NYSIF
New York State Insurance Fund

PO Box 66699; Albany, NY 12206
nysif.com

NYSIF Disability Benefits/Paid Family Leave 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

UDB-89 (5/22)

Submit completed, signed form to:
NYSIF
PO Box 66699
Albany, NY 12206

You may also email your form to
dbpolicy@nysif.com
or fax to **518-437-5278**