



NYSIF Disability Benefits Policyholders must provide a minimum of 30 days written notice to cancel a policy.

DB Policy Number: _____

Policyholder Name & Address: _____

Requested date of cancellation (if greater than 30 days): _____

In accordance with the provisions of the Workers' Compensation Law, § 226, we hereby give notice of our intention to withdraw from the New York State Insurance Fund.

We no longer need disability benefits/paid family leave coverage because:

- No employees Out of business Insurance Elsewhere

Other: _____



Employer's Signature

Date

Employer's Name (Print)

Title

Employer's Phone Number