

2026 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 between December 1, 2025 and March 1, 2026.

- If you are an employer with fewer 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 2026. The employer share of the premium will be calculated during quarterly wage and hour reports.
- This authorization will remain in place until December 31, 2026, 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, 2026.

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. To get your email to the right team, include "UBI" followed by your 9-digit UBI number or "BUSINESS" followed by your business name in the subject line. We are available Monday through Friday between 8:30 a.m. and 4:30 p.m.

2026 Small Employer Premium Opt-in Form

Complete the required information (*) requested below.

Business information			
Legal business name* :			
Unified Business Identifier number (UBI)* :			
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 2026. • This authorization is in place until December 31, 2026, 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 :	

The Employment Security Department is an equal opportunity employer/program. Auxiliary aids and services are available upon request to individuals with disabilities. Language assistance services for limited English proficient individuals are available free of charge. Washington Relay Service: 711