Transaction Number: **10985108**
Your submission was received for processing on 01/27/2026 at 9:33AM. It was submitted by user SHEASLEY.
It has been accepted and processed.

STATE OF NEW YORK WORKERS' COMPENSATION BOARD
DISABILITY BENEFITS LAW 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

Transaction Type: **Initial** **Transaction Effective Date:** **01/01/2026**

A. INSURER/CARRIER	
1/2. INSURER/CARRIER NAME/CODE FIRST RELIANCE STANDARD - B069441	**6. TODAY'S DATE** 01/27/2026

B. CURRENT - EMPLOYER INFORMATION		
7. WCB EMPLOYER NUMBER	**8. NYS UIER NUMBER**	**9. EMPLOYER FEIN** 521707002
10. EMPLOYER'S NAME **Name: Reliant Mission, Inc** **d/b/a:** **c/o:** **Attn:**		**13. LEGAL STATUS** Corporation (03)
11. ADDRESS **Line 1:** 11002 Lake Hart Dr. Ste. 100 **Line 2:**		**14. # OF EMPLOYEES**
12. CITY STATE ZIP CODE Orlando Florida 32832 **COUNTRY** United States		**15. TELEPHONE NO.**

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* DBL1330000248	**16a. COVERAGE TYPE** PFL and DB (1)	**17. POLICY EFFECTIVE DATE** 01/01/2026	**18. POLICY FORM NUMBER*** DBL0896
19. WCB PLAN NUMBER (Only for Assoc., Union or Trustee with Form DB-801 on file.)			**20. ANNUAL PREMIUM AMOUNT**

F. POLICYHOLDER - If different from Employer
27. POLICYHOLDER NAME **Name:** **d/b/a:** **c/o:** **Attn:**
28. POLICYHOLDER ADDRESS **Line 1:** **Line 2:**
29. CITY STATE ZIP CODE COUNTRY
30. POLICYHOLDER FEIN

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 Chairman.
THE WORKERS' COMPENSATION BOARD EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

DB-820/829 rev. 5/01