour reports.
- This authorization will remain in place until Dec. 31, 2024, and cannot be revoked. Once in place you cannot receive a refund of the premiums paid under this authorization.

## How to submit this form

Fax or mail the completed form to the department by March 1, 2024.

**Fax :** 833-535-2273

**Mail :** Employment Security Department
Paid Family and Medical Leave
P.O. Box 19020
Olympia, WA 98507-0020

## Questions

If you have questions, please contact us at 833-717-2273 or email paidleave@esd.wa.gov. We are available Monday through Friday between 8:30 a.m. and 4:30 p.m.

Washington Paid Family & Medical Leave
Employment Security Department

# 2024 Small Employer Premium Opt-in Form

**Complete the required information (*) requested below.**

## Business information

| | | |
|---|---|---|
| **Legal business name* :** | | |
| **Unified Business Identifier Number (UBI)* :** | **Employer Identification Number (EIN) :** | |
| **Mailing Address* :** | | |
| **City* :** | **State* :** | **Zip Code* :** |
| **Phone Number* :** | **Email Address :** | |

## Ownership structure

- ◯ **Sole Proprietor**
- ◯ **Partnership**
- ◯ **Corporation**
- ◯ **Limited Liability Company**
- ◯ **Other:**

## Authorization

By signing below, I certify under penalty of perjury that:

- I am the business owner or officer duly authorized to represent this account.
- I understand that as a small employer, I am not required to pay the employer share of the premium.
- I am electing to pay the employer share of the premium for calendar year 2024.
- This authorization is in place until Dec. 31, 2024, and cannot be revoked.
- I am not entitled to a refund of premiums paid under this authorization.

| | |
|---|---|
| **Signature* :** | **Date Signed* :** |
| **Printed Name* :** | **Title* :** |
| **Phone Number* :** | **Email Address :** |