



REQUEST A QUOTE ON NYSIF.COM FOR EMPLOYERS

If you are a new customer, and would like to create a quote request, visit **nysif.com** and choose "Get a Quote" from the home page Quick Links.

On this page, you can choose from "Request a Workers' Comp Quote," "Request a Domestic Policy Quote" and "Request a Disability Benefits/PFL Quote."

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Request a Worker's Comp Standard Quote Online

Visit www.nysif.com and choose "Get A Quote" from the Quick Link.



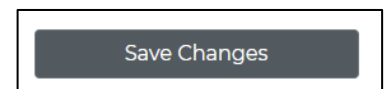
What Will I Need?

To obtain a workers' compensation quote, please have the following information available:

- FEIN (Tax ID)
- Business name and type (e.g. LLC, Corporation, Partnership, etc.)
- Estimated annual payroll, including casual labor, 1099 forms and any payments to uninsured subcontractors
- Payroll verification (copies of NYS Form NYS-45-MN and/or federal Form 941 for the last four quarters)
- Prior workers' comp insurance information, including loss experience (if applicable)

Save your quote

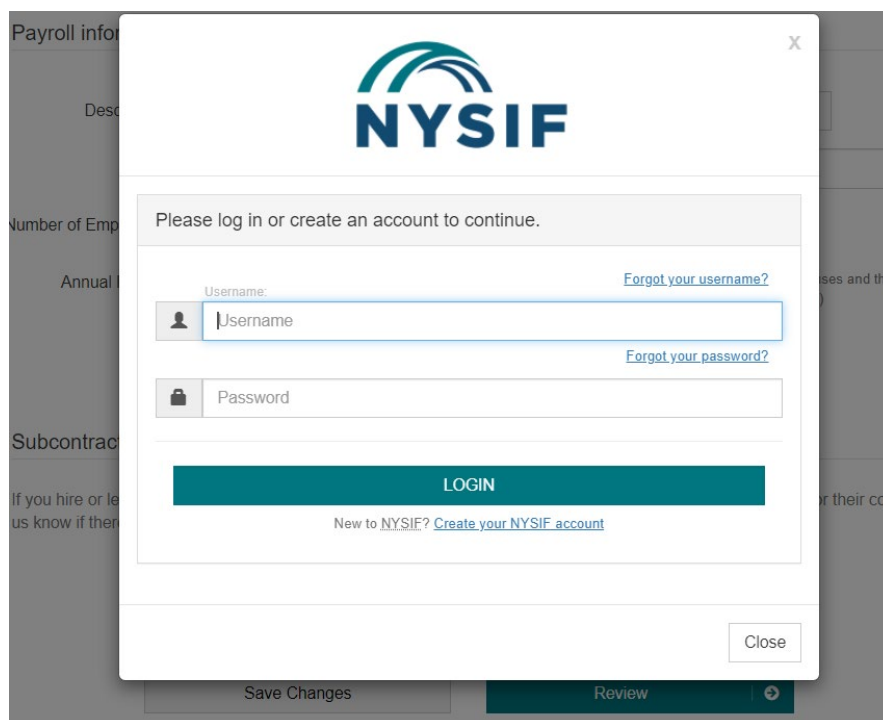
If you are unable to complete and submit your quote at any point in the process, save your form and you will be able to return to it later by logging into your online account. We recommend saving your form periodically while you are entering information.



Create an online account while requesting a quote

If you do not have a NYSIF online account, choosing "Save Changes" will prompt you to begin the online account creation process.

Choose "Create your NYSIF account" under the Login button.



If you are the officer listed, click your name. Complete the signup by choosing a username and password.

Are you one of the officers? X

If you are, we'll copy the form data for you. You'll still be able to make changes.

John Nysif

No, I'm someone else.

Close

Signup

First Name
* Betsy Bod

Last Name
* Testing

Title
* President

Telephone Number
Numbers only - with area code
*

Email Address
*

Verify Email
*

Username
Must be at least 8 characters long.
*

Password
*

Confirm Password

1. Enter Your FEIN (Federal Tax ID)

Online Quote Request Login

Home > Workers' Compensation Online Services > Request a Quote [Need Help?](#)

Request a Workers' Compensation Quote

Business (Employer) Identification Number

Please provide your Federal Tax ID. All fields are required unless otherwise stated.

Federal Tax ID
12-1212121

Confirm Federal Tax ID
12-1212121

We will need a FEIN to process your Quote. Don't have one? You can get an FEIN from [IRS.GOV](https://www.irs.gov)

Next

2. Confirm Employer Information

NYSIF will present you with your business name, based on the FEIN you entered. Confirm that the business shown is correct.

Please confirm your Business Name

ACME FENCE CO., LLC DBA ACME FENCE

No, that is not me Yes, that's me

3. Enter the Requested Effective Date of Insurance

Requested effective date of insurance

Requested Effective Date
07/28/2021 12:01 A.M., Eastern Standard Time

The earliest effective date is the day after you submit a fully completed application and the required deposit premium.

4. Business Information

Business (Employer) Information

Please provide the following information about the business.

Business Type
--- Select ---

- Select ---
- Corporation (For Profit)
- Corporation (Not for Profit)
- Corporation (Religious, Charitable, Educational and Veterans Organization)
- Co-Partnership
- Individual
- Limited Liability Partnership
- Limited Liability Company
- Professional Service Liability Company
- Registered Limited Liability Partnership
- Political Subdivision
- Other - please specify

Is this a newly formed business?

Yes No

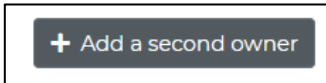
Yes indicates the business has no prior coverage and/or reported payroll history of any kind & has not operated under any other entity.

Years in Business
13 yrs.

Months in Business
0 months

5. Owner/Officer Information

Add a second officer or owner



Choose "Add a second owner" or "Add a second officer" if necessary. You can also add a "second partner" or "second member" if applicable.

If you need to remove an officer or owner, click the red box where you added the additional owner/officer. The information will be removed.

Owner/Officer Information

Please provide information on the sole proprietor, all executive officers, partners, elected or appointed officials, or members of governing boards, if applicable. List all such persons, regardless of whether they will be covered.

Owner Information

First Name	MI (optional)
Last Name	
Title -- Select --	
Duties	
Email	
Primary Telephone	
Annual Salary \$.00	

Cover this individual?

Yes No

6. Enter Address & Work Locations

TIP: "Copy from Mailing Address" will not work if your mailing address is outside New York State. Only New York locations can be covered.

Additional Locations

Add additional work locations as necessary. To remove, click the red box.

Addresses & Work Locations

Please provide the mailing address of the employer.

Address Line 1 PO BOX 594	Include Suite/Apt. when appropriate.
Address Line 2 (optional)	
City WARWICK	
State NY	Zip 10990

List all New York business locations to be covered.

Main Work Location

[Copy from Mailing Address](#) ↓

Street Address	A post office box (P.O. Box) is not acceptable as a location.
City	
State NY	Zip
Number of Employees	

Only New York State locations can be covered.

7. Other Entities

Other Businesses (Entities)

List all other businesses (employers) that you are seeking to cover under this policy. This means any business requiring coverage under this policy that operates under a different FEIN (Federal Employer Identification Number) and/or a separate set of payroll records. For each additional business listed, required forms must be submitted to determine whether it meets the requirements to be written under a single policy.


Are there additional entities to be covered?


Yes No

Business information

Business Type
--- Select ---

Business Name

Business Telephone 

Federal Tax ID 

Don't have one? You can get an [FEIN](https://www.irs.gov) from [IRS.GOV](https://www.irs.gov)

8. Workers' Comp History

Please note:

- If any current relationship exists, NYSIF is not required to issue a policy until all unpaid billed premium on the prior policy is paid.
- If the employer had a prior NYSIF policy that was cancelled, NYSIF is not permitted to issue another policy while any billed premium on that prior policy remains uncollected.

Enter prior coverage information. If you would like to add an additional policy year, choose "Add a second policy year."

Workers' Comp History

Have the employer(s) seeking coverage or their executive officers, partners, elected or appointed officials, or members of governing boards been insured for workers' compensation?

Yes No

Please provide the employer's workers' compensation experience for the latest five years.

These amounts can be found on your loss runs from your current workers' compensation carrier. A copy of loss runs and audit bills from prior insurers will be required.

Prior Coverage Information

Policy Year	Annual Premium \$.00
Number of Claims	Total Incurred Cost \$.00

Employer Rating History

If known, please enter employer's NYCIRB number, latest experience modification factor and the effective rating date.

Employer Rating History

If known, please enter employer's NYCIRB number, latest experience modification factor and the effective rating date.

01/01/2021

9. Business Description

Be as thorough as possible when entering your business description. Include all aspects/operations of your business.

Business Description

Describe business operations
ex. "Tavern (150 seat) open 11 am to 4 am daily - no prepared food - no entertainment"

512 characters left

If the employer is a manufacturer include the raw materials, process, products and equipment used or produced. If the employer is a contractor or engaged in construction then describe the type of work performed including the work performed by subcontractors. If engaged in merchandise, wholesale or retail trade, describe the merchandise sold, types of customers and deliveries. If engaged in a service business describe the type of service performed and location(s) of such service. If engaged in farming include acreage, types and numbers of animals, machinery used and subcontracts.

10. Payroll Information

In the description field, start typing a key word that best identifies the class code you are seeking. If you know the class code, you can also enter that directly. Enter the number of employees, annual payroll and additional payroll groups as needed.

Payroll Information

Please list your estimated annual payroll by the type of work and duties for all your employees. If the official(s) has elected to be excluded from coverage, **do not** include their annual payroll.

Payroll information

6400 - Fence Erection (Metal)

\$.00

Payroll is considered gross payroll plus any cash bonuses and the value of any goods/services given in trade (i.e. lodging, store credit)

Subcontractor and Other Employer Information

If you hire or lease an employee who is not covered by a valid workers' compensation policy, you will be liable for their coverage. Please let us know if there are any such workers, regardless of their coverage.

Subcontractor and Other Employer Information

If you hire or lease an employee who is not covered by a valid workers' compensation policy, you will be liable for their coverage. Please let us know if there are any such workers, regardless of their coverage.

We use subcontractors, independent contractors or 1099 employees.

We lease employees to or from other employers.

Reviewing your quote; submission

Once you have completed all fields, choose **Review**. You will be able to view your quote request in its entirety and print if needed.

If your application is incomplete, you will receive an error message. Click Close, and the error/missing info will be identified.

Invalid or incomplete information ✕

Please resolve any of the validation messages before continuing.

***TIP:** Clicking "Review" does not submit. Once you review, you must scroll to the bottom, check the box and choose **Get a Quote**.*

Once you've reviewed, if you are ready to submit your request, check the box certifying the information is correct and choose **Get a Quote**.

I certify the above information is correct and true to the best of my knowledge.

Confirmation of Submission of Quote

Once submitted, a confirmation screen will display your quote ID and contact information for the underwriter assigned to your quote.

Your Workers' Compensation Insurance Quote has been Submitted

Thank you for submitting your online quote. Your quote reference # is **5270013**.

You will be contacted by your policy representative shortly. If you have any questions, please feel free to contact:

John Nysif
NYSIF Policy Representative

Phone (212) 222-2222
Email: jnysif@nysif.com

We look forward to being your workers' compensation insurance provider!

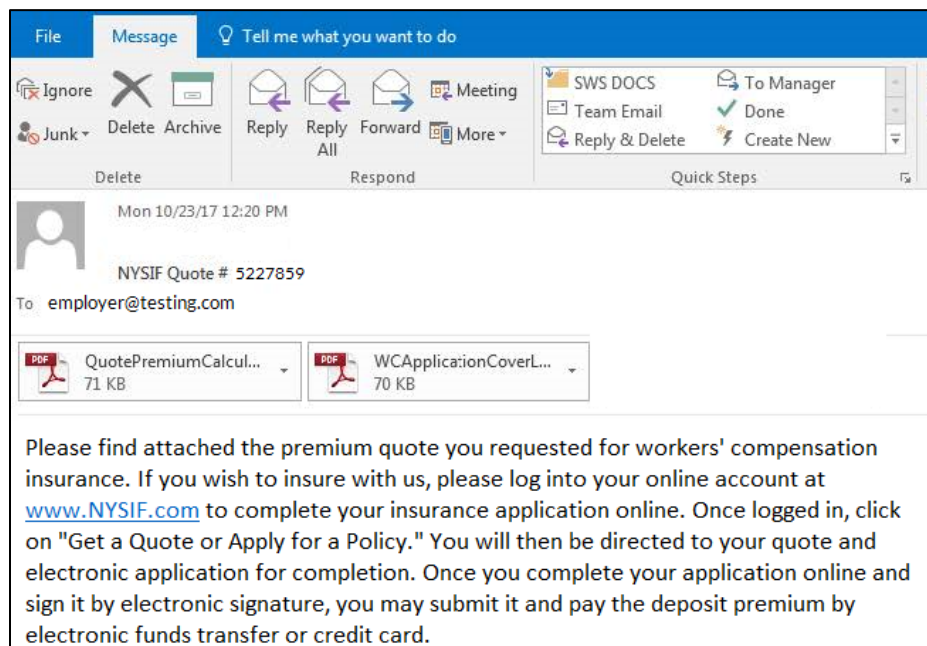
Once your quote is submitted, you will be able to view it via your online account. Visit nysif.com, log in, and choose "Get a Quote" from your landing page. The quote will appear there.

Please note you will not be able to edit the quote request once it has been submitted.

Request a Workers' Compensation QuoteRef #5270013

This quote request has been submitted. No further changes may be made.

You will receive an email from NYSIF with a quote for premium. If you'd like to apply for coverage based on that quote, log in to your nysif.com account to complete an online application.



The screenshot shows an Outlook email interface. The subject is "Request a Workers' Compensation Quote" and the sender is "NYSIF". The email body contains the following text:

Mon 10/23/17 12:20 PM

NYSIF Quote # 5227859

To: employer@testing.com

Attachments:

- QuotePremiumCalcul... 71 KB
- WCApplicationCoverL... 70 KB

Please find attached the premium quote you requested for workers' compensation insurance. If you wish to insure with us, please log into your online account at www.NYSIF.com to complete your insurance application online. Once logged in, click on "Get a Quote or Apply for a Policy." You will then be directed to your quote and electronic application for completion. Once you complete your application online and sign it by electronic signature, you may submit it and pay the deposit premium by electronic funds transfer or credit card.

Applying for WC Coverage Online

Log back in to your nysif.com account. Choose **Get a Quote or Apply for a Policy.**

Choose "Continue to Online Application" for the appropriate quote.

Get a Standard Quote		Get a Domestic Worker Quote	
Quote Requests			
Quote #	Employer Name	...	
5237565	CUSTOMER APPLIED BROKER CORP	Status:	Policy Created
		Received:	06/21/2019
		Expires:	08/20/2019
		Options:	View Application
5237477 🏠	HOME OFFICE	Status:	Quote Created
		Received:	06/19/2019
		Expires:	08/18/2019
		Options:	Continue to Online Application

1. Complete the application.
2. The box to electronically sign and pay online will be checked by default. **If you uncheck this box, you must print your application and mail it with a check for your deposit.**

3. Identify the signer.
4. Agree to NYSIF's User Agreement. Click **Submit.**

Apply for Coverage

Electronically sign and pay online.
Please note that completing the process online will expedite processing.

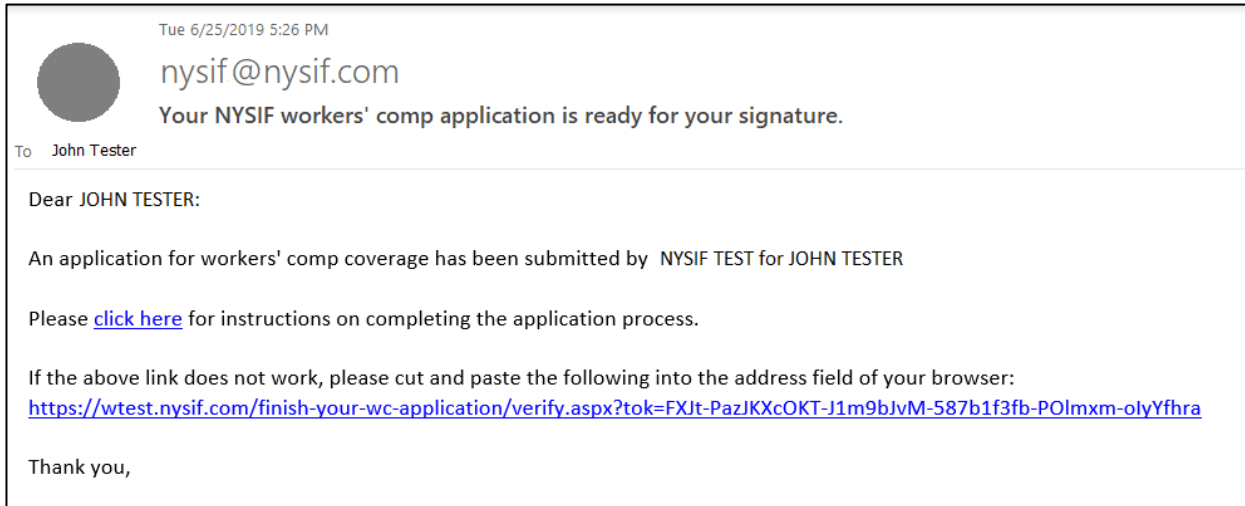
Identify the signing employer:

DANIEL NYSIFTEST (testing@nysif.com)

We will notify the signer via email.

Submit

The signer will receive a DocuSign request from NYSIF.



Click the link in the email and enter the zip code of the business for which the quote was created.

TIP: If you are an out-of-state business, enter the zip code of your main New York State location.

When you have authenticated by entering your zip code, you will be presented the opportunity to electronically sign and pay online.

Continue To Your Application

Please enter the five-digit ZIP Code of the primary business location:

Continue to Electronic Signature

ATN #: 2374659719 - Quote #: 5241475

TIP: Please have your checking account or credit information available before beginning this process.

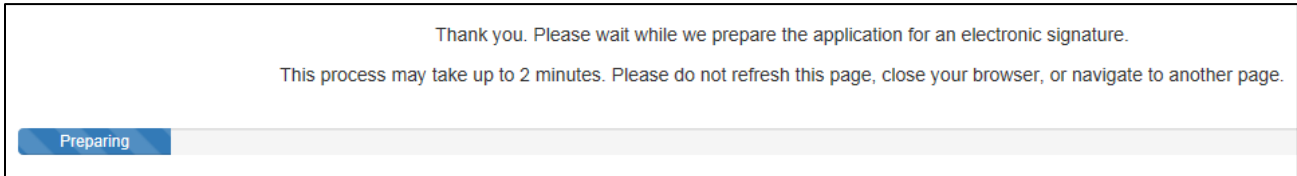
TIP: We also recommend you download a copy from DocuSign prior to beginning the electronic signature process.

Application – Sign Online & Pay Online

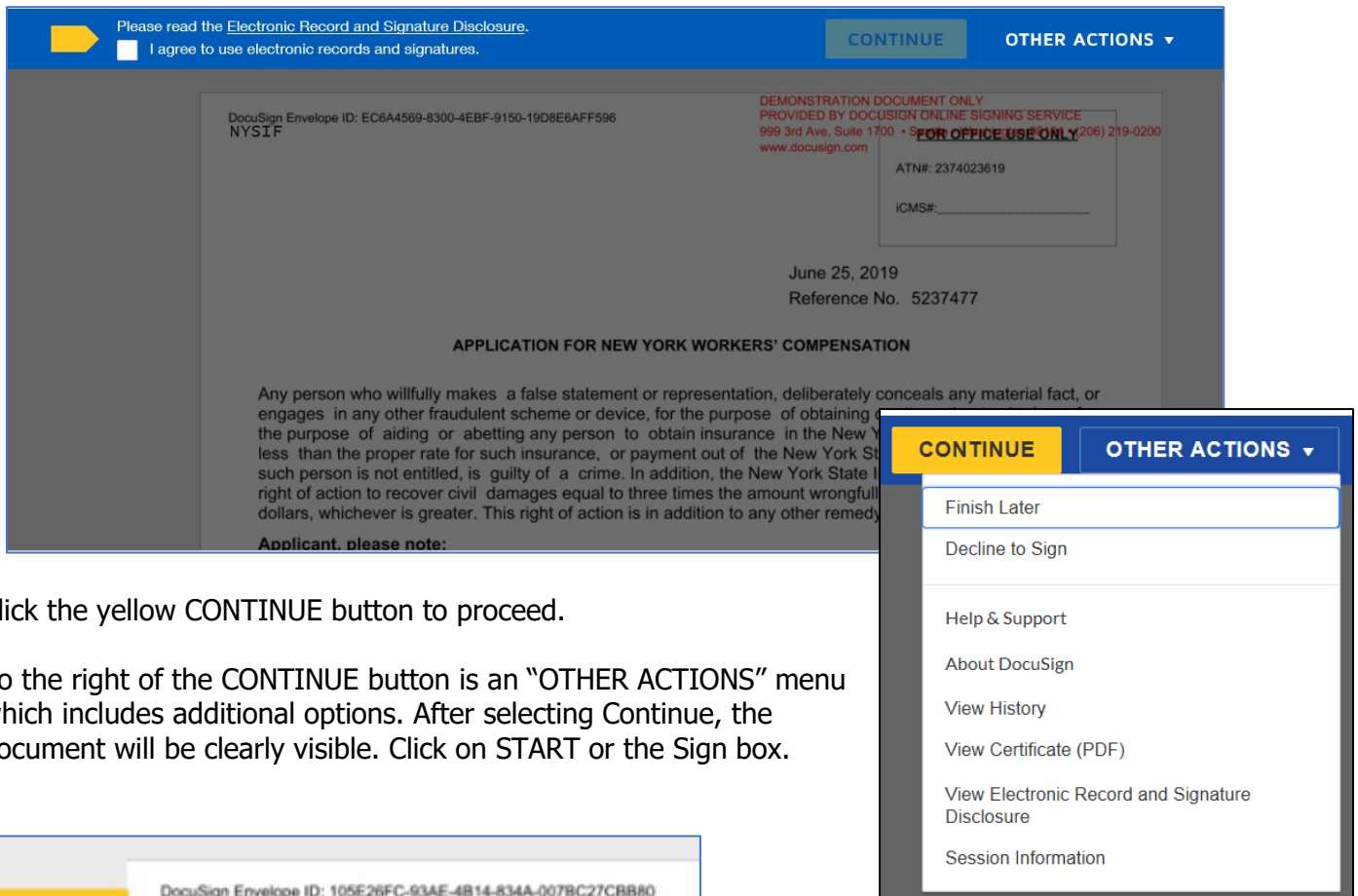
Once you've clicked submit, you will be redirected to DocuSign.

DocuSign

After submitting, allow time for page to load. Please do not close your browser or open another page as you are sent to DocuSign for electronic signature.



You must check the box to agree to use electronic records and signature.



Click the yellow CONTINUE button to proceed.

To the right of the CONTINUE button is an "OTHER ACTIONS" menu which includes additional options. After selecting Continue, the document will be clearly visible. Click on START or the Sign box.

Adopt Your Signature

Confirm your name, initials, and signature.

* Required

Full Name* Initials*

SELECT STYLE DRAW

PREVIEW Change Style

DocuSigned by:

Testing Nysif DS

04D6AE91232D4DB... TN

By selecting Adopt and Sign, I agree that the signature and initials will be the electronic representation of my signature and initials for all purposes when I (or my agent) use them on documents, including legally binding contracts - just the same as a pen-and-paper signature or initial.

ADOPT AND SIGN CANCEL

The screen will gray out the document, and a pop-up box will open with the user's name pre-populated. DocuSign will convert the name into a signature. There is also an option to create a free-hand signature by selecting the Draw option. Once a signature has been created, the user must choose **ADOPT AND SIGN** to electronically sign the document.

DocuSign will insert the signature into the application.

Done! Select Finish to send the completed document. **FINISH** OTHER ACTIONS ▾

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

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 Section 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.


IF YOU HAVE ANY QUESTIONS REGARDING THIS APPLICATION PLEASE CONTACT:


Underwriter: Phone Number: Fax Number: Email:

Click **Finish**. You will receive an email from DocuSign with a copy of the document.

Completed: **Signature Request on Application from New York State Insurance Fund - ATN# 1234567890**

To: John Tester





Your document has been completed

[VIEW COMPLETED DOCUMENT](#)

WC App
nysifapp@nysif.com

All parties have completed Signature Request on Application from New York State Insurance Fund - ATN# 1234567890

Pay Your Deposit Online

Electronic Signature Received

ATN #: 2374595319 - Quote #: 5240725

Pay Deposit

Our records indicate you have completed the electronic signature on your application. To view your signed application, please refer to the confirmation e-mail you received from DocuSign.

Once you have completed the DocuSign process, you will be directed to pay your deposit electronically through NYSIF's electronic payment vendor, KUBRA.

Choose the payment amount, indicate if you are the applicant or third-party payer and click **Submit ePayment**.

Make a Deposit Payment

ATN #: 12345678 Quote #: 5240725

To electronically pay your application deposit please select your payment amount and indicate if you are the applicant or a third-party payer. Click the Submit e-Payment button to continue.

Please note: NYSIF requires a minimum deposit of \$269.16 before your application can be approved. Any amount in excess of your required deposit will be applied to your next premium payment.

Payment Amount:

Minimum Deposit (\$269.16)*
 Total Premium (\$269.16)
 Other

Pay Type:

Submit ePayment

*Total amount required to issue coverage. This amount does not reflect previous payments.

You will be directed to the **KUBRA** website (our electronic payments vendor). Click "Go to Checkout."

NYSIF | Payment Center Get Help 1 item(s) Your Cart

Your Payment Cart

Application Number	Insurance Product	Deposit Due
000999888777	WC	\$730.76
Total Payment		\$730.76

[Go to Checkout](#)

©2020 KUBRA [Terms & Conditions](#) | [Privacy Policy](#) | [Site Map](#)

Payment Options

Cart Items	Payment Amount
1	\$730.76

Application Number	Deposit Due
2375872520	\$730.76
Total	\$730.76

[Back](#)

How would you like to pay?

- [Bank Account](#)
- [Debit / Credit Card](#)

Add your bank or credit/debit card information.

Please note that KUBRA charges a 2.25% convenience fee for each credit card transaction.

Look Up Add **3** Check Out 4 Done

Enter Bank Account

Bank Account Type
 Checking Savings

Routing Transit Number
Routing Transit Number

Bank Account Number Confirm Bank Account Number

Account Holder Name
Account Holder Name

[Back](#) [Next](#)

Where do I find my bank info?
Your bank account info can be found on a check for the account.

MEMO
⑆331674485⑆ 1456874801 ⑈ 3321
Routing Number Account Number Check #
⑆331674485⑆ 1456874801 ⑈ 3321

✓ Look Up ✓ Add **3** Check Out 4 Done

Enter Card Information

Card Number

Card Holder Name

Supported Cards

Back

Next

Enter your receipt information; an email address is required. Check the box and add your mobile number if you would like text verification.

Enter Your Receipt Info

Name

Phone Number

Send receipt to my mobile phone NEW! ?

Email

+ Add more email recipients

Enter your mobile number and get your payment receipt sent to your mobile phone for easy access.


Back

Next

Review your payment details.

Review Your Payment Details

Total Payment **\$747.20** Payment Date **Jun 30, 2020**

Application Number	Pay By	Service Fee	Deposit Due	Total
000999888777	 (9130)	\$16.44	\$730.76	\$747.20
Total Payment				\$747.20

A receipt will be sent to testing@nysif.com
 Text -


*Please note the full amount of the \$16.44 fee is passed to KUBRA as the provider of the service.
By clicking Pay, I agree to the fee and the [Terms & Conditions](#).

If you are ready to pay, choose the green button. A confirmation will display.

Look Up Add Check Out **4 Done**

Your payment was successful

Your payment of **\$747.20** has been processed.
A payment receipt has been emailed to testing@nysif.com.

Policy Number	Confirmation #	Details	Status	Amount
000999888777	123456789	Processed successfully		\$747.20
Total Payment				\$747.20

You will receive an email confirmation of payment. Click "Done" to return to nysif.com.

Application – Mail Your Signed Application & Check Payment

Complete the application. **Uncheck** the box to sign and pay online.

Agree to NYSIF's User Agreement. Click **Submit**.

Apply for Coverage

Electronically sign and pay online.
Please note that completing the process online will expedite processing.

I agree to the New York State Insurance Fund [User Agreement and Privacy Policy](#).


Submit

Print your application and sign. Mail your application and payment to the address below. **Be sure to include the ATN or reference number on your check.**

NYSIF
PO Box 66699
Albany, NY 12206

Thank you for submitting your Workers' Compensation Application,

You must now print, sign and mail the Application along with the required deposit.

[Get Application PDF](#) 

Because you have declined to sign the application via DocuSign, please mail a signed copy of the application to the following address:

NYSIF
PO Box 66699
Albany, NY 12206

Enclose a check for your deposit, payable to "New York State Insurance Fund."

This deposit is required before your application can be approved.

Request a Domestic Household Workers' Comp Quote

Choose "Get a Domestic Worker Policy Quote."

The two classifications of domestic workers are inside and outside. They are further categorized by the number of hours they work a week.

Inside domestic workers are employees exclusively engaged in household or domestic work primarily performed inside the residence. Examples: cook, housekeeper, home health aide, babysitter.

- **Domestic Full Time – Inside** (Inside domestic who works more than 20 hours per week)
- **Domestic Part Time – Inside** (Inside domestic who works 20 hours or less per week)


Outside domestic workers are employees exclusively employed in household or domestic work primarily performed outside the residence. Examples: private driver, gardener.

- **Domestic Full Time – Outside** (Inside domestic who works more than 20 hours per week)
- **Domestic Part Time – Outside** (Inside domestic who works 20 hours or less per week)

Enter the requested effective date of insurance. Enter the payroll information for the type of domestic coverage you need, using the descriptions above as a guide. Enter the duties and number of employees. Add a second group as needed.

Enter the employer information, the FEIN and the mailing address.

Requested effective date of insurance


Requested Effective Date
07/29/2021  12:01 A.M., Eastern Standard Time

The effective date must be at least one business day from today's date in order to allow sufficient time for us to process your request.

Employee Information

Please list the type of work and duties for all your employees. All fields are required unless otherwise stated.


Payroll information

Description
Domestic Part Time - Outside 

Domestic Workers (outside) are employees engaged exclusively in household work performed outside the residence. Examples include a gardener or private driver.

Part-time / Occasional: Any household worker who is employed 20 hours or less per workweek.

Duties

Number of Employees 

[+ Add a second payroll group](#)

Once you submit, you will receive an instant quote for domestic policy coverage. Follow the steps in the standard quote process to apply and pay online.

Estimate Disability Benefits/Paid Family Leave Premium

Use our premium calculator to estimate a policy's premium. (While NYSIF offers a gender-neutral price for disability benefits coverage, statutory reporting mandates require NYSIF collect this information separately.)

Premium Calculator

Disability Payroll

STATUTORY
Disability insurance claim benefits equal $\frac{1}{2}$ the average weekly wage of the employee, up to a maximum of \$170 per week for 26 weeks (if required) within a 52 week period.

ENRICHED
Disability insurance claim benefits equal $\frac{1}{2}$ the average weekly wage of the employee, for the "Selection of Coverage" at the "Maximum Weekly Claim Benefit", for 26 weeks (if required) within a 52 week period.

Choose One

Statutory Benefit Coverage (minimum required New York State disability benefits insurance)

Enriched Benefit Coverage

Male

Enter number of covered employees

Enter limited* employee wages

Female

Enter number of covered employees

Enter limited* employee wages

*Annual premium for Disability Benefits Insurance is calculated based on an employee's estimated annual wages. Wages are limited to the first \$17,680 each employee earns during a policy period. If an employee is expected to earn less than \$17,680 during the policy period, then the lower amount should be provided. If an employee is expected to earn more than \$17,680, then only the first \$17,680 of their wages should be provided.

Paid Family Leave (PFL) Payroll

Male

Enter number of covered employees

Enter limited** annual wages

Female

Enter number of covered employees

Enter limited** annual wages

**Annual premium for Paid Family Leave coverage is calculated based on an employee's estimated annual wages. For 2021, annual wages are limited to the first \$75408.84 each employee earns. If an employee is expected to earn less than \$75408.84 annually, then the lower amount should be provided. If an employee is expected to earn more than \$75408.84 annually, then only the first \$75408.84 of their wages should be provided.

Request a Disability Benefits/Paid Family Leave Quote

Visit www.nysif.com and choose "Get A Quote" from the Quick Link

(While NYSIF offers a gender-neutral price for disability benefits coverage, statutory reporting mandates require NYSIF collect this information separately.)



NYSIF Disability and Paid Family Leave Benefits Insurance Quote System

Get your **NYSIF** disability and paid family leave benefits quote in minutes!

Please note that completing and submitting this form does not bind coverage. All policies require underwriting approval. Please allow 10-14 days for your disability and paid family leave benefits insurance policy to become effective.

New York State requires employers to provide short-term disability and paid family leave benefits insurance for their employees. NYSIF provides employers with New York State mandated disability and paid family leave benefits insurance to cover your employees in compliance with this requirement.

Within moments of answering the questions that follow, you will receive a reference number and an annual premium estimate for **NYSIF** disability and paid family leave benefits insurance. Receiving this quote does not guarantee coverage for **NYSIF** disability and paid family leave benefits insurance. You must complete and mail a disability and paid family leave benefits application to **NYSIF** with your premium deposit to bind coverage.

Get a New Quote

To receive a new quote, select the country of origin in which your business is headquartered, and click on "Get a New Quote".

[Get a New Quote](#)

Retrieve a Quote

Please enter your reference number to retrieve the information you previously submitted.

Reference Number*

Email Address*

[Retrieve a Quote](#)

1. Business Information

Legal Business Name*

Business Address (must use New York State address, no P.O. boxes)*
Address

City, State, Zip, Country*
City State Zip Code United States

Contact Information*

<input type="text" value="First Name"/>	<input type="text" value="Last Name"/>	<input type="text" value="Telephone"/>
<input type="text" value="Email"/>		

Legal Entity Type
Business Type
 Sole Proprietor Corporation LLC Partnership LLP Union

1. Confirm Employer Information

Your reference number is **012345**

Please save this reference number, you will need it should you wish to revisit your quote.

Please confirm your contact information.

Contact Information

Company Name	NYSIF QUOTE TESTERS
Business Type	Partnership
Address	15 COMPUTER DRIVE ALBANY, NY 12206
Phone	(123) 456-7890
First name	BETSY
Last name	NYSIF
Email	NYSIFTESTERS@NYSIF.COM

1. Business Information

2. Payroll Information

3. View Quote

\$2. Payroll Information

Your reference number is **012345**

Please save this reference number, you will need it should you wish to revisit your quote.

Premium is determined based upon the level of coverage chosen. NYSIF allows policyholders to choose the level of claim benefit for their employees.

- Statutory Benefit Coverage
50% of average weekly wage up to \$170 per week. (Minimum required New York State disability benefits insurance)
- Enriched Benefit Coverage
Provides greater disability claim benefits to qualified employees while satisfying the New York statutory requirement.

Disability Benefits (DB)

Males

Number of Covered Employees

3

Total Wages for All Employees

\$ 53040

Subject to an annual cap of \$17680, per employee

Total Gross Annual Payroll

\$ 500000

Females

Number of Covered Employees

8

Total Wages for All Employees

\$ 133760

Subject to an annual cap of \$17680, per employee

Total Gross Annual Payroll

\$ 710000

Paid Family Leave (PFL)

Males

Number of Covered Male Employees

0

Total Wages for All Covered Male Employees

\$ 0

(Subject to an annual cap of PFL \$75408.84, per employee)

Females

Number of Covered Female Employees

0

Total Wages for All Covered Female Employees

\$ 0

(Subject to an annual cap of PFL \$75408.84, per employee)

1. Employer Information

2. Payroll Information

3. View Quote

3. View Quote

Here is your Quote for NYSIF Disability and Paid Family Leave Benefits Insurance

Your reference number is **012345**. Please use this number when referencing your quote.

The annual premium for a policy is based on the total estimated annual gross capped wages for all employees.

The estimated premium in this quote is based upon the information entered in your quote request and may change based upon the actual payroll. A premium differential may be applied to the Disability portion of your policy when annual disability claims history is greater than the estimated annual premium.

STATUTORY DISABILITY BENEFIT QUOTATION			
	Payroll	Rate	Total
Estimated annual male capped wages	\$53,040	\$0.14 per \$100	\$74.26
Estimated annual female capped wages	\$133,760	\$0.14 per \$100	\$187.26
Disability Premium subtotal			
Adjustment for minimum disability premium			\$0.00
Total Disability Benefits Premium			\$261.52
PAID FAMILY LEAVE			
	Payroll	Rate	Total
Estimated annual male capped wages	\$226,226.52	\$0.511 per \$100	\$1,156.02
Estimated annual female capped wages	\$603,270.72	\$0.511 per \$100	\$3,082.71
Total Paid Family Leave Premium			\$4,238.73
Total NYSIF Premium			\$4,500.25
*PFL rates change annually based on calendar year.			
View Quote Letter		Continue to DB/PFL Insurance Application	

Once you submit your application electronically, you will be given the opportunity to pay your deposit online.

To submit your application by mail, please complete the form online, print and sign. Please include the required premium deposit and reference DBL **012345** on your check, made payable to NYSIF Disability Benefits. Mail the application and payment to:

NYSIF Document Control Center- Disability Underwriting
 1 Watervliet Avenue Extension
 Albany, NY 12206-1629

Policies cannot be backdated. Unless a future date of inception is requested on line 1 of the application, insurance coverage will begin the day after postmark.

Retrieve a Quote

Visit <https://www.nysif.com/DBL/Quote/Default.aspx>. Enter the reference number you were given when you began the quote process, along with your email.

You will be taken to Step 3, shown above, to complete your quote or application.

Retrieve a Quote

Please enter your reference number to retrieve the information you previously submitted.

Reference Number*

Email Address*

[Retrieve a Quote](#)

Apply for a DB/PFL Policy Online

New York State Disability and Paid Family Leave Benefits Application

1. Employer Information

Your reference number is **012345**.

Legal Business Name*

Federal Tax ID. If you do not have one, enter your SSN*.

Trade Name or Doing-Business-As-Name

Business Address must use New York State address, no P.O. boxes.*

City, State, Zip, Country*

Contact Information*

Mailing Address (if different than above)

Select Country

Address

City, State, Zip, Country

Policy Inception Date

Future Inception Date*

Note: Policy Inception Date will be 12:01 A.M. Eastern Standard Time following the postmark date or online submission date, unless a future date is indicated.

Legal Entity Type

Business Type*
 Sole Proprietor Corporation LLC Partnership OLLP Union Other

Are you a Not For Profit Corporation?*

Yes No

Nature Of Business

Standard Industrial Classification (SIC) Code

Do you have additional entities to add to this policy?
 Yes No

[1. Employer Information](#)

[2. Additional Entity](#)

[3. Coverage Information](#)

[4. Payroll Information](#)

[5. Insurance Broker/Representative](#)

[6. Corporate Officers, Owners, Partners or Members of the Organization](#)

[7. Payment Options](#)

[8. Application Submission](#)

3. Coverage Information

Your reference number is **012345**.

Does your organization desire all employees and corporate officers (officers applicable only to Corporations) working in New York State, as defined in and subject to New York State Disability Benefits Law, to be covered under this NYSIF Disability Benefits Insurance Policy?*

Yes No

Current Insurance Provider Information (if applicable)

Name of current Workers' Compensation Insurance provider

Name of current Disability Benefits Insurance provider

Dollar amount of Disability claims in the last 3 years

[1. Employer Information](#)

[2. Additional Entity](#)

[3. Coverage Information](#)

[4. Payroll Information](#)

[5. Insurance Broker/Representative](#)

[6. Corporate Officers, Owners, Partners or Members of the Organization](#)

[7. Payment Options](#)

[8. Application Submission](#)

4. Payroll Information

Your reference number is **012345**.

Coverage Options For Disability Claim Benefit Levels

Premium is determined based upon the level of coverage chosen. NYSIF allows policyholders to choose the level of claim benefit for their employees.

- Statutory Benefit Coverage-50% of average weekly wage up to \$170 per week. (minimum required New York State disability benefits insurance)
- Enriched Benefit Coverage-Indicate desired multiple of the statutory benefit: 1.5x, 2x, 2.5x, 3x, 4x, 5x (provides greater disability claim benefits to qualified employees while satisfying the New York statutory requirement)

Employee Contributions for Disability Benefits only

Indicate whether employees contribute to disability benefits (DB) insurance premium (do not include contributions toward Paid Family Leave):

- No, they do not contribute to DB insurance premium
- Yes, they contribute to DB insurance premium

Employers providing disability benefits insurance are entitled to withhold at a rate limited to 1/2 of 1 percent of the weekly wage of the employee (not to exceed \$0.60 per week for statutory benefits). Employers providing enriched benefits coverage are entitled to an employee contribution reasonably related to the value of benefit.

Disability Benefits (DB)

Males	Females
<p>Number of Covered Employees</p> <input style="width: 100%; height: 25px;" type="text" value="3"/> <p>Total Wages for All Employees</p> <input style="width: 100%; height: 25px;" type="text" value="53040"/> <p><small>Subject to an annual cap of 17680 per employee</small></p> <p>Total Gross Annual Payroll</p> <input style="width: 100%; height: 25px;" type="text" value="500000"/>	<p>Number of Covered Employees</p> <input style="width: 100%; height: 25px;" type="text" value="8"/> <p>Total Wages for All Employees</p> <input style="width: 100%; height: 25px;" type="text" value="133760"/> <p><small>Subject to an annual cap of 17680 per employee</small></p> <p>Total Gross Annual Payroll</p> <input style="width: 100%; height: 25px;" type="text" value="710000"/>

Paid Family Leave (PFL)

Males	Females
Number of Covered Male Employees <input type="text" value="0"/>	Number of Covered Female Employees <input type="text" value="0"/>
Total Wages for All Covered Male Employees	Total Wages for All Covered Female Employees

6. Corporate Officers, Owners, Partners, or Members of the Organization

List all Corporate Officers, Owners, Sole Proprietors, Partners, Members or Authorized Representatives of the Organization. This information is also required if the individuals reside Out-of-State.
 Your reference number is **012345**.

Officer 1 ● Application Signer

Country

Home Address (P.O. Box is not acceptable)

City, State, Zip, Country*

Contact Information*

Covered in Policy?*
 Yes No

NOTE: To submit this document online, instead of by mail, you must respond to identity affirming questions posed on the Docusign website. If you do not wish to respond to these questions, please submit this form by mail. All applications must be submitted by an officer or owner of the business.

I agree to the New York State Insurance Fund [User Agreement and Privacy Policy](#)

Print Application For Mailing

Submit Application Online

Previous

Electronic Signature
NYSIF

ID Check - Personal Information

Enter your home address. This information, along with your name will be used to generate a list of questions to verify your identity.

Required Information (Home Address) Optional Information

Name: _____

Street 1: _____ Last 4 digits of SSN: _____

Street 2: _____ Date of Birth: _____ / _____ / _____

City: _____

State: _____

Zip: _____ - _____

You must enter required and valid information before you can continue.

CONTINUE **CANCEL**

ID Check - Identification Questions

These questions are being generated as a means of an identity check requested by the document sender. None of this information is provided to the document sender or to anyone except you.

In which of the following housing complexes or communities have you ever lived or owned property?

NYSIF Estates Sunny Hills Estates
 Fordville 123 Main Street
 Heron Bay I have never been associated with any of these communities

Which of the following addresses have you ever been associated with?

111 Nysif Street 39 Route 99
 1724 56th Street 611 Hosta
 23 Main Road I have never been associated with any of these addresses

Which of the following corporations have you ever been associated with?

Combined Business Service Ltd Lifeline Associates
 ACME Fence Co Testing, Incorporated
 Evisionboard Inc None of the above

In which of the following counties have you ever lived or owned property?

Bronx, New York Nysif, New York
 County, New York Tompkins, New York
 Nassau, New York I have never lived in any of these counties

Based on your background, in what county is '11813 Northwest 79th Court'?

Alachua Florida
 Nysif County
 Broward I have never been associated with this address

If your answers do not meet DocuSign's criteria, your e-signature will be cancelled, and you must mail your application.

NYSIF's Online Messaging

Your electronic signature verification has failed. You may print the form from DocuSign and mail it in.

After successfully answering the questions on the ID Check, the user will advance through DocuSign.

The user must check the box to agree to use electronic records and signature, and then click the yellow CONTINUE button to proceed.

CONTINUE **OTHER ACTIONS** ▾

Please read the [Electronic Records and Signature Disclosure](#).

I agree to use electronic records and signatures.

To the right of the CONTINUE button is an "OTHER ACTIONS" menu which includes additional options. After selecting Continue, the document will be clearly visible.

CONTINUE **OTHER ACTIONS** ▾

- Finish Later
- Decline to Sign
- Help & Support
- About DocuSign
- View History
- View Certificate (PDF)
- View Electronic Record and Signature Disclosure
- Session Information

Click on START or the Sign box.

The screen will again gray out the document, and a pop-up box will open with the user's name pre-populated. DocuSign will convert the name into a signature. There is also an option to create a free-hand signature by selecting the Draw option. Once a signature has been created, the user must choose **ADOPT AND SIGN** to electronically sign the document.

DocuSign will insert the signature into the application. Click **Finish**. You will receive an email from DocuSign with a copy of the document.

Pay Your Deposit Online

Once you have completed the DocuSign process, you will be provided the option to pay your deposit electronically through NYSIF's electronic payment vendor, KUBRA. Choose the dollar amount and then click **"Make a Payment."**

New York State Disability and Paid Family Leave Benefits Application

- [1. Business Information](#)
- [2. Additional Entity](#)
- [3. Coverage Information](#)
- [4. Payroll Information](#)
- [5. Insurance Broker/Representative](#)
- [6. Corporate Officers, Owners, Partners or Members of the Organization](#)
- 7. Payment Options**
- [8. Application Confirmation](#)

7. Payment Options

Your pending Disability Benefits policy number is: DB0987654

You may click "Review/Print Application" to obtain a copy of this application for your records.

Review/Print Application

Click "Make a Payment" to complete and submit your application to NYSIF.

You must pay either the Total Annual Estimated Premium OR Minimum Deposit Required.

Total Annual Estimated Premium: \$282.90

Minimum Deposit Required: \$282.90

Make a Payment

Previous
Next

You will be directed to the **KUBRA** website. Click "Go to Checkout."

Your Payment Cart

Application Number	Insurance Product	Deposit Due
6640784	DB	\$282.90
Total Payment		\$282.90

Go to Checkout

Payment Options

Cart Items	Payment Amount	
1	\$282.90	

Application Number	Deposit Due	
6640784	\$282.90	
Total		\$282.90

Back

How would you like to pay?

Bank Account
>

Debit / Credit Card
>

Add your bank or credit/debit card information.

Please note that KUBRA charges a 2.25% convenience fee for each credit card transaction.

Look Up Add **3 Check Out** 4 Done

Enter Bank Account

Bank Account Type
 Checking Savings

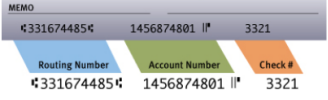
Routing Transit Number
Routing Transit Number

Bank Account Number Confirm Bank Account Number
Confirm Bank Account Number

Account Holder Name
Account Holder Name

Back Next

Where do I find my bank info?
Your bank account info can be found on a check for the account.



MEMO			
331674485	1456874801	11	3321
Routing Number	Account Number	Check #	
331674485	1456874801	11 3321	

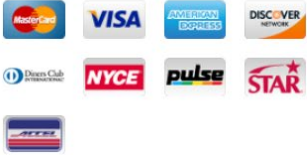
Enter Card Information

Card Number

Card Holder Name
Enter card holder's name

Back Next

Supported Cards



Enter your receipt information; an email address is required. Check the box and add your mobile number if you would like text verification.

Enter Your Receipt Info

Name

Phone Number
Enter your phone number


Send receipt to my mobile phone **NEW!** ?

Email
Enter your email address

+ Add more email recipients

Back Next


Enter your mobile number and get your payment receipt sent to your mobile phone for easy access.




Review your payment details.


Review Your Payment Details

Total Payment **\$289.27** Payment Date **Aug 19, 2020**

Application Number	Pay By	Service Fee	Deposit Due	Total
6640784	 (9130)	\$6.37	\$282.90	\$289.27
			Total Payment	\$289.27

A receipt will be sent to

 bmccorma@nysif.com

 Text - (518) 437 - 5215

*Please note the full amount of the \$6.37 fee is passed to KUBRA as the provider of the service.

By clicking Pay, I agree to the fee and the [Terms & Conditions](#).

[Back](#) **Pay \$289.27**


If you are ready to pay, choose the green button. A confirmation will display.

Look Up Add Check Out **4 Done**


Your payment was successful

Your payment of \$289.27 has been processed.
A payment receipt has been emailed to testing@nysif.com.

[PRINT RECEIPT](#)

Policy Number	Confirmation #	Details	Status	Amount
000999888777	123456789	Processed successfully	 PAID	\$289.27
			Total Payment	\$289.27

[Done](#) >

[Send Your Feedback](#) 

You will receive an email confirmation of payment. Click "Done" to return to nysif.com.