



<b><u>FOR OFFICE USE ONLY</u></b>
ATN: _____
iCMS No.: _____

## APPLICATION FOR NEW YORK WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

Any person who wilfully makes a false statement or representation, deliberately conceals any material fact, or engages in any other fraudulent scheme or device, for the purpose of obtaining or attempting to obtain, or for the purpose of aiding or abetting any person to obtain insurance in the New York State Insurance Fund at less than the proper rate for such insurance, or payment out of the New York State Insurance Fund to which such person is not entitled, is guilty of a crime. In addition, the New York State Insurance Fund shall have a right of action to recover civil damages equal to three times the amount wrongfully obtained, or five thousand dollars, whichever is greater. This right of action is in addition to any other remedy provided by law.

**Applicant, please note:**

Application is hereby made to the NEW YORK STATE INSURANCE FUND for a policy insuring the applicant's liability for the payment of benefits to the applicant's employees under the New York Workers' Compensation Law. **No coverage will be effected unless the required deposit premium is received along with this application.** Applicant understands that no liability shall attach to the NEW YORK STATE INSURANCE FUND under this application and that insurance shall not be effective unless and until this application is accepted by the NEW YORK STATE INSURANCE FUND as evidenced by the inception date indicated in a policy, the terms and provisions of which will be binding upon the applicant. Applicant further understands that a policy of insurance issued pursuant to this application will not extend coverage under the Disability Benefits Law, the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law; any liabilities of the applicant under such laws to employees, executives or others must be separately insured under a Disability Benefits insurance policy, Volunteer Firefighters' Benefit Law policy or Volunteer Ambulance Workers' Benefit Law policy for which separate applications must be submitted.

PLEASE PRINT YOUR ANSWERS.

- (1) REQUESTED EFFECTIVE DATE OF INSURANCE: \_\_\_\_/\_\_\_\_/\_\_\_\_ 12:01 A.M., EASTERN STANDARD TIME.
- (2) WHAT IS THE FULL NAME(S) OF THE EMPLOYER(S) INCLUDING ANY TRADE NAME(S) OR DOING BUSINESS AS NAME(S)?

Name of Employer(s)	Trade Name(s) or Doing Business As Name(s)	*Business Type

Attach a separate sheet if additional space is needed.

**\*Business types:** Sole Proprietor/Self Employed; Partnership; Corporation; Political Subdivision; Limited Liability Company; Professional Service Liability Company; Registered Limited Liability Partnership; Limited Liability Partnership; or if Other-Specify.

(3) PLEASE PROVIDE THE MAIN NEW YORK STATE WORK LOCATION OF THE EMPLOYER:  
(P.O. BOX IS NOT ACCEPTABLE AS A WORK LOCATION)

For the purpose of serving notice of cancellation in accordance with section 54(5) of the New York Workers' Compensation Law, the insured(s) agree(s) that service of notice upon the person or entity designated at the address specified is service of notice upon all insureds insured under one insurance policy. All bills, correspondence and other mailed material also will be sent to that person or entity at that address.

Address:

City:  State: **NY** Zip Code:

Telephone:  Fax:  E-Mail:

NEW YORK STATE COUNTY FOR THE EMPLOYER'S MAIN WORK LOCATION:

IS THE WORK LOCATION SHOWN ALSO THE EMPLOYER'S MAILING ADDRESS?  YES  NO

IF NO, PLEASE PROVIDE THE MAILING ADDRESS:

Address:

City:  State:  Zip Code:

(4) DO YOU HAVE A REPRESENTATIVE?  YES  NO

(4a) IF YES, PLEASE ENTER INFORMATION ON YOUR REPRESENTATIVE:

Name:  Requested NYSIF Group No.:

Address:

City:  State:  Zip Code:

Telephone:  Fax:  E-Mail:

(5) HOW LONG HAS YOUR COMPANY BEEN IN BUSINESS?  YEARS  MONTHS

(6) HAVE YOU EVER BEEN INSURED FOR WORKERS' COMPENSATION?  YES  NO

(6a) IF YES, PLEASE PROVIDE INFORMATION ON YOUR WORKERS' COMPENSATION EXPERIENCE FOR THE PAST 5 YEARS:

Year	Insurer	Policy #	Annual Premium	# of Claims	Total Incurred Claims Cost	Amount Paid

Attach a separate sheet if additional space is needed.

(7) IF KNOWN, PLEASE ENTER YOUR LATEST EXPERIENCE MODIFICATION FACTOR AND EFFECTIVE RATING DATE:

Experience Modification Factor:  Effective Rating Date:



QUESTION (11) CONTINUED

Description	Duties	# of Employees	Annual Payroll
CLERICAL OFFICE EMPLOYEES			
SALESPERSONS / COLLECTORS / MESSENGERS			
EXECUTIVE OFFICERS / PARTNERS / MEMBERS / SELF-EMPLOYED			
OTHER-DESCRIBE			
OTHER-DESCRIBE			
OTHER-DESCRIBE			

Attach a separate sheet if additional space is needed.

(12) IF YOU ARE A CORPORATION, IN WHAT STATE ARE YOU INCORPORATED?

(12a) DATE OF INCORPORATION:  /  /

(13) LIST ALL BUSINESS LOCATIONS TO BE COVERED IN NEW YORK STATE:  
(P.O. BOX IS NOT ACCEPTABLE AS A LOCATION. ONLY NEW YORK STATE LOCATIONS CAN BE COVERED.)

Street Name	City	State	Zip Code	# of Employees
		NY		
		NY		
		NY		

Attach a separate sheet if additional space is needed.

(14) ADDITIONAL INFORMATION ON THE EMPLOYER(S) SEEKING COVERAGE, LISTED IN QUESTION (2):

Name of Employer(s)	Federal Tax ID	NYS Unemployment ID

Attach a separate sheet if additional space is needed.

(15) WHAT IS THE NAME AND ADDRESS OF YOUR BANK?

Bank Name:

Address:

City:  State:  Zip Code:  -

(16) INFORMATION ON THE PERSON YOU WISH US TO CONTACT FOR A PREMIUM AUDIT:

Name:

Address:

City:  State:  Zip Code:  -

Telephone:  Fax:  E-Mail:

(17) PLEASE PROVIDE INFORMATION ON THE SOLE PROPRIETOR, ALL EXECUTIVE OFFICERS, PARTNERS, ELECTED OR APPOINTED OFFICIALS, OR MEMBERS OF GOVERNING BOARDS, IF APPLICABLE:

First Name :  MI:  Last Name:

Title:  Annual Salary:

Duties:

Address:

City:  State:  Zip Code:  -

Telephone:  Fax:  E-Mail:

First Name :  MI:  Last Name:

Title:  Annual Salary:

Duties:

Address:

City:  State:  Zip Code:  -

Telephone:  Fax:  E-Mail:

First Name :  MI:  Last Name:

Title:  Annual Salary:

Duties:

Address:

City:  State:  Zip Code:  -

Telephone:  Fax:  E-Mail:

Attach a separate sheet if additional space is needed.

(17a) IF ANY OF THE INDIVIDUALS LISTED IN QUESTION (17) IS A PARTNER OR CORPORATE OFFICER FOR A PARTNERSHIP OR CORPORATION OTHER THAN THE EMPLOYER(S) SPECIFIED IN QUESTION (2), LIST THE NAMES OF ALL SUCH PARTNERSHIPS AND/OR CORPORATIONS WITH THE PRINCIPAL BUSINESS ADDRESS AND, FOR A CORPORATION, THE PERCENTAGE OF STOCK OWNERSHIP.

First Name:  MI:  Last Name:   
 Name of Partnership or Corporation:  % of Stock:   
 Address:   
 City:  State:  Zip Code:

First Name:  MI:  Last Name:   
 Name of Partnership or Corporation:  % of Stock:   
 Address:   
 City:  State:  Zip Code:

Attach a separate sheet if additional space is needed.

(18) PLEASE PROVIDE INFORMATION ON YOUR DISABILITY BENEFITS INSURANCE:

Disability Benefits Carrier:  Disability Policy Number:

(18a) DO YOU WANT A DISABILITY BENEFITS INSURANCE QUOTE?  YES  NO

(19) PLEASE PROVIDE INFORMATION ON YOUR GENERAL LIABILITY INSURANCE:

General Liability Insurance Carrier:  General Liability Policy Number:

(20) HAVE YOU EVER BEEN IN BUSINESS UNDER A DIFFERENT NAME?  YES  NO

(20a) IF YES, PLEASE COMPLETE:

Name(s) Used	Trade Name(s) (if any)	Date Usage of Name was Stopped or Changed

Attach a separate sheet if additional space is needed.

(21) IF YOU ARE INCORPORATED, HAVE THE PRINCIPALS OF THE CORPORATION PREVIOUSLY MANAGED A BUSINESS BY ANOTHER NAME?  YES  NO

(21a) IF YES, PLEASE COMPLETE:

Name(s) Used	Trade Name(s) (if any)	Date Usage of Name was Stopped or Changed

Attach a separate sheet if additional space is needed.

(22) IS YOUR BUSINESS OR COMPANY AN AFFILIATE OR A SUBSIDIARY OF ANY OTHER COMPANY?  YES  NO

(22a) IF YES, PLEASE COMPLETE:

Name of Affiliate or Subsidiary:	<input type="text"/>	Relationship:	<input type="text"/>	Present Workers' Comp. Carrier:	<input type="text"/>
Address:	<input type="text"/>				
City:	<input type="text"/>	State:	<input type="text"/>	Zip Code:	<input type="text"/>

Attach a separate sheet if additional space is needed.

(23) ARE YOU ENGAGED IN ANY OTHER TYPE OF BUSINESS?  YES  NO

(23a) IF YES, PLEASE DESCRIBE OTHER BUSINESS OPERATIONS INCLUDING THE PRODUCTS AND SERVICES SOLD:

Business Description (Attach a separate sheet if additional space is needed.)

(24) ARE SUB-CONTRACTORS OR INDEPENDENT CONTRACTORS USED?  YES  NO

(25) PAYROLL VERIFICATION:  
(This requirement does not apply to employers of domestic workers or to municipalities or other political subdivisions.)

At least one of the following items of payroll verification MUST accompany this application. Failure to provide payroll verification may result in rejection of your application for insurance. Please attach at least one of the following items to your application:

- A copy of your previous insurance company's premium audit bill showing the classifications and payrolls for the most recent policy period
- Copies of Federal Tax Form 941 for the last four quarters
- Copies of New York State Tax Form NYS-45-MN quarterly combined withholding, wage reporting and unemployment insurance return for the last four quarters

If none of the foregoing documents are available because you are a new business or did not have employees, then check this box:

(26) I UNDERSTAND THAT THE INFORMATION WHICH I HAVE PROVIDED ON THIS APPLICATION WILL BE USED TO CALCULATE MY WORKERS' COMPENSATION INSURANCE PREMIUM. I ALSO UNDERSTAND THAT I HAVE A CONTINUING OBLIGATION TO NOTIFY THE NEW YORK STATE INSURANCE FUND OF ANY CHANGES IN:

- THE KINDS OF WORK WHICH THE BUSINESS IS DOING
- THE SIZE OF OUR WORKFORCE
- THE SIZE OF OUR PAYROLL
- THE BUSINESS OWNERSHIP OR BUSINESS STRUCTURE

Print or Type Name of Owner, Partner or Officer:

Signature of Owner, Partner or Officer:

Date:

**PLEASE PRINT, SIGN AND MAIL YOUR COMPLETED APPLICATION ALONG WITH THE REQUIRED DEPOSIT**

**Applicant, please note:**

**INFORMATION YOU PROVIDE IS PROTECTED BY THE PERSONAL PRIVACY PROTECTION LAW**

The authority to obtain the personal information requested herein is found in Section 83 of the Workers' Compensation Law as supplemented by Sections 450.1, 450.3 and 450.5 of Chapter VI of Title 12( c ) of the Official Compilation of Codes, Rules and Regulations of the State of New York. The principal purpose for which the information is sought is to assist the New York State Insurance Fund in processing your insurance coverage with the New York State Insurance Fund and its release is governed by the limitations of the Personal Privacy Protection Law. This information will be maintained by the Director of Underwriting, New York State Insurance Fund, 199 Church Street, New York, NY 10007.

To ensure prompt service and processing, please mail your fully completed and signed application along with your deposit premium check and supporting documentation to:

NEW YORK STATE INSURANCE FUND  
DOCUMENT CONTROL CENTER – NEW BUSINESS  
1 WATERVLJET AVENUE EXTENSION  
ALBANY, NY 12206

For additional assistance, customer service and contact information:

Please visit our website at [WWW.NYSIF.COM](http://WWW.NYSIF.COM) or telephone us at 1-888-875-5790

**New York State Insurance Fund Workers' Compensation and Employers' Liability Application**