PO Box 66699; Albany, NY 12206
nysif.com

CANCELLATION REQUEST

Policyholder: ____ DB Policy #: ___________

Policyholder address: ____

____

Entity Number, if applicable: ____________________________

New York State Law requires a minimum of 30 days written notice to cancel this policy. All cancellations will be effective 30 days from the date this notice is received unless a date greater than 30 days has been requested.

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 insurance coverage because:

_____ No employees Date of last payroll: ___________

_____ Out of Business As of (date): ______________

_____ Insurance Elsewhere (See below)

_____ Other

Other: ____

____

Requested Date of Cancellation (if greater than 30 days): __________________

If you are replacing coverage elsewhere, including if coverage is being provided through an employee leasing agreement, and you have determined the new carrier, please provide the carrier details below:

Carrier: ____ Effective Date: ________________

Reason for Replacing Coverage: ____

____ ____________________
Employer's Signature Date

____ _________________________________
Employer's Name (Print) Title

Please return your completed, signed form to: PO Box 66699; Albany, NY 12206.
You can also fax it to: 518-437-5278 or email it to **DBPolicy@nysif.com**.