

# NYSIF.com Online Account User Guide POLICYHOLDERS September 9, 2022

## Contents

<b>Create an Account</b> .....	<b>3</b>
Workers' compensation policyholders .....	3
Disability benefits policyholders .....	4
<b>Enhanced Security Enrollment (Multi-Factor Authentication)</b> .....	<b>5</b>
<b>Online Account Management</b> .....	<b>6</b>
Forgot Password or Username: .....	6
Online Customer Account Administration .....	7
User Management (add or delete an authorized user) .....	8
Consolidate Online Accounts or Link Other Policy .....	11
Update Policy Contact Information .....	12
<b>Workers' Comp Policyholders</b> .....	<b>13</b>
Notification Center .....	13
Paperless Enrollment .....	14
Notification Management .....	15
Enrollments .....	17
Messages .....	17
<b>Granting Broker Claims Access</b> .....	<b>18</b>
<b>Report an Injury</b> .....	<b>19</b>
For New York State Agencies & Employees .....	27
NYSIF eFROI Worksheet .....	28
<b>Claim Search</b> .....	<b>30</b>
By Policy .....	30
By Claim Number .....	31
Master Claims Screen Tab .....	31
Notes Tab .....	35
Hearings Tab .....	35
Reserve History Tab .....	35
By WCB (or JCN*) Number .....	36
By Claimant Name .....	36
<b>Documents</b> .....	<b>37</b>
Policy Document Retrieval .....	37
Claims Document Retrieval .....	38
Policy Document Upload .....	38
Upload Audit Documents .....	39
<b>eCert Menu</b> .....	<b>43</b>
Browse Certificates .....	43
Create a New Certificate .....	45
Renew a Certificate .....	49
Validate/Subscribe to a Certificate .....	51
<b>Request a Worker's Comp Standard Quote</b> .....	<b>53</b>
Save your quote .....	53
1. Enter Your FEIN (Federal Tax ID) .....	53

2. Confirm Employer Information.....	53
3. Enter the Requested Effective Date of Insurance .....	54
4. Business Information .....	54
5. Owner/Officer Information .....	54
6. Enter Address & Work Locations .....	55
7. Other Entities .....	55
8. Workers' Comp History.....	55
9. Business Description .....	56
10. Payroll Information .....	57
Reviewing your quote; submission.....	57
<b>Applying for WC Coverage Online.....</b>	<b>59</b>
Application – Sign Online & Pay Online.....	61
Application – Mail Your Signed Application & Check Payment.....	67
<b>Request a Domestic Household Workers' Comp Quote .....</b>	<b>68</b>
<b>Risk Control Resource Center .....</b>	<b>69</b>
<b>Forms .....</b>	<b>70</b>
Create a C-105 (Notice of Compliance).....	70
Prescription Benefits .....	70
eSignature Forms .....	71
<b>Billing Menu .....</b>	<b>74</b>
Pay My Bill.....	74
Make a one-time payment .....	75
Enroll in AutoPay .....	76
Notifications .....	79
View Monthly Bills.....	80
<b>Policy Menu .....</b>	<b>81</b>
Account Summary.....	81
Earned Premium Audit (Audit Documents).....	82
Endorsements .....	85
Monitor Subcontractor Coverage.....	86
NYCIRB Rating Data.....	87
Payroll Reporting .....	88
Policy Information.....	93
Report Requests .....	94
Statement of Account.....	98
<b>Disability Benefits Policyholders.....</b>	<b>99</b>
Notification Center .....	100
Paperless Enrollment.....	100
Notification Management.....	101
Enrollments .....	102
Messages .....	102
Request a DB/PFL Quote .....	103
Apply for a DB/PFL Policy .....	106
Policyholder Services.....	114
View Entities.....	114
Certificates .....	114
Pay My Bill.....	116
Documents.....	116
Estimate Premium.....	117
Report Payroll.....	118
Claims Services.....	119
Claims Payment Report .....	119


# Create an Account

Visit nysif.com, choose "Login" at the top and click "[Create an Account](#)" from the dropdown menu. Choose the appropriate policy type (or both, if applicable).

## Workers' compensation policyholders

To register, you will need your NYSIF policy number and document number from your most recent Information Page **OR** the bill number from a recent statement.

<b>THE STATE INSURANCE FUND</b> 8 Corporate Center Dr, 2nd Floor, Melville, NY, 11747-3166 (888) 875-5790			
Document Type: <b>INFORMATION PAGE</b>	Group No: <b>090</b>	Period Covered: * <b>03/20/2022 TO 03/20/2023</b>	R.B. File No: <b>000287090</b>
INSURED: N 123 456-7			Policy No: <b>N 123 456-7</b>
ACME FENCE CO. 123 MAIN STREET ANYTOWN, NY 10001			Date: <b>01/31/2022</b>
			Document Number: <b>E10001551202</b>

 New York State Insurance Fund	<b>WORKERS' COMPENSATION ST.</b>
<b>ABC ROOFING INC.</b> 16 MAIN AVE ALBANY NY 12240	<b>Policy Number: G 012 345-6</b> <b>Bill Number: 61063018</b> Statement Date: December 29, 2021
<b>Previous Policy Balance</b>	<b>\$1,835.29</b>

### Contact Information

All fields are required unless otherwise stated.

#### Your Information

First Name
Middle Initial (optional)
Last Name
Job Title Select a Job Title
Company
Telephone Number <small>Numbers only - include area code</small>
Email
Verify Email

**Previous** **Next**

### Business Relationship

All fields are required unless otherwise stated.

Account Type Policyholder
------------------------------

You are creating an account for (select one or both):

**Workers' Compensation**

Disability Benefits

#### Workers' Compensation Policyholder Account Verification

Please enter your policy number. Next, please enter the Document Number from a recent [Information Page](#) or your Bill Number from a recent [Billing Statement](#) of your policy.

Policy Number <small>(Enter numbers only; do not include letters, dashes or spaces.)</small>
Document Number or Bill Number

## Choose Username and Password

All fields are required unless otherwise stated.

Username

Password

Password must contain at least 10 characters and include at least one of each: uppercase [A-Z], lowercase [a-z], numeric [0-9] and special [-!#\$%+?] characters

Confirm Password

## Terms & Conditions

By checking this box, I agree to the New York State Insurance Fund's [User Agreement](#) and [Privacy Policy](#).

Sign Up

Previous

Once you complete registration, you will be sent a confirmation email.

## Disability benefits policyholders

To register, you will need your NYSIF policy number, your FEIN and the mailing zip code for the policy.

## Disability Benefits Policyholder Account Verification

Disability Benefits Policy Number

FEIN

Mailing Zip Code

## Contact Information

All fields are required unless otherwise stated.

### Your Information

Email

Verify Email

Previous

Next

## Choose Username and Password

All fields are required unless otherwise stated.

Username

Password

Password must contain at least 10 characters and include at least one of each: uppercase [A-Z], lowercase [a-z], numeric [0-9] and special [-!#\$%+?] characters

Confirm Password

## Terms & Conditions

By checking this box, I agree to the New York State Insurance Fund's [User Agreement](#) and [Privacy Policy](#).

Sign Up

Previous

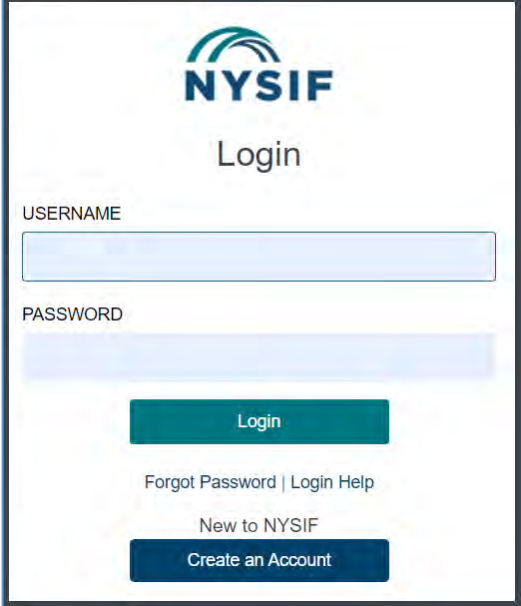
# Enhanced Security Enrollment (Multi-Factor Authentication)

NYSIF takes your privacy seriously. To protect the personal information of its customers, including health records, NYSIF has implemented an enhanced security feature (also known as multi-factor authentication) for all NYSIF online account holders. Enhanced security allows NYSIF to identify you as the true owner of your online account by adding a layer of protection against unauthorized access. We do this by sending you a one-time passcode, in addition to requesting your username and password.

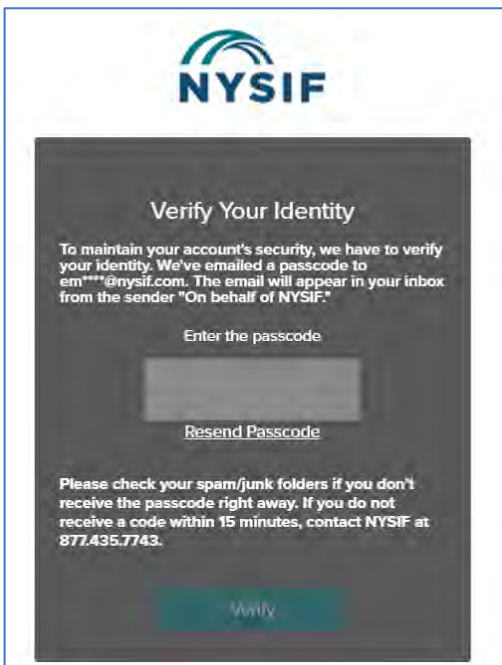
Please see the following screen shots for more information on how your account is enrolled in enhanced security.

## LOGIN

1. Visit [nysif.com](https://nysif.com). Click Login in the upper right corner.
2. Enter your username and password.

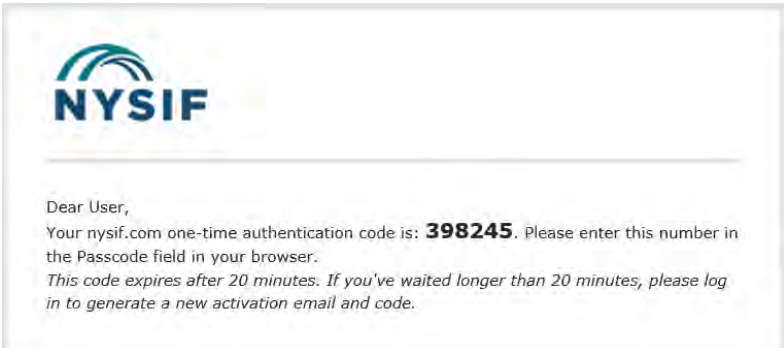


## Passcode

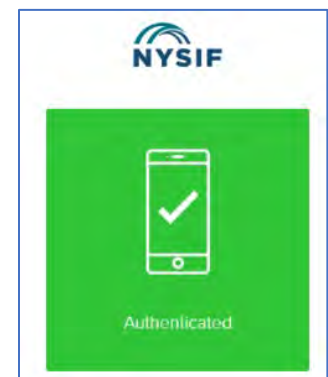


The first time you log into your NYSIF online account, you will be prompted to enter a passcode to verify your identity. The passcode will be sent to the email address associated with your NYSIF online account. At this time, you can only retrieve this passcode via email.

The passcode will expire after 20 minutes. The email will appear in your inbox from the sender **"On behalf of NYSIF."**



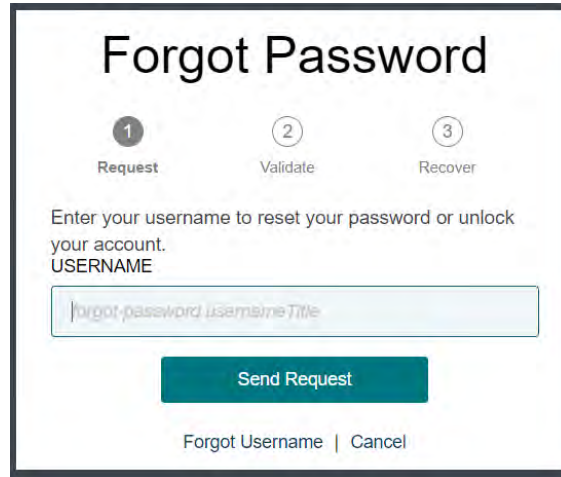
Enter the passcode in the field provided. Click "Verify." If authenticated, users will receive confirmation before being directed to their customer landing page or the application they were trying to reach.



# Online Account Management

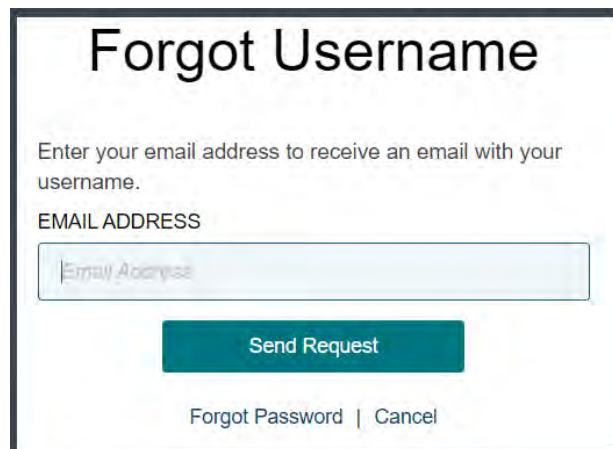
## Forgot Password or Username:

**I forgot my Password:** Click **LOGIN**. Click **NYSIF Login**. Click the **Forgot Password** hyperlink. Enter your username to reset your password or unlock your account. Click the **Send Request** button. A temporary password will be sent to the email address associated with the online account.



The screenshot shows a web form titled "Forgot Password". At the top, there are three numbered steps: 1. Request, 2. Validate, and 3. Recover. Below the steps, the text reads: "Enter your username to reset your password or unlock your account." followed by the label "USERNAME". There is a text input field with a light blue border and a placeholder text "forgot-password username Title". Below the input field is a teal button labeled "Send Request". At the bottom, there are two links: "Forgot Username" and "Cancel".

**I forgot my Username:** Click **LOGIN**. Click **NYSIF Login**. Click the **Forgot Password** hyperlink. Next, select the **Forgot Username** hyperlink. Enter your email address to receive an email with your username. Click the **Send Request** button. Our system will send the username associated with that email address to the email address.



The screenshot shows a web form titled "Forgot Username". The text reads: "Enter your email address to receive an email with your username." followed by the label "EMAIL ADDRESS". There is a text input field with a light blue border and a placeholder text "Email Address". Below the input field is a teal button labeled "Send Request". At the bottom, there are two links: "Forgot Password" and "Cancel".

**Verification Code Errors:** Once the NYSIF website generates a Verification Code, you **must not** leave the verification page/screen to access the email. Doing so will invalidate the code sent and a new code will need to be generated by clicking the Resend Code option. Please check your spam/junk folders if you don't receive the passcode right away. If you do not receive a code within 15 minutes, contact NYSIF at 888-875-5790 and select option "5", followed by option "1", and then option "1" again to reach the NYSIF Service Desk for assistance.



## Online Customer Account Administration

If you have both workers' compensation and disability benefits policies with NYSIF, you can toggle between accounts by choosing the appropriate tab at the top.

The screenshot shows the NYSIF Customer Account Administration interface. At the top, there is a navigation bar with the NYSIF logo, a user profile for 'nysiftest', and a 'Logout' button. Below this is a 'Customer Account' header with dropdown menus for 'WC Links' and 'DBL Links'. The main content area is divided into two tabs: 'Workers' Compensation Online Services' (selected) and 'Disability Benefits Online Services'. Under the selected tab, there is a 'Workers' Compensation Policy Summary' section. It includes a 'View Another Policy' dropdown menu with the value '01234567'. Below this are three columns of information: 'Policy Info', 'Billing', and 'Broker of Record'. The 'Policy Info' table shows Policy Number 01234567, Current Policy Period from November 1, 2018, to October 31, 2019, Policy Status as Active, and Information as of 10/10/2019. The 'Billing' table shows Current Balance of \$-1,184.27, Last Payment Posted of \$-363.60 on 09/13/2019, Minimum Amount Due Now of \$0.00, and Next Statement Due on 11/01/2019. The 'Broker of Record' table shows GENERAL INSURANCE as the Broker of Record, Telephone Number 5185551212, and Email Address testing@nysif.com. There are buttons for 'Pay Your Bill', 'View Monthly Bills', and 'Revoke Access'. A warning message states: 'Your Broker of Record has access to claims data. Claims data will be available for one year or until you decide to revoke access. You may revoke access at any time.'

To manage your online account, select Account Management from the dropdown menu under your username at the top right of the page.

This screenshot shows the user profile dropdown menu at the top right of the page. It includes the user name 'nysiftest' and a 'Logout' button. Below the user name, there are two options: 'Online Services' and 'Account Management', both with gear icons. To the right of the dropdown, there are 'WC Links' and 'DBL Links' dropdown menus.

### Administration Console

Choosing "Account Management" will bring you to your "Administration Console Home" page, where you can update your profile or password, add authorized users, consolidate your workers' comp and disability benefits customer accounts and manage email notifications.

### Update Email Address & Change Password

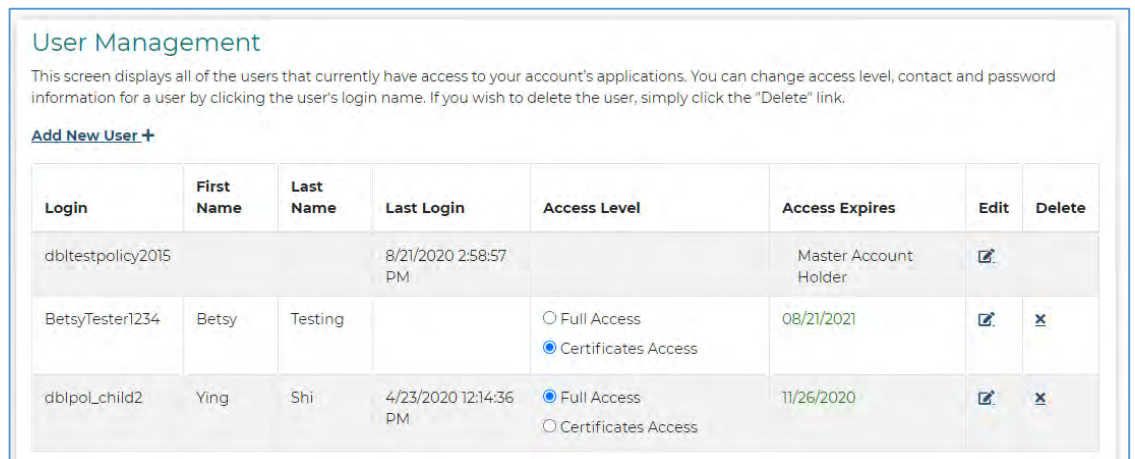
From your Administration Console under Profile Management, choose "Update Your Profile." Change your email address or password and submit.

The screenshot shows the Administration Console page. At the top, it says 'Administration Console' and 'Manage your NYSIF account using the links below.' There are six main sections, each with an icon and a title: 'Profile Management' (gear icon), 'Consolidate Accounts' (gear icon), 'User Management' (people icon), 'Link Account' (envelope icon), 'Help' (question mark icon), and 'Email Notifications' (envelope icon). Each section contains a brief description and a link to the corresponding functionality. For example, 'Profile Management' includes the text 'Review and update your account information at any time.' and a link 'Update Your Profile'. 'Consolidate Accounts' includes 'To achieve single sign on please consolidate your accounts.' and a link 'Consolidate'. 'User Management' includes 'Add new authorized users and manage existing users.' and a link 'Manage Users'. 'Link Account' includes 'Here you can add a new Disability Benefits Policyholder account to the current account.' and a link 'Link Account'. 'Help' includes 'Need technical help? Please contact the NYSIF Service Desk. 1-877-435-7743'. 'Email Notifications' includes 'Set email addresses for audit/infopage notifications.' and a link 'Notifications'.

## User Management (add or delete an authorized user)

Choose Account Management from the drop-down under your username. Select "Manage Users" under "User Management" to add, edit or delete an authorized user account. Please note: The master account holder chooses the level of access when creating the user account.

- "Full access" enables users to view **all policy, claims, certificates**, and Risk Control Resource Center information.
- "Certificates/Resource Center" allows users to create and download **certificates** and access the Risk Control Resource Center.
- "Risk Control Resource Center Only" allows users to access the Resource Center and Learning Management System.



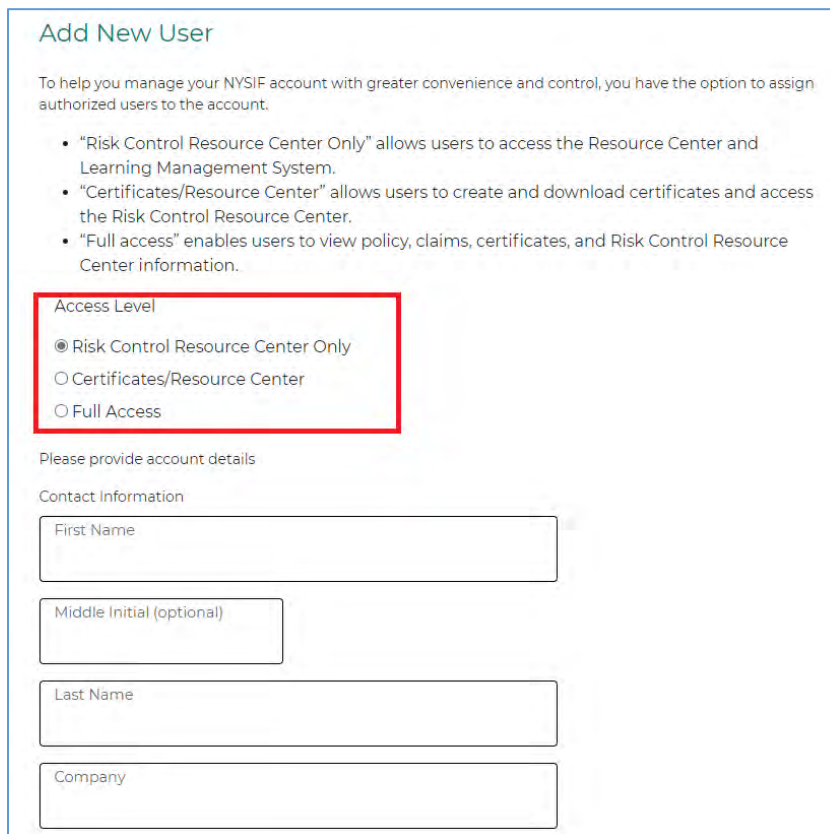
**User Management**

This screen displays all of the users that currently have access to your account's applications. You can change access level, contact and password information for a user by clicking the user's login name. If you wish to delete the user, simply click the "Delete" link.

**Add New User +**

Login	First Name	Last Name	Last Login	Access Level	Access Expires	Edit	Delete
dbtestpolicy2015			8/21/2020 2:58:57 PM		Master Account Holder		
BetsyTester1234	Betsy	Testing		<input type="radio"/> Full Access <input checked="" type="radio"/> Certificates Access	08/21/2021		
dblpol_child2	Ying	Shi	4/23/2020 12:14:36 PM	<input checked="" type="radio"/> Full Access <input type="radio"/> Certificates Access	11/26/2020		

Choose "Add New User+" to add a new user account. Complete all required fields.



**Add New User**

To help you manage your NYSIF account with greater convenience and control, you have the option to assign authorized users to the account.

- "Risk Control Resource Center Only" allows users to access the Resource Center and Learning Management System.
- "Certificates/Resource Center" allows users to create and download certificates and access the Risk Control Resource Center.
- "Full access" enables users to view policy, claims, certificates, and Risk Control Resource Center information.

**Access Level**

Risk Control Resource Center Only  
 Certificates/Resource Center  
 Full Access

Please provide account details

Contact Information

First Name

Middle Initial (optional)

Last Name

Company

***Please note that a master account is limited to 30 authorized user accounts.***



Username

New Password  
●●●●●●●●●●

(Password must contain at least 10 characters and include at least one of each: uppercase [A-Z], lowercase [a-z], numeric [0-9] and special [~!#\$%+<>?] character.)

Confirm New Password

(Password and Confirm Password must match.)

Save Changes Discard Changes

When adding a new user, in addition to contact information, you will be asked to choose a username and password for this individual. This person will receive a notification email from NYSIF advising him/her to obtain the username and password from you. The user will be prompted to change the password upon first login, and must enroll in our enhanced security protocol and accept NYSIF's Terms & Conditions before gaining access to the online account.

For edits to an existing user, make any changes and click Submit.

The master account holder will also receive a confirmation email.

**Please note that any authorized user added to this online customer account with **FULL ACCESS** will inherit nearly all\* permissions of the master account. This may include access to policy and claims information for both NYSIF workers' compensation and disability benefits clients. Please ensure that all authorized users understand the legal obligation to handle this sensitive and confidential information appropriately.**

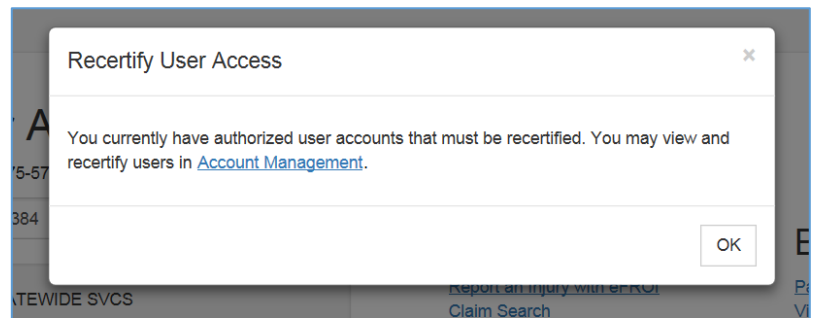
**\*Authorized users cannot create other authorized user accounts, edit/delete user accounts or grant claims access to brokers.**

## Recertifying Authorized Users

NYSIF has established a recertification process for authorized user accounts. The master account holder will be required annually to recertify each authorized user account.

### Master Account Holder

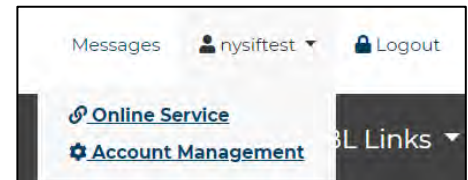
If a master account holder has accounts that must be recertified, the user will encounter this pop-up window upon login. The link will take the user directly to the Account Management page.



The master account holder will receive an email notification of upcoming recertifications 30 days from expiration, 15 days from expiration and the day of expiration.

Following the directions from the email, the master account holder will:

1. Go to [nysif.com](https://nysif.com) and log in to the online master account.
2. At the top right of your landing page, select "Account Management" from the drop-down menu under your user name.
3. Under "[User Management](#)," select "Manage Users."
4. Click "Extend Access" on the authorized user whose access is scheduled to expire (or whose access has already expired) to recertify the user.



PLEASE NOTE: The master account holder can recertify any user at any time. For example, if the master account logs in to recertify **Child1** because that user's access will be expiring first, the user can also recertify **Child2** and **Child3** at the same time. This is an added convenience for the user.

Once the user recertifies, the access expiration date will be updated to one year in the future. (There is no confirmation screen.) If a user's access expires before recertification, the User Management page will reflect that it is expired. The master account holder can choose "Extend Access" to certify the expired user.

### Authorized User Account Holder

The authorized user will receive an email notification of upcoming recertification 30 days from expiration, 15 days from expiration and one day from expiration.

If the authorized user's access expires, the user will be presented with the following message upon login.

#### Unexpected Error

Your online account has been suspended, due to not having been recertified by the master account holder. To reestablish access, please contact the master account holder for account recertification.

**Please note that only the master account holder can recertify an authorized user; NYSIF cannot provide this authorization.**

## Consolidate Online Accounts or Link Other Policy

Consolidating your NYSIF workers' comp and disability benefits online accounts allows you to log in using only one username and password. If you need assistance consolidating or linking your accounts, please contact 888-875-5790 for assistance.

### Consolidate Your Account

In order to better serve our customers, NYSIF is asking that you consolidate your username and password. This will let you use a Single Sign On process for both Workers' Compensation and Disability Benefits. You are currently logged in as a Disability Benefits Policyholder under the username dbtestpolicy2015. If you have an online Workers' Compensation account with NYSIF, you can enter your login credentials below to merge the accounts.

Please note that the username and password for your Workers' Compensation account will change to that of your current Disability Benefits account under the username dbtestpolicy2015.

Please note that if you enrolled your disability benefits policy in AutoPay, consolidating your online accounts removes your policy from that feature. Please choose Pay My Bill to re-enroll your disability account in recurring payments.

To consolidate your account, please provide the following information. All fields are required unless otherwise stated.

Username:	<input type="text"/>
Password:	<input type="password"/>
<input type="button" value="Consolidate"/>	<input type="button" value="Reset"/>

### Link A Policy

If you have a workers' comp online account, you can link your DB policy, and vice versa. Please enter the information requested.

### Link New Account

You are currently logged in as a Workers' Comp Policyholder under the username testpolicy2015. If you have a disability benefits policy with NYSIF, you can add that to this online account.

#### Disability Benefits Policy Services

Disability Benefits Policy Number	<input type="text"/>
	<small>Enter numbers only (no dashes).</small>
FEIN	<input type="text"/>
	<small>Enter numbers only (no dashes).</small>
Zip Code	<input type="text"/>
	<small>(Zip for Disability Benefits Account)</small>

### Link New Account

You are currently logged in as a Disability Benefits Policyholder under the username dbtestpolicy2015. If you have a workers' compensation policy with NYSIF, you can add that to this online account.

#### Policyholder Identity Verification

Please provide the following information as shown on the information page of your policy.


Policy Number	<input type="text"/>
	<small>(for example: enter A123-4567-8 as 12345678)</small>
Document Number	<input type="text"/>
	<small>Enter both letter (case-sensitive) and digits.</small>
Period covered end date	<input type="text"/>
	<small>mm/dd/yyyy (mm/dd/yyyy)</small>
Group Number	<input type="text"/>
	<small>Enter digits only</small>

#### Contact Information

First Name	<input type="text"/>
Middle Initial	<input type="text"/>
Last Name	<input type="text"/>
Company	<input type="text"/>
Title	<input type="text" value="Choose one"/>
Telephone Number	<input type="text"/>
	<small>(numbers only - with area code)</small>
Email Address	<input type="text" value="AMANDA@NYSIF.COM"/>

## Update Policy Contact Information

Select "Account Management" from the dropdown menu under your username at the top right of the page. Choose "View Contact Information" in the Review box.



Review/Update your policy contact information.

Review and update your policy contact information at any time.

[View Contact Information](#)

You will be presented with the current contact information NYSIF has associated with your policy.

Choose **Confirm** if there are no changes to the contact information. A check mark will appear at the top of the box.

Choose **Edit** if changes need to be made to the contact information. A pop-up form will display. Change the information as needed. Once changes are made, check "" at the bottom of the page and click **Save changes**.

Your Changes Have Been Saved. ✕

Choose Confirm or edit for each policy number, for both workers' compensation and disability benefits.

Policy Number: 98765432 ✕

Policyholder Name  
**ACME BOX CO**

Country  
USA

Address Line 1  
3844 ALLENS BRIDGE RD

Address Line 2  
SUITE 1234

Attention To

Zip Code 01234    Zip 4    City ALBANY    State NY

Contact Information ⓘ

Phone (555) 555-1212    Ext.

By checking this box, you are affirming that you are legally authorized to make these changes to the policy contact information

Close    Save changes

# Workers' Comp Policyholders

Workers' Compensation Links

<p><b>Claims</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Claim Search</a></li> <li>- <a href="#">Report an Injury with eFROI</a></li> </ul>	<p><b>Forms</b></p> <ul style="list-style-type: none"> <li>- <a href="#">C-105 Notice of Compliance</a></li> <li>- <a href="#">Pharmacy Benefits for Claimants</a></li> </ul>
<p><b>Documents</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Document Retrieval</a></li> <li>- <a href="#">Policy Document Upload</a></li> <li>- <a href="#">Upload Audit Documents</a></li> </ul>	<p><b>Policy</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Account Summary</a></li> <li>- <a href="#">Earned Premium Audit</a></li> <li>- <a href="#">Endorsements</a></li> <li>- <a href="#">Monitor Subcontractor Coverage</a></li> <li>- <a href="#">NYCIRB Rating Data</a></li> <li>- <a href="#">Policy Information</a></li> <li>- <a href="#">Report Request</a></li> <li>- <a href="#">Statement of Account</a></li> <li>- <a href="#">Unit Stat Inquiry</a></li> </ul>
<p><b>eCert</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Create/Renew Certificates</a></li> <li>- <a href="#">WC Certificate Validation/Subscription</a></li> </ul>	
<p><b>eQuote</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Get A Quote OR Apply for a Policy</a></li> </ul>	<p><b>Billing</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Pay My Bill</a></li> <li>- <a href="#">Report WC Payroll</a></li> <li>- <a href="#">View Monthly Bills</a></li> </ul>
<p><b>Risk Control</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Resource Center (external website: zywave.com)</a></li> </ul>	<p><b>Need Help?</b></p> <ul style="list-style-type: none"> <li>- <a href="#">Get Policy Help</a></li> <li>- <a href="#">Get Claims Help</a></li> <li>- <a href="#">Policyholder User Guide</a></li> </ul>

## Notification Center

Choose “**Email Notifications**” from your Administration Console to view your Notification Center and enroll in paperless for bills and Info Pages. The Notification Center also allows you to manage email notifications by policy or user for bills, Info Pages or Audits.

Authorized User accounts will have access to **only** the Notification Management and Messages tabs.

Administration Console

Manage your NYSIF account using the links below.

<p><b>Profile Management</b></p> <p>Review and update your account information at any time.</p> <p><a href="#">Update Your Profile</a></p>	<p><b>Consolidate Accounts</b></p> <p>To achieve single sign on please consolidate your accounts.</p> <p><a href="#">Consolidate</a></p>
<p><b>User Management</b></p> <p>Add new authorized users and manage existing users.</p> <p><a href="#">Manage Users</a></p>	<p><b>Link Account</b></p> <p>Here you can add a new Disability Benefits Policyholder account to the current account.</p> <p><a href="#">Link Account</a></p>
<p><b>Help</b></p> <p>Need technical help? Please contact the NYSIF Service Desk. 1-877-435-7743</p>	<p><b>Email Notifications</b></p> <p>Set email addresses for audit/infopage notifications.</p> <p><a href="#">Notifications</a></p>

**Only the master account holder can enroll in paperless for the policy.**

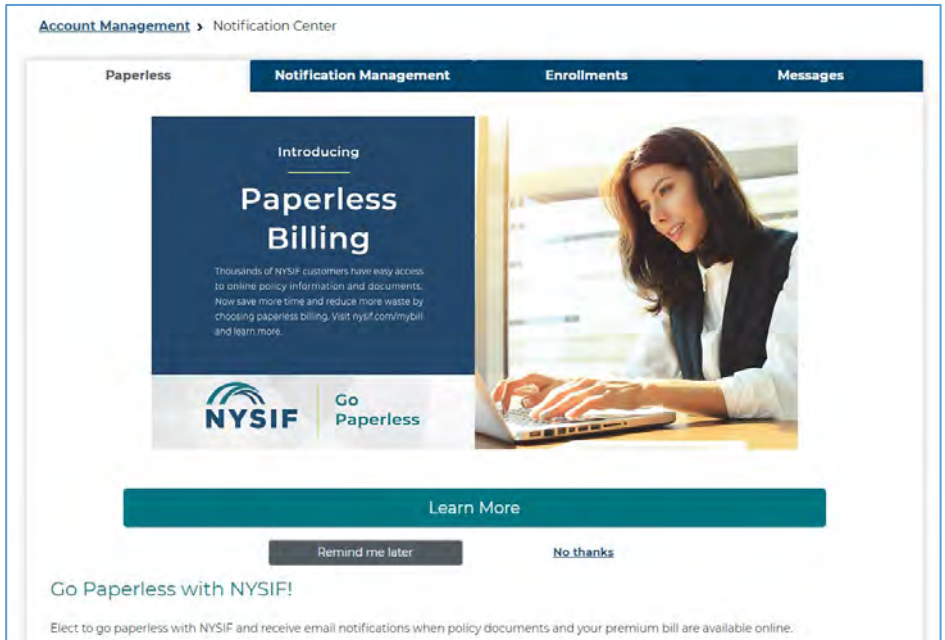


## Paperless Enrollment

To enroll in paperless billing, choose the Paperless tab.

(To unenroll, uncheck the box in Step 2 and save.)

Step 1: Verify your email address if needed.



### Step 1: Verify your email address.

We will send email notifications to the email address associated with your policyholder account. Please note your email address must be verified to receive communications from NYSIF.

Your email address (**testing@nysif.com**) has been verified. Please continue to step 2.

In Step 2, check the box(es) to go paperless and receive email notifications for your workers' compensation policy. Be sure to click "Save Changes."

### Step 2: Update your paperless options.

Check the box(es) below to go paperless and receive email notifications for your workers' compensation policy. Once you have enrolled, if you would like to revert to receiving paper copies, uncheck the boxes and click Save Changes.

If you are also a disability benefits policyholder, look for more information on DB email notifications coming soon.

A screenshot of the Step 2 enrollment form. It features two checkboxes: 'WC Bills' (checked) and 'WC Policy Documents' (unchecked). Below the checkboxes is a link to 'Terms and Conditions' and a 'Save Changes' button.

This category consists of workers' compensation policy documents such as Information Pages. As we add additional document types in the future, your enrollment in this category will include those documents. Audit Notifications are not included in WC Policy Documents paperless enrollment.

Please note: any documents NYSIF is required to send via U.S. mail will continue to be mailed in hard copy.

### Step 3: You're all set!

Please note:

- Once you've enrolled to go paperless, you can designate authorized users to receive email notifications via the [Notification Management](#) tab.
- You can create additional authorized user accounts via the [User Management](#) screen on your Admin Console. Once those users have verified their email addresses, you can manage their email notifications as described above.
- To view all notification enrollments associated with your account, visit the [Enrollments](#) tab.

**NOTE: If a policy chooses to go paperless, the master account holder will automatically receive all paperless email notifications. The master account holder cannot opt-out of email notifications without unsubscribing from paperless.**

## Notification Management

In the Notification Management tab, master account holders can enroll and manage notifications for authorized user accounts. Use the dropdown to choose a user and click "Go." Make your choices and Choose "Save Changes" to finish.

User: NYSIFTESTER (self) [Go]

### Email Notification Settings (NYSIFTESTER)

For Accounts

Audit Notifications	123456, 789000, 987654	
Incurred Cost Notifications	Nothing selected	Manage Threshold
Workers' Comp Bills	123456	
WC Policy Documents	789000, 987654	?
Disability Benefits Bills	Nothing selected	
DB Policy Documents		?

[Save Changes]

To manage notifications for Incurred Cost (reserves), first choose a policy, then the threshold.

Set Threshold [X]

Select each of policies you wish to make changes to and update the threshold choice. After closing the window use the save changes button to save changes.

Account	Threshold
123456	Nothing selected
789000	≥\$5K
987654	≥\$10K
	≥\$20K
	≥\$30K
	≥\$40K
	≥\$50K

The Changes you made on the "Save Changes" on the main window

[Close]

**NOTE: If a policy chooses to go paperless, the master account holder will automatically receive all paperless email notifications. The master account holder cannot opt-out of email notifications without unsubscribing from paperless. This means that on the Notification Management tab, the master account holder will not see an option to choose a policy number for Workers' Comp Bills or WC Policy Documents. (Shown below.)**

### Notification Management

#### User selection

In addition to your master online account, you can enroll and manage notifications for your authorized user accounts here. Use the dropdown to choose a user and click "Go". Please note, if you switch users without saving, any unsaved changes will be lost.

User  
nysiftest (self) ↕ Go

#### Email Notification Settings (nysiftest)

Audit Notifications For Accounts  
0123457 ▼

Save Changes

## Enrollments

The Enrollments page allows the master account holder to manage email preferences for workers' comp bills, policy documents and audits by policy designated on the Notification Management tab. If a policy has chosen to go paperless, the master account holder will receive all paperless notifications.

**If a master account holder chooses to unsubscribe to paperless notifications, NYSIF will preserve the notification choices made for authorized users should the policyholder choose to re-enroll. These choices will still appear in Enrollments, but authorized users will not receive email notifications while the policy is unsubscribed.**

To add or remove a notification to an authorized user account, go to the Notification Management page or click the "Edit" icon in the table.

**Enrollments**

This page allows you to manage email preferences for workers' compensation bills, policy documents and audits by policy designated on the Notification Management tab only. If an email address is not specified for a particular entity, no notifications will be made.

To add or remove a notification to an authorized user account, go to the Notification Management page or click the "Edit" icon in the table below.

Show 10 entries Search:

Notification Type	Account	Username	Email Address	Edit
Audit Notification	01234567	chld_nysifttest3	TESTING@NYSIF.COM	
Audit Notification	01234567	nysifttest_chld	WTEST@NYSIF.COM	
Workers' Comp Bills	01234567	chld_nysifttest3	TESTING@NYSIF.COM	
Workers' Comp Bills	01234567	nysifttest_chld	WTEST@NYSIF.COM	

## Messages

When bills or policy documents are issued and you receive an email notification, you are also notified in your Message Center. You can access these by choosing "Messages" at the top of your landing page or in the Notification Center.

**Account Management** > Notification Center

**Messages**

The following notifications have been sent to your NYSIF online account. Messages will remain available for six months. The most recent messages will appear at the top.

Message	Date
<b>! Your newest workers' compensation bill is now available.</b>	10/01/2019
New "Information Pages" documents are ready to be viewed in Document Retrieval.	09/21/2019



## Granting Broker Claims Access

Workers' compensation policyholders have been given the ability to grant online access to claims for their brokers of record. NYSIF cannot provide claims information to a broker or grant permissions to view this information.

Please note that only the master account holder for the policyholder can grant access to the broker of record. If the policyholder has created authorized user accounts, those authorized users do not have permission to grant access.

If you have a broker of record, your landing page will display the broker's name, phone number and email address in the right column. In this box, you have the option to grant, revoke or recertify your broker's access to claims information. Your permission to this claims data will continue unless or until you decide to revoke access.

**\*\* If you are a member of a Safety Group, your Group Manager already has access to these features and the button will not be visible to you. \*\***

Choose "Grant Access" and you will be asked to confirm your authorization. Click "Submit."

You can revoke access at any time. Simply choose the "Revoke Access" button.

**Broker of Record**

Broker of Record	ABC INSURANCE CO
Telephone Number	5185551212
Email Address	TESTING@NYSIF.COM

**⚠ You may grant your Broker of Record access to claims data until you decide to revoke access.**

**Grant Access**

**Broker Access Terms and Conditions**

By selecting this option, you as the Policyholder are affirming that the Broker of Record ("Broker") named above is authorized to access your employer information and claimants' personal, private and protected health information ("Policyholder Data") through NYSIF's Web Portal ("Portal"); that you, the Policyholder, are authorizing this Broker access in your capacity as employer to individually identifiable information of claimants where Broker is acting within the scope of its duties in evaluating, processing or settling a claim where the employer is a party of record; and that Policyholder is responsible for Broker's compliance with the Terms and Conditions of the NYSIF website and Portal concerning access to your Policyholder Data. It is solely your responsibility as Policyholder to promptly remove Broker access to Policyholder Data when the Broker is no longer authorized to access your Policyholder Data.

By checking the box, I agree to the New York State Insurance Fund's Broker Access Terms and Conditions.

**Submit**

**Broker of Record**

Broker of Record	ABC INSURANCE CO
Telephone Number	5185551212
Email Address	TESTING@NYSIF.COM

**⚠ Your Broker of Record has access to claims data. Claims data will be available until you revoke access. You may revoke access at any time.**

**Revoke Access**



## Report an Injury

Employers **must** file a report of work-related injury or illness with NYSIF immediately upon becoming aware of the injury or illness, and no later than 10 days after the employer's knowledge of the injury or illness, in all cases where the injury or illness:

- Has caused or will cause the employee's loss of time from regular duties of one day beyond the workday or shift during which the incident occurred, or
- Has required or will require medical treatment beyond ordinary first aid, or more than two treatments by a person rendering first aid

**Once received, NYSIF will submit the report of injury to the Workers' Compensation Board (WCB) on behalf of the employer.**

Visit [nysif.com/reportinjury](https://nysif.com/reportinjury) to start. To help you in completing your report, you may want to review our worksheet (at the end of this section), which details all the information requested in the report.

## Resume an eFROI

Do you have an eFROI Transaction ID and/or a Loss ID?

Enter the policy number and the Loss ID or eFROI Transaction ID.

Click **Start eFROI**.

**All fields are required unless otherwise stated.**

**Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.**

**Start or Resume Your eFROI**  
All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?  
 Yes  No

Are you resuming an eFROI?  
 Yes  No

NYSIF Policy Number  
1234567

For example: enter A123-4567-8 as 12345678

eFROI Transaction ID  
NP20558391E211TCC

Transaction ID begins with NP or SP, followed by numbers and ends in letters

**Start eFROI**

## Start Your eFROI

If you do not have an eFROI Transaction ID or Loss ID, choose **No** to begin your report.

1. Enter your NYSIF policy number, date of injury/illness and employee information, including DOB and address.
2. Enter your information, as preparer of this report. (You must choose preparer type or you will not be able to proceed.)
3. Click **Start eFROI**.

**eFROI** Login

**Start or Resume Your eFROI** [Need Help?](#)

All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?  
 Yes  No

**Start eFROI**

### Start or Resume Your eFROI

All fields are required unless otherwise stated.

Do you have an eFROI Transaction ID and/or a Loss ID?

Yes  No

NYSIF Policy Number  
0000011

For example: A123-4567 as 1234567.

Date of Injury/Illness  
05/12/2021

Does the injured worker have a SSN?

Yes  No

First Name

Middle Initial (optional)

Last Name

Date of Birth  
mm/dd/yyyy

### Preparer Info

First Report of Injury Preparer Type

Employer  Third Party  NYSIF Employee

eFROI Initiator Email

This email address may be an individual or group email distribution

Broker/Safety Group Email (optional)

This email address will receive the same emails as the eFROI Initiator

OSHA Case Number (optional)

Start eFROI

## eFROI Workflow

You can always view the status of your report using the icons across the top of the page. Green checkmarks indicate sections that are complete. Red circles indicate information is missing. A blue circle indicates the current page. You can choose a circle at any time to navigate to that section.



## Policyholder Information

The information displayed in the table is auto-completed based on the policy number you entered. (You cannot change this information.) Choose the Policy Entity and Policy Location.

**TIP:** Your entities will be listed in the drop-down in the order they are listed on your policy.

### Transaction Detail

Please record this eFROI Transaction ID for future reference.

Need Help?

eFROI Transaction ID  
NP20558391E21ITCC

Loss ID

### Policyholder Information

All fields are required unless otherwise stated.

Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.

Name	ACME BOX CO
Address Line 1	123 MAIN STREET
Address Line 2	
City, State Zip	ELMWOOD PARK, NJ 07407
FEIN	987654321
Telephone Number	555-555-5555

Policy Entity  
ACME BOX - 00000011

Policy Location  
123 MAIN STREET

eFROI Initiator Email Address	boss@nysif.com
Broker/Safety Group Email Address	

If your policy or policy entity does not have a NAIC code indicated in our system, you may be asked to identify the Industry Type for your business.

Policy Location Select a Location	
<b>eFROI Initiator Email Address</b>	
<b>Broker/Safety Group Email Address</b>	
Industry Type Select an Industry Type	
Select an Industry Type	
Accommodation and Food Services-72	
Administrative and Support and Waste Management and Remediation Services-56	
Agriculture, Forestry, Fishing and Hunting-11	
Arts, Entertainment, and Recreation-71	
Construction-23	
Educational Services-61	
Finance and Insurance-52	
Health Care and Social Assistance-62	
Information-51	
Management of Companies and Enterprises-55	
Manufacturing (Food, Beverage, Tobacco, Textiles, Apparel and Leather)-31	
Manufacturing(Metal, Machinery, Electronic, Appliance, Transport Equip., Furniture, Misc.)-33	
Manufacturing(Wood, Paper, Printing, Petroleum, Coal, Chemical, Plastics, Rubber, Nonmetal Mineral)-32	
Mining, Quarrying, and Oil and Gas Extraction-21	
Other Services (except Public Administration)-81	
Professional, Scientific, and Technical Services-54	
Public Administration-99	

Complete the question regarding the Claimant Information Packet.

Have you given the employee a Claimant Information Packet?

Yes  No

The Workers' Compensation Board requires employers to provide a Claimant Information Packet to workers at the time of their injury/illness. Select the Workers' Comp Claims Forms - Employer link on our [forms](#) page to download the latest version of the Claimant Information Packet for your employee.

Save Form Previous Next

Once this page is complete, click **Next**.

## Employee Information


The employee's name is carried over from the first page. If needed, you can amend the employee's mailing address here.

Employee's Personal Information

First Name  
Jane

Middle Initial (optional)

Last Name  
Doe


Date of Birth  
01/16/1970 



Enter work start time and time of injury, if available.



Indicate whether the employee gave notice of injury, and if so, to whom.

Once this page is complete, click **Next**.

### Employee's Injury Or Illness

Date of Injury/Illness  
05/12/2021 

Employee began work at (optional)  
--:-- --    
(hh:mm AM/PM)

Time of Injury (optional)  
--:-- --    
(hh:mm AM/PM)



Has the employee given you notice of injury/illness?  
 Yes  No

If Yes, who was notice given to? (one of the following fields is required)

First Name

Last Name

If Yes, was notice given orally, in writing, or both?  
 Orally  In Writing  Both

Date Notice was Provided  
mm/dd/yyyy  

## Accident Information

Complete all fields regarding the accident/injury/illness, including the names of witnesses, if any.

If the accident location is not the same as the policy location, please indicate if the location was a "lessee" or "other."

Is the accident location the same as the policy location?

Yes  No

Accident Premises Code  
Select an Accident Premises Code

**-Lessee:** accident occurred on the premises of the lessee for which the injured was hired to work.  
**-Other:** accident occurred at a location other than the employer's or lessee's premises.

### Accident Information

All fields are required unless otherwise stated.

Where did the injury/illness happen? (e.g. 1 Main St, Accident City, NY. At front door)

This field accepts letters, numbers, space, enter, and . ? # \$ ( ) - : ; ' " / &

Is the accident location the same as the policy location?

Yes  No

Accident County  
ALBANY

Was this the location where the employee normally worked?

Yes  No

Employee's Supervisor's First Name (optional)  
betsy

Employee's Supervisor's Last Name (optional)  
tester

Did the Supervisor see the injury happen?

Yes  No  Unknown

Describe what the injured worker was doing when they became injured or ill, along with how the injury/illness occurred.

Did anyone else see the injury happen?

Yes  No  Unknown

What was the employee doing when they were injured or became ill?

This field accepts letters, numbers, space, enter, and . ? # \$ ( ) - : ; ' " / &  
200 characters left

How did the injury/illness occur?

This field accepts letters, numbers, space, enter, and . ? # \$ ( ) - : ; ' " / &  
200 characters left



## Injury Cause

Select the body part and then the nature of injury from the drop-downs and then click **Add**. To add additional body parts, select another body part and nature of injury and click **Add** again. You are limited to 20 selections.

### Injury Cause

All fields are required unless otherwise stated.

Please complete as much eFROI information as possible and click "Save Form" before you exit your eFROI session.

**Select Body Part and Nature of Injury, then click "Add."**

To add additional body parts, select another Body Part and Nature of Injury and click "Add" again. Body parts are limited to twenty (20) selections.

Body Part

Select a Body Part

Nature of Injury

Select Nature of Injury

+ Add

**Select Body Part and Nature of Injury, then click "Add."**

To add additional body parts, select another Body Part and Nature of Injury and click "Add" again. Body parts are limited to twenty (20) selections.

<p style="font-size: small; margin: 0;">Body Part</p> <p style="margin: 0;">Arm, Lower Right</p>	<p style="font-size: small; margin: 0;">Select Nature of Injury</p> <ul style="list-style-type: none"> <li>AIDS</li> <li>Amputation</li> <li>Angina Pectoris (Chest Pain)</li> <li>Asbestosis</li> <li>Asphyxiation (Strangulation, Drowning)</li> <li>Black Lung</li> <li>Burn (Heat and Chemical)</li> <li>Burn (Heat)</li> <li>Burn (Scald)</li> <li>Burn Chemical</li> <li>Byssinosis (Pneumoconiosis of cotton, flax and hemp workers.)</li> <li>COVID-19 - Coronavirus</li> <li>Cancer</li> <li>Carpal Tunnel Syndrome</li> </ul>
<p style="font-size: small; margin: 0;">Cause of Injury</p> <p style="margin: 0;">Select a Cause of Injury</p>	
<p style="font-size: small; margin: 0;">Type of Loss</p> <p style="margin: 0;">Select a Type of Loss</p>	

Arm, Lower Right	Contusion (Bruise)	<b>X Remove</b>
Elbow, Right	Crushing	<b>X Remove</b>
Cause of Injury		

Choose **Cause of Injury** from the drop-down. Example shown.

Arm, Lower Right	Contusion (Bruise)	<b>X Remove</b>
Elbow, Right	Crushing	<b>X Remove</b>
Cause of Injury	<div style="border: 1px solid #ccc; padding: 5px;"> <p style="font-size: small; margin: 0;">Crash of Motor Vehicle: Collision or sideswipe with another</p> <ul style="list-style-type: none"> <li>Caught in, under or between Collapsing Materials</li> <li>Caught in, under or between Machine or Machinery</li> <li>Caught in, under or between Object Handled</li> <li>Caught in, under or between, NOC</li> <li>Collision with a fixed object (standing vehicle or stationary object)</li> <li>Contact with Abnormal Air Pressure</li> <li>Contact with Chemicals (includes hydrochloric, sulfuric, battery acid; methanol, antifreeze)</li> <li>Contact with Cold Objects or Substances</li> <li>Contact with Dust, Gases, Fumes or Vapors</li> <li>Contact with Electrical Current</li> <li>Contact with Fire or Flame</li> <li>Contact with Hot Objects or Substances</li> <li>Contact with Radiation (includes xrays, microwaves, nuclear and sunburn)</li> <li>Contact with Steam or Hot Fluids</li> <li>Contact with Temperature Extremes</li> <li>Contact with Welding Operation. Includes welder's flash (burns to skin or eyes due to intense light from welding)</li> <li>Contact with, NOC</li> <li>Continual noise</li> <li>Crash of Airplane</li> <li style="background-color: #006666; color: white;">Crash of Motor Vehicle: Collision or sideswipe with another vehicle</li> </ul> </div>	

Choose **Type of Loss**: Traumatic, Occupational Disease or Cumulative Disease

**Traumatic Injury**: Injury is traceable to an accident in the worker's present employment. Example: Slip or fall, struck by an object, injured while using equipment, suffered burns, etc.

**Occupational Disease**: Injury/illness caused by exposure to a disease producing agent in the worker's occupational environment. Not traceable to a definite accident in the worker's past or present employment. Example: An occupational disease arises from the conditions to which a specific type of worker is exposed. The disease must be produced as a natural incident of a particular occupation, such as asbestosis from asbestos removal.

**Cumulative Injury (other than disease)**: Injury having occurred from, or aggravated by, a repetitive employment activity. Not traceable to a definite accident in the worker's past or present employment. Example: Carpal tunnel syndrome; hearing loss resulting from continued exposure to harmful noise over time, etc.

Answer a few additional questions. If the accident involved machinery or a motor vehicle, there will be additional details required from you. Click **Next**.

To your knowledge, did the employee have another work-related injury to the same body part or a similar illness while working for you?  
 Yes  No

Did the injury/illness result in the employee's death?  
 Yes  No  Unknown

Was an object involved in the injury/illness? (e.g. forklift, hammer, acid)  
 Yes  No

Was the injury the result of the use or operation of a licensed motor vehicle?  
 Yes  No

Did this injury occur in the course of patient handling?  
 Yes  No

Buttons: Save Form, Previous, Next

## Medical Treatment

Please complete all fields regarding the injured employee's medical treatment (to the best of your knowledge).

Click **Next**.

### Medical Treatment

All fields are required unless otherwise stated.

Did the employee already receive treatment for this injury/illness?  
 Yes  No  Unknown

If yes, what was the date of the employee's first treatment?  
mm/dd/yyyy

Extent of medical treatment received by claimant immediately following the accident(select one)

- Minor on-site remedies by employer medical staff
- Minor clinic/hospital medical remedies and diagnostic testing
- Emergency evaluation, diagnostic testing, and medical procedures
- Hospitalization greater than 24 hours
- Future major medical/lost time anticipated(i.e.hernia case)

Who treated the employee?

Where was the employee treated?

Is the employee still being treated for this injury/illness?  
 Yes  No  Unknown

## Work Info

The last section before eFROI submission is information about the employee's work history: job title, occupation, class code, average gross weekly pay, work frequency, etc.

**Return To Work**  
Did the employee lose more than one day or one shift because of their injury/illness?

Yes  No

If yes, what was the last date the employee worked?  
mm/dd/yyyy

What was the first scheduled work day or work shift they missed after the accident?  
mm/dd/yyyy

When did the employer become aware that the employee's lost time was due to their injury/illness?  
mm/dd/yyyy

Has the employee returned to work?

Yes  No

If yes, on what date?  
mm/dd/yyyy

If yes, in what capacity?

Regular Duty  Limited Duty

If yes, did employee return to work with physical restrictions?

Yes  No

If yes, did employee return to work with the same employer?

Yes  No

Employee's job is

Regular/Full-Time

Part-Time Employee

Volunteer

Seasonal

Piece Worker

Apprenticeship Full-Time

Apprenticeship Part-Time

Unemployed/Not Employed

Retired

On Strike

Disabled

Other

## eFROI Submission

Before submitting, be sure to make a note of your eFROI Transaction ID.

Enter your contact information, click the attestation box and click **Submit eFROI**.

I affirm that the information I am providing is true and accurate to the best of my knowledge and belief.

Are you, the "submitter" the same person as the "notifier" for this FROI-00 transaction?

Yes  No

Name & Telephone Number of Employer/Policyholder who provided information necessary to prepare this form:

First Name

Last Name

Telephone Number

Extension (optional)

Numbers only - include area code

Up to 5 digits

**A confirmation page will display. Be sure to make a note of the Loss ID and the Transaction ID.** (A Transaction ID begins with NP or SP, followed by several numbers and letters.)

### Thank you for using eFROI!

Your FROI-00 has been successfully created and will be sent to the Workers' Compensation Board (WCB). Your loss record identification number a/k/a claim number is shown below. Please refer to this loss record identification number when communicating with NYSIF.

Loss Record Identification Number

0321654

eFROI Transaction ID

SP20558391E211XYZ

To **view and/or print a copy of the FROI-00**, please enter:

- Your policy number
- The last four digits of the injured worker's SSN, or if not available, the eFROI Transaction ID (as shown above)
- The loss record identification number (as shown above)

NYSIF may contact you to confirm the information contained in this report so that this claim may be processed in a timely manner. Please be available to provide any additional information that may be required.

On and after April 1, 2009, you must also provide your injured employee with a Claimant Information Packet before filing the Employer's Report of Work-Related Injury/Illness (Form FROI-00). The Claimant Information Packet is available in several languages under the "Workers' Comp Claim Forms - Employer" section and can be accessed by clicking on the link below.

## For New York State Agencies & Employees

To report a New York State agency employee injury, call the state Accident Reporting System at 1-888-800-0029.

For those state entities that report via eFROI, you will be asked to choose the bargaining unit, policy entity and include the employee's NYS Employee ID number.

NYSIF Policy Number 240960
For example: A123-4567 as 1234567.
Is injured worker a volunteer? <input type="radio"/> Yes <input checked="" type="radio"/> No
Bargaining Unit Select a Bargaining Unit
Policy Entity Select an entity
Date of Injury/Illness mm/dd/yyyy
Does the injured worker have a SSN? <input type="radio"/> Yes <input type="radio"/> No
Does Injured Worker have a NYS Employee ID or 'N-number'? <input type="radio"/> Yes <input type="radio"/> No

## NYSIF eFROI Worksheet

<b>Initial Information: (If resuming an eFROI, you must have the Transaction ID)</b>	
* NYSIF Policy Number (must be active on Date of Accident being reported)	
* Date of Injury/Illness	
* Does Injured Worker have a SSN? If yes, SSN is required.	
* First and Last Name of Injured Worker	
* Date of Birth of Injured Worker	
* Mailing Address of Injured Worker	
* First Report of Injury Preparer (Employer, Third Party or NYSIF Employee)	
* eFROI Initiator e-mail address	
Broker/Safety Group Manager's email (optional)	
<b>Policyholder Information:</b>	
* Policy Entity	
* Policy Location	
* Industry Type	
* Did you give the employee a Claimant Information Packet? If yes, date required.	
<b>Employee Information:</b>	
* Gender	
Telephone Number	
Employee's Mailing Address (update if necessary)	
Time employee began work	
Time of injury	
* Did employee give notice of accident/illness? If yes, must indicate when and to whom. Was it given orally, in writing or both?	
<b>Accident Information:</b>	
* Where did the accident/illness happen?	
* Is the accident location the same as the policy location? If no, select Accident Premises Code (Lessee or Other)	
* Accident County	
* Was this the location where the employee normally worked? If no, indicate why the employee was there.	
First and Last Name of Employee's Supervisor	
* Did Supervisor see injury happen?	
* Did anyone else see injury happen? If yes, need names and contact info.	
* What was employee doing when they were injured or became ill?	
* How did the injury/illness occur?	
<b>Injury Information:</b>	
* Body part(s) injured (up to 20 body parts may be selected)	
* Nature of Injury (such as laceration, bruise, fracture, burn, etc.)	
* Cause of Injury (ex: caught under vehicle, contact with fire, tripped over wire)	
* Type of Loss (traumatic, occupational disease or cumulative injury)	



* To your knowledge, did the employee have another work-related injury to the same body part or similar illness while working for you?	
* Did the injury/illness result in the employee's death?	
* Was an object involved in the injury/illness? If yes, what object?	
* Was the injury the result of the use or operation of a motor vehicle? If yes, was it the employee's vehicle, employer's vehicle or other vehicle?	
* Did this injury occur in the course of patient handling?	
<b>Medical Treatment Information:</b>	
* Did the employee receive treatment for this injury/illness? If no, skip this section.	
* What was the date of the employee's first treatment?	
* What was the extent of medical treatment received by claimant immediately following the accident? (minor, emergency room, hospitalization, etc.)	
* Who treated the employee?	
* Where was the employee treated?	
* Is the employee still being treated?	
<b>Employment Information:</b>	
* Did the employee lose more than one day or one shift because of their injury/illness?	
* What was employee's last date worked?	
* What was the first scheduled work day or work shift they missed after the accident?	
* When did the employer become aware that the employee's lost time was due to their injury/illness?	
* Has employee returned to work? If yes, on what date?	
* If employee returned to work, was it regular duty or limited duty?	
* If employee returned to work, was it with physical restrictions?	
* If employee returned to work, was it for the same employer?	
Date of Hire	
Job Title	
* Occupation Description	
* Manual Classification Code	
What types of activities did claimant normally perform at work?	
* Employee's average gross weekly pay	
* Did employee receive lodging or tips in addition to pay? If yes, describe.	
* Employee's job was... (choose Full-Time, Part-Time, Seasonal, etc.)	
* Which days of the week did the employee usually work?	
Last Day Paid	
* Was the employee paid for a full day on the day of the injury/illness?	
* Did you continue to pay the employee after the injury/illness?	
<b>Additional Information:</b>	
Please provide any additional information. (This information is provided to NYSIF only)	
* FROI submitter contact information	

## Claim Search

Choose "Claim Search" from your landing page on nysif.com. You can search by policy number, claim number, WCB number (JCN) and claimant name.

Because these searches are web-based, it may take a moment for the page to load with your results.

### Search for a Claim

To search for a claim, fill out the information below and click 'Submit'. All fields are required unless otherwise stated.

Search By  
Policy Number

Select a Search Parameter  
Policy Number  
**Claim Number**  
WCB Number (JCN)  
Claimant Name

mm/dd/yyyy   ▼   📅    mm/dd/yyyy   ▼   📅

## By Policy

Choose Claim Search. Choose Policy Number from the dropdown. Enter a policy number; add an accident date if needed. Choose to filter by Open, Retired or All claims. This will return an alphabetical list of all claims that fit the criteria. Click the Claim Number to view details for that specific claim. You can also choose to download this information to a spreadsheet.

### Search for a Claim

To search for a claim, fill out the information below and click 'Submit'. All fields are required unless otherwise stated.

Search By  
Policy Number

Policy Number  
01234567

Accident Date From (Optional)  
mm/dd/yyyy   ▼   📅

Accident Date To (Optional)  
mm/dd/yyyy   ▼   📅

Status (optional)  
All

Direct Download

**Submit**

**Policy Number**  
01234567

**Policyholder Name**  
TESTING TESTERS, INC.

**Policyholder Address**  
229 RUSSELL STREET, ANYTOWN, NY 00000

Claimant Name	Claim Number	Unit	Status	Accident Date	WCB Number	Medical Paid	Medical Reserve	Medical Incurred	Comp Paid	Comp Reserve	Comp Incurred	Legal Paid	Legal Reserve	Legal Incurred
Allen, John	<a href="#">98765432</a>	302	Closed	1/15/2003	4375215	\$437.06	\$0.00	\$437.06	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00	\$0.00
Berry, Barry	<a href="#">99887700</a>	302	Closed	7/25/2000	4896313	\$578.70	\$0.00	\$578.70	\$240.00	\$0.00	\$240.00	\$0.00	\$0.00	\$0.00
Columbus, Christopher	<a href="#">00112233</a>	301	Open	10/9/1997	00305807	\$15,411.25	\$706.75	\$16,118.00	\$91,017.15	\$21,977.85	\$112,995.00	\$0.00	\$0.00	\$0.00
Tester, Mary	<a href="#">33333333</a>	235	Closed	12/5/2000	00052012	\$7,663.13	\$0.00	\$7,663.13	\$57,120.00	\$0.00	\$57,120.00	\$0.00	\$0.00	\$0.00

Upon clicking a claim number, you will be taken to that claim's "home page." This landing page now includes payment history at the top of the page, under the claim number. Payment information is now prominently displayed, broken out by comp, medical and legal payments. More details in next section.

## By Claim Number

### Master Claims Screen Tab

Search by claim number. The search returns the Master Claims Screen tab, which contains information about the claimant, claim, payments, case manager and policyholder. It will also display the reserves at the top. Use the tabs to navigate.

### Search for a Claim

To search for a claim, fill out the information below and click 'Submit'. All fields are required unless otherwise stated.

Search By  
Claim Number

Claim Number  
987654

Submit

**Assured Name**  
ACME BOX CO

**Claimant Name**  
TESTER, JOHNNY

**Claim - Unit**  
987654 - 100

**Accident Date**  
10/9/1997

	Compensation	Medical	Legal
Paid to Date	\$91,017.15	\$15,411.25	\$0.00
(+) Reserve	\$21,977.85	\$706.75	\$0.00
(-) Incurred	\$112,995.00	\$16,118.00	\$0.00

Master Claims Screen
Claim Summary
Diary Screen
Notes
Reserve History
Hearing Dates

### Master Claims Screen

Claimant Information

+

Claim Information

+

Payment Information

+

Case Manager Information

+

Policy Information

+

Claimant Information		Payment Information	
Claimant Name	Tester, Johnny	Compensation Last Paid Date	12/13/2019
Claimant Address	123 MAIN STREET ANYTOWN, NY 12345	Medical Last Paid Date	3/24/2014
D. O. B.	12/27/1935	Last Incurred Date	12/9/2014
SSN	XXXXX6055	Special Estimate Date	7/29/2014
Gender	Male	Special Compensation Incurred	0
Phone Number	555-555-1212	Special Medical Incurred	N/A
Occupation	N/A	Group Compensation	0
Claimant Attorney	Pasternack, Tilker, Ziegler,	Supplemental Benefits	F
Claimant Attorney (Continued)	WALSH, STANTON & ROMANO,	Initial Return To Work	N/A
Address	100 ELM AVENUE	Apportionment	No
City/State/Zip	BROOKLYN, NY 11201-5078	Average Weekly Wage	\$600.00
Attorney Phone	555-555-8989	Concurrent AWW	\$0.00
		Composite AWW	\$600.00
		Compensation Rate	\$100.00

Claim Information			
Claim Number	987654	Pay Class	HEAT AIR COND DUCT SHOP OUT&DRIVERS
Accident Date	10/9/1997	Legal Status	No
WCB# (JCN)	G0000001	Last Hearing Date	5/25/2007
WCB/(JCN) Type	Open	Concurrent Emp	No
Cause	N/A	Wage Expectancy	No
Patient Handling	N/A	Employer Reimbursement	No
Injury Type	Other Dust	25A	N/A
Body Part	Lung, Right (53) Lung, Left (54)	Fraud	N/A
Initiating Doc	EC-84	15-8 Percentage	N/A
Claim Status	Open	3rd Party	Pursued
Date Disability Began	2/24/2000	SLU Award	No
Special Condition	No Special Condition Established	Death	N/A
Jurisdiction	New York Workers' Compensation Law	Lump Sum	No
Kind of Injury	Average value (initial system amount)	Retired	No
Question of Coverage	No	Additional Cases	Yes <a href="#">View</a>
Controverted	No	Disfigurement	No
		Classified (Y/N)	Yes
		Sec 32	No

### Policy Information

Policy Number	00112233
Policyholder Name	ACME BOX CO
Status	ACTIVE
Group	411
Principal's Name	OBEDIAH MASTERSON
Policyholder Address	1 MAIN AVE ANYTOWN, NY 12345
Policy Phone Number	555-555-7878
Inception Date	5/16/1978
Policy Date for This Claim	1/1/2015
County	Kings (Brooklyn)
Underwriting Office	Safety Office
Number of Entities	1
Number of Locations	3
Entity Number	0
Entity Name	N/A
Entity Address	N/A
Catastrophe	0
Bargaining Unit	N/A
Business Type	(01) Corporation

### Case Manager Information

Case Manager Assigned	CASEY MANAGER
Telephone	555-666-1212
Fax	555-666-1313
Email	CMANAGER@NYSIF.COM
Office Name	NYC Claims



## Claims Summary Tab

The Claims Summary tab provides details on the following:

- Compensation Paid
- Medical Paid
- Biographical Info
- Strategy/Outstanding Issues
- Investigation
- Description of Accident
- Statement Summary
- Witnesses
- Official Reports
- Consultant Reports
- Attending Physician Diagnosis
- Attending Physician Prognosis
- Additional Attending Physicians
- Other Medical Providers
- Hospital Info
- Emergency Room Report
- Surgery
- Diagnosis Testing
- Treatment Authorization
- Case Management & Rehab Services
- WCB Decision & Hearing Reports
- Litigation
- Mitigation & Subrogation
- Case Summary & Other Factors

## Diary Screen Tab

The Diary Screen tab will display diary entries, the date, the reason for entry and status (pending or completed).

Master Claims Screen	Claim Summary	Diary Screen	Notes	Reserve History	Hearing Dates
Claim Info		Claim Info (Continued)		Claim Info (Continued)	
Claim Number	987654	DOA	10/9/1997	Policy Number	00112233
Claimant Name	Tester, Johnny	SSN	XXXXX6055	Group Number	411
Employer Name	ACME BOX CO	DOB	12/27/1935	WCB Number	G0000001
Pending Diary Entries					
Review Date	Requested By	Reviewer	Reason	Status	
3/21/2016	H. Barnett	E-Billing Process	Check PBM eligibility.	P	
11/5/2015	H. Barnett	WCB Decisions	A AD-NSL for claim: 43115674_09664414 received	P	
4/3/2015	H. Barnett	E-Billing Process	Check CVSCaremark eligibility.	P	
3/3/2015	H. Barnett	R. Hall	Make a comp payment!	P	
<a href="#">Show All History</a>					

## Notes Tab

The Notes screen can be filtered by either Claims or Legal, and includes details from the case manager, hearings, decisions and a summary of any contact with the claimant.

Notes			
<input type="radio"/> View Claims Notes <input type="radio"/> View Legal Notes <input checked="" type="radio"/> View All Notes			
Note Type	Date	Added By	Note
Claims	9/6/2018	A. Batchtest	S32 Interest Lt/16-pt Questionnaire sent - 04/26/2018
Claims	10/7/2014	G. Moore	NO ISO MATCH.
Claims	9/24/2014	A. Batchtest	Ipratropium solution(used in nebulizer) authorized -it is c/r to COPD-Iomn requested from prescriber-(there are No medical bills in med bill tab).
Claims	9/24/2014	G. Moore	PBM/CVS Budesmide(pulmicort)inhaler authorized-Iomn requested.ODNCR is Chronic Obstructive Pulmonary Disease as per WCB NOD on 2/24/2006.

## Hearings Tab

Hearings for Claim		
Hearing ID	Hearing Date/Time	Completion Status
<a href="#">2685762</a>	11/13/2013 2:00:00 PM	Report Completed

## Reserve History Tab

Reserve History		
Date	Added By	Note
12/18/2012	C. Manager	Med CHG 16119 to 16118; Reserves updated.
12/22/2011	L. Watson	Med CHG 16118 to 16119; Reserves updated
6/24/2011	C. Manager	Med CHG 6118 to 16118; reflects ongoing medical treatment
3/4/2010	C. Manager	Med CHG 2861 to 4000; Reserves updated
9/18/2006	B. Jones	Med CHG 1550 to 1551; ppd
3/6/2006	L. Gardner	Comp CHG 2500 to 28600; PPD RESERVE SET FOR HEARING ON02/24/06

## By WCB (or JCN\*) Number

Enter the WCB number. Clicking the claim number will bring you to the master claims tab with full details on the claim. *\*Please note: to be consistent with WCB eClaims submissions, NYSIF has begun replacing "WCB Number" with "JCN," which stands for Jurisdiction Claim Number. "JCN" is the universal term for the claim number assigned to a claim by the adjudicating/regulatory body.*

Search by:

\*WCB# (JCN):

Policy Number: 012345678  
 Policyholder Name: ACME FENCE CO  
 Policyholder Address: 123 MAIN ST, ANYTOWN, NY 12345

Claimant Name	Claim Number	Unit	Status	Accident Date	WCB# (JCN)	Medical Paid	Medical Reserve	Medical Incurred	Comp Paid	Comp Reserve	Comp Incurred	Legal Paid	Legal Reserve	Legal Incurred
Smith, John	<a href="#">98765432</a>	242	Open	02-SEP-2014	G987654	\$263.76	\$1,736.24	\$2,000.00	\$0.00	\$1,500.00	\$1,500.00	\$0.00	\$0.00	\$0.00

## By Claimant Name

You must enter the full first and last name, the date of birth and the date of accident. Clicking the claim number will bring you to the master claims tab with full details on the claim.

Search by:

First Name:

\*Last Name:

\*Date of Birth:

\*Accident Date:

Policy Number: 0123456-7  
 Policyholder Name: ABC COMPANY  
 Policyholder Address: 123 MAIN STREET, ANYTOWN, NY 12345

Claimant Name	Claim Number	Unit	Status	Accident Date	WCB# (JCN)	Medical Paid	Medical Reserve	Medical Incurred	Comp Paid	Comp Reserve	Comp Incurred	Legal Paid	Legal Reserve	Legal Incurred
Nysif, John	<a href="#">98765432</a>	248	Open	23-MAR-1993	0000003	\$17,524.22	-\$527.22	\$16,997.00	\$43,258.00	-\$10,500.00	\$32,758.00	\$0.00	\$0.00	\$0.00

## Documents

Use this option to view policy info pages such as declarations, renewals, and bills. You can also view claims documents including forms, medical bills and WCB notices. If you have agreed to payment terms with NYSIF, that payment arrangement can also be found here.

(If you have a consolidated online account, you will also see your [disability benefits bills and info pages](#), as in the example shown.)

## Policy Document Retrieval

For policy documents, choose the “Document Type” – Info Pages, DP517 or Self-Audit – and enter the policy number. Click the envelope or document ID to view the document.

If searching for a particular time frame, please be sure to include the transaction date in the search parameters. (Ex.: Policy renews July 1. Expand your search to include May, when the renewal would have been issued.)

Click on the Envelope ID number to view the policy document.

### Document Retrieval

#### Search documents

To search documents, select document type, group number and/or NYSIF policy Number, and date range, then click Search Documents.

Document Type  
Select a Document Type

- Select a Document Type
- Info Pages
- Claim Information
- Cancellation Form
- Payroll Verification Form
- Payment Arrangement
- DBL Info Pages
- DBL Monthly Bills

#### Search documents

To search documents, select document type, group number and/or NYSIF policy Number, and date range, then click Search Documents.

Document Type  
Info Pages

Policy Number  
12653283 - NYSIF

The date range is limited to three years for search by policy and displays up to the current day, if no date range is specified.

Start Date(optional)  
mm/dd/yyyy

End Date(optional)  
mm/dd/yyyy

Search Documents

Policy Number: 12653283

Assured Name: NYSIF

Address: PRODUCTION CONTROL  
POLICY ONE1234 NEW  
YORK,NY10007

Policy Period: 12/26/2021-12/26/2022

Envelope ID	Transaction Date	Category	Details	Description
<a href="#">84741396</a>	08/04/2022	Info Pages	Special Endmt	Print Endorsement
<a href="#">84720141</a>	08/03/2022	Info Pages	Broker Delete Letter	MISCELLANEOUS LETTERS
<a href="#">84681626</a>	08/01/2022	Info Pages	Broker Delete Letter	MISCELLANEOUS LETTERS
<a href="#">83222166</a>	05/02/2022	Info Pages	INT Policy Endmt	Prnt Internal Endorsement
<a href="#">82883592</a>	04/11/2022	Info Pages	INT Special Endmt	Prnt Internal Endorsement
<a href="#">73878884</a>	11/09/2020	Info Pages	Notice-to-Post Notice Of Right To Appeal Pending TRIA Endorsement v.2 Domestic Terrorism Endorsement Terrorism Endorsement Notice of Rate Change(WC) Interest and Service Charge Endorsement V.5 Location, entity, endorsement, premium calc info	INFORMATION PAGE RENEWAL POLICY

## Claims Document Retrieval

For claim documents, choose Claim Information in the “Document Type” dropdown menu and enter the claim number.

Tabs will display documents for these categories: Medical Bills, Medical Exams, Claimant/Employer Forms, WCB, FROI/SROI, 15-8, Investigations, Legal Forms, Medical Authorizations/Variations. Click the envelope or document ID to view the document. Click “Date Received” to sort by date.

Search Documents

Medical Bills
ME
Claimant/Employer forms
WCB
FROI/SROI
15-8
Investigations
Legal Forms

Medical Authorizations/Variations

Document ID	Document Name	Document Type	Data Received	Document Category
<a href="#">42882717</a>	audit letter 43115674	audit letter	04/16/2013	Medical Bills

## Policy Document Upload

You can upload forms, payroll, loss runs, etc., & associate them with either a quote request or a policy from your online account. Under “Documents” on your home page, choose Policy Document Upload.

Document Upload
Online Services ▾

Select Upload Category

In the boxes below, please first choose whether you will be uploading documents associated with a quote request or with your existing NYSIF workers' compensation policy. Once you make that selection, please enter the Quote ATN or your policy number in the next box.

Next, choose the form type and enter a brief description of the documents being uploaded in the Document Description box.

You may only upload documents for that specific quote or policy number. Once you have submitted, you may upload a new set of documents associated with a different policy number if needed.

The maximum size per file is 30 MB.  
 The maximum size for the entire file upload is 300 MB.  
 The following file formats are acceptable: .jpg, .jpeg, .gif, .png, .pdf, .bmp, .tif, .tiff, .htm, .html

Document Upload
Online Services ▾

The maximum size per file is 30 MB.  
 The maximum size for the entire file upload is 300 MB.  
 The following file formats are acceptable: .jpg, .jpeg, .gif, .png, .pdf, .bmp, .tif, .tiff, .htm, .html

Cancellation Request  
 Premium Verification  
 Loss Information  
 Group Authorization  
 U-111 Additional Entity  
 U-619 Executive Officer Exclusion  
 U-627/C-105.32 Sole Proprietor/Partner Inclusion  
 U-629 Not-for-Profit Unsalariated Officer Exclusion  
 U-431 Religious, Charitable, Education Officer Inclusion  
 U-435 Municipal Officer Inclusion  
 U-445/ERM-14 Experience Rating Ownership Information  
 Policy Change Request  
 Certificate  
 Correspondence  
 ACORD

Select Files

No file chosen

Payroll Verification
Loss Information
Group Authorization
Correspondence



## Upload Audit Documents

Representatives and policyholders can securely upload financial records to nysif.com in lieu of an on-premise audit. All you need is a policy number and the audit number or appointment ID to get started.

Choose Upload Audit Documents from your landing page.

On the Audit Upload screen, enter the first one or two numbers of the policy for which you plan to upload audit documents. The Policy Number field will display a dropdown menu of all of your policies beginning with that number(s), allowing you to quickly and easily choose the one you need.

You can find your appointment ID or audit number on your audit correspondence from NYSIF. (You must complete the captcha test before progressing to the next screen.) Click **NEXT**.

**BROWN, NYSIF & NYSIF, CPAS**  
C/O MANAGER  
111 MAIN STREET  
NEW YORK, NY 00000

Re: Premium Review for Workers' Comp  
Audit Period: 06/08/2015 - 06/08/2015

Policyholder: ACME BOX CO  
Additional Entities: BOXES, INC.  
ACME CORRUL

Audit Number: 9876543

Dear Policyholder or Representative:

**BOB CONTRACTING CORP**  
C/O BOB JONES  
100 MAIN STREET  
ANYTOWN, NY 12345

Re: Premium Review for Workers' Compensation Polic  
Audit Period: 11/01/2014-11/01/2015 and any outsta

Policyholder: BOB CONTRACTING CORP  
Additional Entities: BOB CARPENTRY INC  
BUILDING CONSULTANTS I

Appointment Date: 03/29/2016  
Appointment ID: 0123456 20160223

Dear Policyholder:

## Audit Document Upload

### Welcome to the Premium Audit Secure Document Upload Site

You may upload up to 30 files to this site. The maximum size per file is 50 MB.  
The maximum size for the entire file upload is 300 MB.  
The following file formats are acceptable: txt, tiff, rtf, pdf, doc, docx, bmp, gif, jpg, xls, xlsx

Policy Number: 12345678

Audit Number or Appointment ID:

Please enter your audit number or the first 7 digits of your appointment ID, found on your audit letter.

Policy Number: 12345678

Audit Number: 987654

\*First Name:

\*Last Name:

\*Title/Relationship to Policyholder:

\*Email Address to Receive Confirmation of Documents Uploaded:

\*Confirm Email Address:

\*Please provide a phone number where we may reach you with any questions.

I am submitting documents:

in lieu of a physical audit.

to address an audit-related matter.

Next

All fields on this page are required. Click **NEXT**.

Complete the fields on this page. If additional officers/owners need to be added, please choose "Add another." Click "Next," and you will be directed to the upload screen.

Policy number: 12345678  
Audit number: 987654

**1. Description of Business Operations**  
Please provide a brief description of business operations.

**2. Business Type**  
 Sole Proprietor  Partnership/LLC/LLP  Corporation  Other

**3. Owner/Partner/Member/Officer Information**  
Please provide the information below for each owner, partner, member or corporate officer. In the gross payroll field, please enter the amount filed or reported for the specified individual in state or federal tax reporting for the audit period.

Owner/Partner/Member/Officer 1

Name

Title

Duties

Gross Payroll

Ownership %

State

[+ Add another](#)

[Next](#)

Choose the document type you'd like to upload. Browse to the appropriate file location on your computer. Click "Add File."

## Audit Document Upload

Policy number: 12345678  
Audit number: 987654

Select the document type and then browse to the appropriate file location. Select and add the desired file. You will have a chance to review and remove files before submitting.

**Add File to Upload**

Select Document Type

Select One

[Browse...](#) No file selected. [Add File](#)

- You may upload a maximum of 30 files
- Individual files must be no larger than 50 MB.
- The entire file upload must be no larger than 300 MB.
- Allowed file formats: txt, tif, tiff, rtf, pdf, doc, docx, bmp, gif, jpg, xls, xlsx

Please note:

- You may upload a maximum of 30 files.
- Individual files must be no larger than 50 MB.
- The entire file upload must be no larger than 300 MB.
- Allowed file formats: txt, tif, tiff, rtf, pdf, doc, docx, bmp, gif, jpg, xls, xlsx

Policy number: 12345678  
Audit number: 987654

Select the document type and then browse to the appropriate file location.  
Select and add the desired file. You will have a chance to review and remove files before submitting.

### Add File to Upload

Select Document Type

Select One

Select One

- 1099 forms for individual employees
- Bills and Invoices (for services, labor and materials)
- Check Book/Day Book with Cash Expenses/Cash Book (Disbursements and Receipts)
- Certificates of Insurance for Subcontractors Used
- Contracts (for services, labor and materials)
- Form 1096-Summary of 1099s
- General Ledger
- Income Tax Returns (1120/S-Corporate; 1065-Partnership; 1040-Schedule C Sole Proprietor; 990-Organization Exempt from Income Tax)
- Payroll Book/Register/Report
- Payroll Tax Returns (941, NYS-45, NYS-45 ATT)
- W2 forms for individual employees
- W3 form - Summary of W2s
- Other

## Audit Document Upload

Policy number: 12345678  
Audit number: 987654

Select the document type and then browse to the appropriate file location.  
Select and add the desired file. You will have a chance to review and remove files before submitting.

### Add File to Upload

Select Document Type

W2 forms for individual employees

Choose File | PAD Test W2.docx

Add File

- You may upload a maximum of 30 files
- Individual files must be no larger than 50 MB.
- The entire file upload must be no larger than 300 MB.
- Allowed file formats: txt, tif, tiff, rtf, pdf, doc, docx, bmp, gif, jpg, xls, xlsx

Repeat for additional documents.

Browse... No file selected. Add File

- You may upload a maximum of 30 files
- Individual files must be no larger than 50 MB.
- The entire file upload must be no larger than 300 MB.
- Allowed file formats: txt, tif, tiff, rtf, pdf, doc, docx, bmp, gif, jpg, xls, xlsx

#	File Type	File	Size	Remove
1.	W2 forms for individual employees	PAD Test W2.docx	0.011 MB	

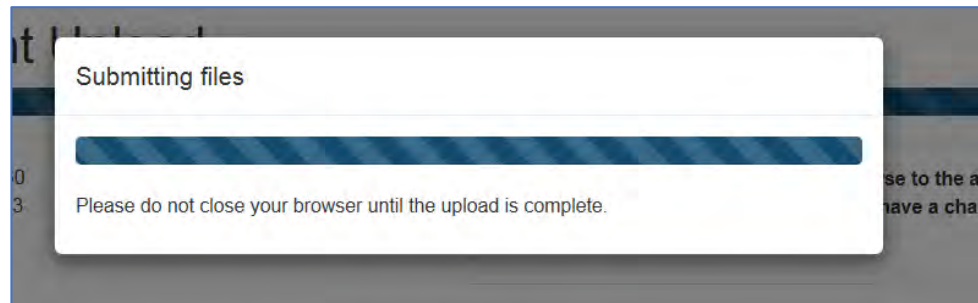
Are you ready to submit your documents?

Yes  No

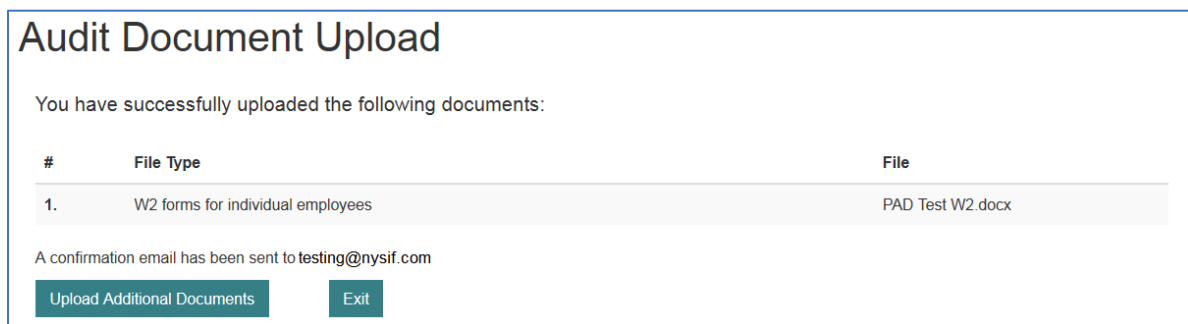
Upload Files

Once you are ready to submit your documents, choose "Yes" and then "Upload Files."

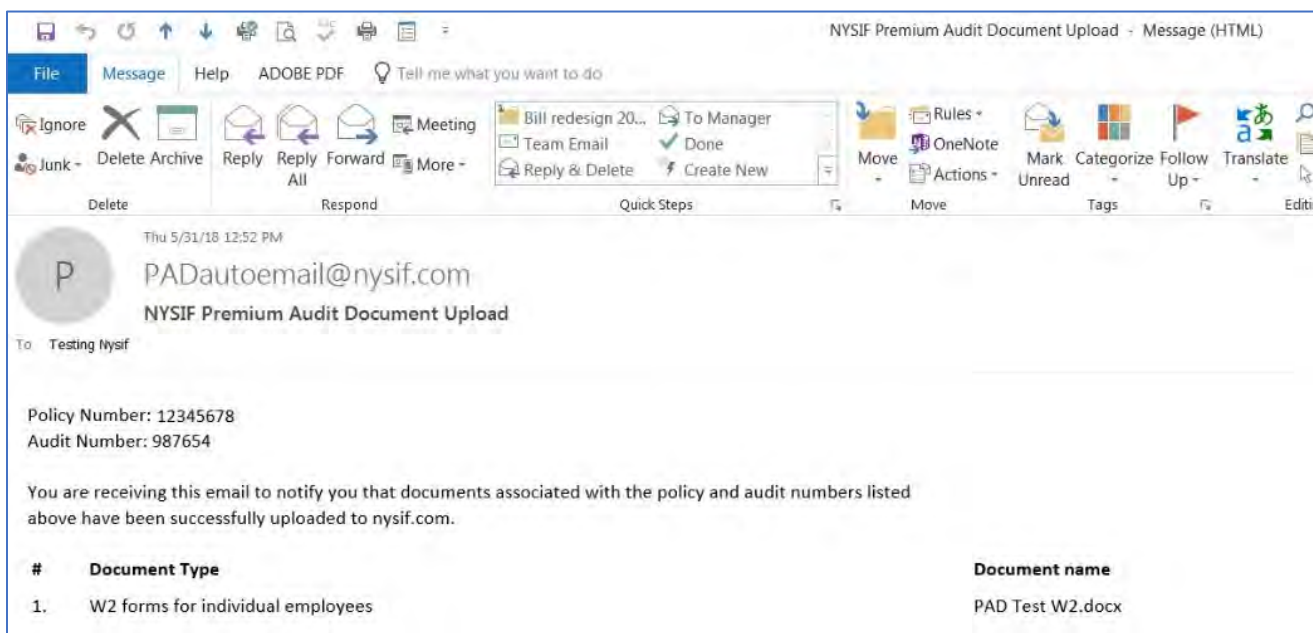
Please do not close your browser until the upload is complete.



Once the upload is complete, the user will see a confirmation screen.



The user will also receive a confirmation email with the list of documents that were uploaded. The new application securely delivers your audit documents to the appropriate NYSIF auditor.



## eCert Menu

Select Create/Renew Certificates under the eCert menu, and you will be directed to the Browse Certificates page.

### Browse Certificates

Select a policy number. The Browse page allows you to search by:

- certificate number
- name
- address
- job ID
- email address

You can also elect to have your results sorted by date or alphabetically by Certificate Holder. You may also choose to include a specific type of certificate by identifying if it includes a wrecking provision.

Workers' Compensation Online Services > eCertificate Search

Browse Certificates [Create New Certificate](#) [Renew Certificates](#)

### Browse Certificates

To browse certificates, enter the information below and click "Search." All fields are required unless otherwise stated.

Policy Number

Certificate Number (optional)

Name, Address, Job Id, or Email (optional)

Sort by  
Newest issued

[Advanced Search Options](#)

Certificate Type:  
 All  General  Wrecking

Date Search Type:  
 None  Created  Updated

A search by policy number returns a table of all active certificates, listing dates and certificate holder.

**Certificates**

Click on a Cert # to view the details for that certificate. To view more certificates, click "Next."

Showing 25 Certificates

Cert #	Create Date	Certificate Holder	Job ID	Entity #	Loc #	Start Date	End Date	Clause	View
<a href="#">922890</a>	05/23/2019	CERT_NAME	04324394-32	0	0	06/09/2018	06/09/2019	.EB...	
<a href="#">922871</a>	05/22/2019	TSIU TEST RENEW 15-16		0	0	06/09/2018	06/09/2019	..B...	
<a href="#">922889</a>	05/22/2019	CERT_NAME	4564565	0	0	06/09/2019	06/09/2020	.EB...	
<a href="#">922887</a>	05/22/2019	STEVE SMITH	987654	0	0	06/09/2019	06/09/2020	REB...	

**TIP:** Click the Adobe icon in the View column to quickly view, download and save, or print a certificate.

Cert #	Create Date	Certificate Holder	Job ID	Entity #	Loc #	Start Date	End Date	Clause	View
<a href="#">922871</a>	05/22/2019	TSIU TEST RENEW 15-16		0	0	06/09/2018	06/09/2019	..B...	



Click on the certificate number to view certificate details.

<b>922871</b>	05/22/2019	TSIU TEST RENEW 15-16		0	0	06/09/2018	06/09/2019	..B...	
---------------	------------	-----------------------	--	---	---	------------	------------	--------	--

### Certificate Detail

**Certificate Summary**

Policy Number	98765432
Certificate Number	922871
Policy Status	Active
Certificate Type	General
Show on Renew List	Visible

**Certificate Contact**

Policyholder	ACME FENCE CO 123 MAIN STREET ANYTOWN, NY 00001
Certificate Holder	TSIU TEST RENEW 15-16 TEST ALBANY, NY 12211

**Certificate Status**

Create Date	05/22/2019 11:00:05 A.M.
Update Date	05/22/2019 11:00:05 A.M.
User Name (Created/Updated)	JOHN TESTER

[View Certificate](#)

**Certificate Information**

Start Date	06/09/2018
End Date	06/09/2019
Entity Number	0
Entity Name	
Entity Term Date	
Location Number	0
Location Address	
Location Term Date	
Certificate Emailed To	
✉ Certificate Holder	
✉ Policyholder	tester@nysif.com
Certificate Emailed On	
Certificate Mail-To	Policyholder
Extra-Territorial Phrase Added	No
Liability Phrase Eliminated	No
Waiver of Subrogation Added	No
Building Demolition Restricted	Yes

You can also view the PDF of the certificate from this screen by choosing "View Certificate."

## Create a New Certificate

Select a Policy Number and click **Get Policy Info**.

The **eCertificates Create** screen will now display the policy information and the fields needed to create the certificate.

Select the entity, location and policy period requested.

### Create New Certificate

To create a certificate, select a policy number, click "Get Policy Info," and then enter the certificate details below. All fields are required unless otherwise stated.


Policy Number  
12345678


**Get Policy Info**


---

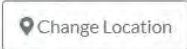
### New Certificate

Policy Number  
12345678

Policyholder Name  
ACME FENCE CO. 



Policyholder's Address  
123 MAIN STREET  
ANYTOWN, NY 00001 




Policy Period

Select	Start		End
<input type="radio"/>	06/09/2017	-	06/09/2018
<input type="radio"/>	06/09/2018	-	06/09/2019
<input checked="" type="radio"/>	06/09/2019	-	06/09/2020

Enter the Certificate Holder information. If you have previously created a certificate for this business, the system will search to match it.

#### Certificate Holder Information

 Please note that out-of-country certificates cannot be issued via this online system. If the Certificate Holder's address is outside the United States, please email [certificates@nysif.com](mailto:certificates@nysif.com) with your request.

Certificate Holder Name  
CERT HOLDERS COMPANY, LLC

Address Line 1  
789 ELM STREET

Address Line 2 (optional)  
SUITE 100

City  
ANYTOWN

State  
NY

ZIP Code  
00001

+4 (optional)

Matching Certificates (by name)  
No certificates were found with a matching name.

Choose your certificate options. Be sure to choose a certificate renewal plan appropriate for the project. If you anticipate a short-term project, choose "Do not renew," and it will not be available for renewal.

Certificate Options

Certificate Renewal Plan  
Select an option

Select an option  
Do not renew  
**Automatically renew for 1 year**  
Automatically renew for 2 years

Job ID (optional)  
111 SOUTH ST PROJECT

Email Certificate To  
Certificate Holder's Email (optional)  
testing@nysif.com

Automatically renewed certificates will become available when the next policy period is established.

Job ID will display on the certificate in the Certificate Holder section and can be used for searches on the Browse Certificates screen.

If you wish to provide to the certificate holder any notice of cancellation, check the box and choose the number of desired days from the drop-down. Please note that NYSIF will not provide this notification, and you, as the policyholder, will be responsible for notifying the certificate holder.

Advance Notice of Cancellation (optional)

Add following to the certificate:

"By causing this Certificate to be issued to the Certificate Holder, the Policyholder undertakes to provide the Certificate Holder XX calendar days' notice of any cancellation of the policy."

Note: By checking this box, I am causing this sentence to be placed on the Certificate and I agree to provide the Certificate Holder with advance notice of any cancellation of the policy by the number of calendar days I have selected.

Days' Notice  
15

Select Days' Notice  
5  
10  
**15**  
20  
25  
30

Preview Certificate

Choose "Preview Certificate."

[Preview Certificate](#)

### Preview Certificate ✕

This is a preview of your certificate.  
 If it is correct, scroll down and click "Create Certificate".  
 Once the certificate is created you can view, print and/or save the certificate.

12345678  
 ACME FENCE CO  
 123 MAIN STREET  
 ANYTOWN, NY 00001

POLICYHOLDER ACME FENCE CO 123 MAIN STREET ANYTOWN, NY 00001	CERTIFICATE HOLDER 111 SOUTH ST PROJECT CERT HOLDERS COMPANY, LLC 789 ELM STREET SUITE 100 ANYTOWN, NY 00001
---	--

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
12345678	*****	06/09/2019 TO 06/09/2020	6/19/2019

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2077 080-6 , COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY.

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

BY CAUSING THIS CERTIFICATE TO BE ISSUED TO THE CERTIFICATE HOLDER, THE POLICYHOLDER UNDERTAKES TO PROVIDE THE CERTIFICATE HOLDER 15 CALENDAR DAYS' NOTICE OF ANY CANCELLATION OF THE POLICY.

Close
Create Certificate

Click the "Create Certificate" button.

Choose the "View Certificate" button to generate the certificate PDF. Please note it will open in a new window.

### Certificate Issued ✕

Your Certificate Number 922946 has been successfully created.

To view, print, or save the certificate, click "View Certificate."

Close
View Certificate





199 CHURCH STREET, NEW YORK, N.Y. 10007-1100  
| nysif.com

### CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

\*\*\*\*\* 01234567  
ACME FENCE CO  
123 MAIN STREET  
ANYTOWN, NY 12345



SCAN TO VALIDATE  
AND SUBSCRIBE

<b>POLICYHOLDER</b>  ACME FENCE CO 123 MAIN STREET ANYTOWN, NY 12345		<b>CERTIFICATE HOLDER</b>  COUNTY DEPARTMENT 987 ELM STREET ANYTOWN, NY 12345	
--	--	---	--

<b>POLICY NUMBER</b> N 01234567	<b>CERTIFICATE NUMBER</b> 00000	<b>POLICY PERIOD</b> 07/01/2019 TO 07/01/2020	<b>DATE</b> 10/31/2019
------------------------------------	------------------------------------	--	---------------------------

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 01234567, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW.

**IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT [HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP](https://www.nysif.com/cert/certval.asp). THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS.**

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR, INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 99999999

U-26.3



## Renew a Certificate

Choose the policy number. The Renew page allows you to search by:

- certificate number
- certificate holder

You can also elect to have your results sorted by date or alphabetically by Certificate Holder.

### Renew Certificates

For a full list of available certificates, select a policy number and click "Search." All fields are required unless otherwise stated.

Policy Number 98765432
Certificate Number (optional) 922871
Certificate Holder Name (optional)
Sort by Newest Issued

Continue to include advance notice of cancellation on certificates where the certificate being renewed included such language? (optional)

Note that by issuing renewed certificates containing advance notice of cancellation language you agree to provide the certificate holder with advance notice of cancellation of the policy by the number of calendar days indicated on the certificate.

#### Advanced Search Options

Search

This example displays a result of search by certificate number.

### Certificates

Select the certificates to renew and click the Renew Selected Certificates button at the bottom of the page.

Showing 1 Certificates

Renew	Cert #	Period	Certificate Holder	Job ID	Entity #	Loc #	Clause	Create Date	View
<input type="checkbox"/>	<a href="#">922871</a>	06/09/2018 - 06/09/2019	TSIU TEST RENEW 15-16 TEST ALBANY NY 12211		0	0	..B...	05/22/2019	

Renew Selected Certificates

If searching for all certificates for a policy, choose the policy and click Search. Choose the certificate(s) you'd like to renew by clicking the check box and then click "Renew Selected Certificates."

**Certificates**  
 Select the certificates to renew and click the Renew Selected Certificates button at the bottom of the page.  
 Showing 6 Certificates

Renew	Cert #	Period	Certificate Holder	Job ID	Entity #	Loc #	Clause	Create Date	View
<input type="checkbox"/>	<a href="#">922920</a>	06/09/2018 - 06/09/2019	KPK RENEWAL PLAN TEST 18-20 15 COMPUTER DR ALBANY NY 12205	AUTO RENEW 1YR	0	0	.EB...	06/05/2019	
<input checked="" type="checkbox"/>	<a href="#">922871</a>	06/09/2018 - 06/09/2019	TSIU TEST RENEW 15-16 TEST ALBANY NY 12211		0	0	..B...	05/22/2019	
<input type="checkbox"/>	<a href="#">922856</a>	06/09/2018 - 06/09/2019	TEST DBOWEN 199 CHURCH STREET NEWYORK NY 10007		0	0	.EB...	05/14/2019	
<input checked="" type="checkbox"/>	<a href="#">922849</a>	06/09/2018 - 06/09/2019	STEVE SMITH 123 2ND AVE TROY NY 12180	TEST	0	0	.EB...	05/07/2019	
<input checked="" type="checkbox"/>	<a href="#">922796</a>	06/09/2018 - 06/09/2019	TEST TWO YEAR RENEW TEST ADDRESS TESTCITY NY 12345	z-74	0	0	.EB...	04/03/2019	
<input checked="" type="checkbox"/>	<a href="#">922795</a>	06/09/2018 - 06/09/2019	TEST 1554314497851 TEST ADDRESS TESTCITY NY 12345	z-74	0	0	.EB...	04/03/2019	

**Renew Selected Certificates**

To renew all certificates displayed (15 per page), select the top check box in the Renew column and click the Renew Selected Certificates button.

*A renewed certificate is automatically emailed to the certificate holder if a certificate holder email is present on the detail screen.*

## Validate/Subscribe to a Certificate

EMPLOYER	CLAIMANT	INSURAN REPRESEN
Review My Account		
Validate/Subscribe to a Workers' Comp Certificate		
Validate a Disability Benefits Certificate		

Visit [nysif.com](https://www.nysif.com), choose Employer, and choose Validate a Workers' Comp Certificate. You can also save this link as a bookmark for direct access: <https://www.nysif.com/cert/certval.asp>.

Enter the policy number and certificate number in the validation fields. Choose Validate Certificate.

### Workers' Compensation Online Services > Certificate Validation

#### Validate Certificate

To validate a Certificate of Insurance, enter the Policy Number and Certificate Number shown on the certificate and click "Validate Certificate." After validating the certificate, you may subscribe or unsubscribe from notifications for that certificate.

Policy Number	98765432
Certificate Number	922871

Validate Certificate



Alert me if this policy cancels

#### Certificate Validated

✓ This confirms that a Certificate of Insurance was issued with the following information:

##### Policy Info

Policy Number	98765432
Policyholder	ACME FENCE CO
Policy Period	06/09/2018 - 06/09/2019

##### Certificate Info

Certificate Number	922871
Certificate Holder	TSIU TEST RENEW 15-16

Notice of cancellation is only sent to subscribed Certificate Holders. Click "Manage Subscriptions" to subscribe to or unsubscribe from notifications for this certificate.

Manage Subscriptions

If the policy is not valid, a message will be returned stating:

### Invalid Certificate

No valid certificate found for Certificate 988765 Policy 98765432.

Please recheck the information and try again.

[I suspect my certificate is fraudulent.](#)

## Subscribe to a Certificate

Once you validate a certificate, choose the blue Alert button or the “Manage Subscriptions” button to subscribe to email or mail notifications regarding changes in the policy. **Please note: You must subscribe to receive notifications on newly created or renewed certificates.**

To subscribe to email notifications, enter your email address in the “Email to” field and re-enter it to confirm. Click Subscribe.

You will receive a confirmation message of your subscription, as well as an email confirmation to the email address entered.

### Manage Subscriptions

To subscribe to or unsubscribe from notifications for this certificate, fill out and submit the Subscription options below.

Policy Number 98765432	Cert Number 922871
---------------------------	-----------------------

Subscription Options

Subscribe to or unsubscribe from certificate?

Subscribe  Unsubscribe

Select certificate notification delivery method

Send to email address  Mail to Certificate Holder

Email Address to Subscribe

Re-enter Address to Confirm

[Subscribe](#)

[Go to Certificate Validation](#)

✓ Thank you for subscribing to electronic notifications for Certificates of Insurance from the New York State Insurance Fund. Please be sure to add `certificate_notifications@nysif.com` to your approved sender list in your email to avoid notifications going to your Spam folder.

Certificate holders can subscribe to mail notifications. Select the radio button next to Mail to Certificate Holder and click Subscribe. Mail notifications will be sent to the address listed on the certificate. No further action is required.

Subscription Options

Subscribe to or unsubscribe from certificate?

Subscribe  Unsubscribe

Select certificate notification delivery method

Send to email address  Mail to Certificate Holder

[Subscribe](#)

To unsubscribe, follow the validation steps, choose Manage Subscriptions and click “Unsubscribe.” Please note that you cannot unsubscribe from Mail Subscriptions.

# Request a Worker's Comp Standard Quote

Choose "Get a Quote or Apply for a Policy" from your landing page. Choose "Get a Standard Quote."



## What Will I Need?

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

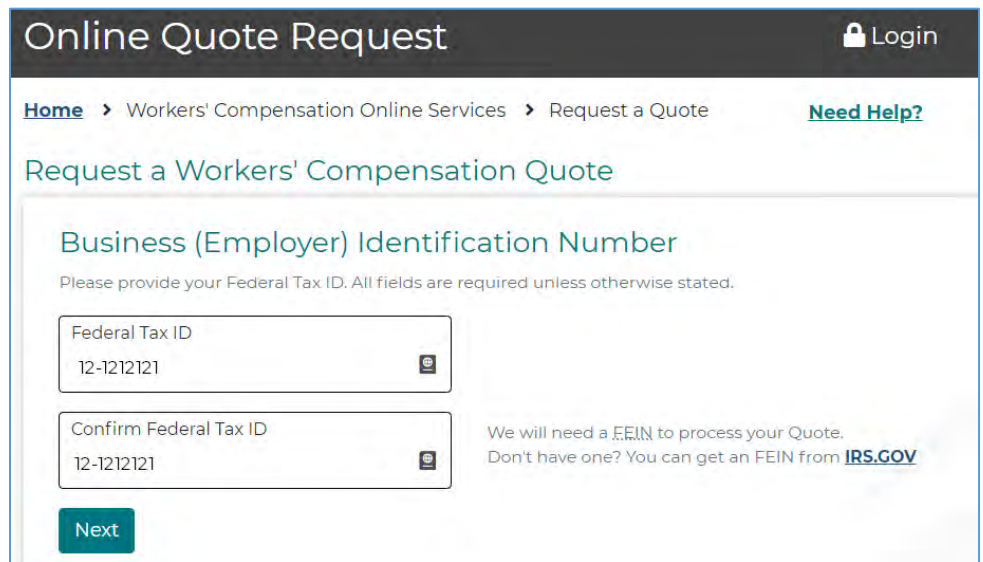
- FEIN (Tax ID)
- Business name and type (e.g. LLC, Corporation, Partnership, etc.)
- Estimated annual payroll, including casual labor, 1099 forms and any payments to uninsured subcontractors
- Payroll verification (copies of NYS Form NYS-45-MN and/or federal Form 941 for the last four quarters)
- Prior 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. Be sure to log in to your online account before beginning the quote process.

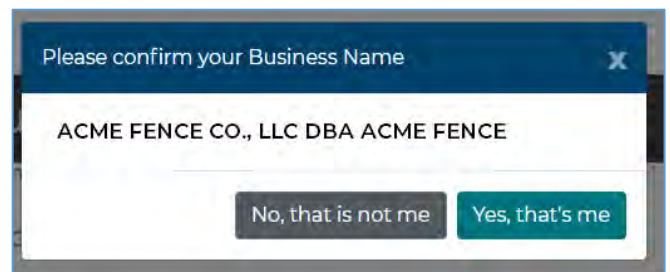


### 1. Enter Your FEIN (Federal Tax ID)



### 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.





### 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

+ Add a second 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](#) from [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.

NYCIRB # (optional)

Experience Modification Factor (optional)

Effective Rating Date (optional)  
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**

Description  
Fence Erection (Metal)

Duties

Number of Employees

Annual Payroll  
\$ .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.

Save Changes Review

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.

Close

***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.

Make changes Get a Quote Print



## 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](mailto:jnysif@nysif.com)

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

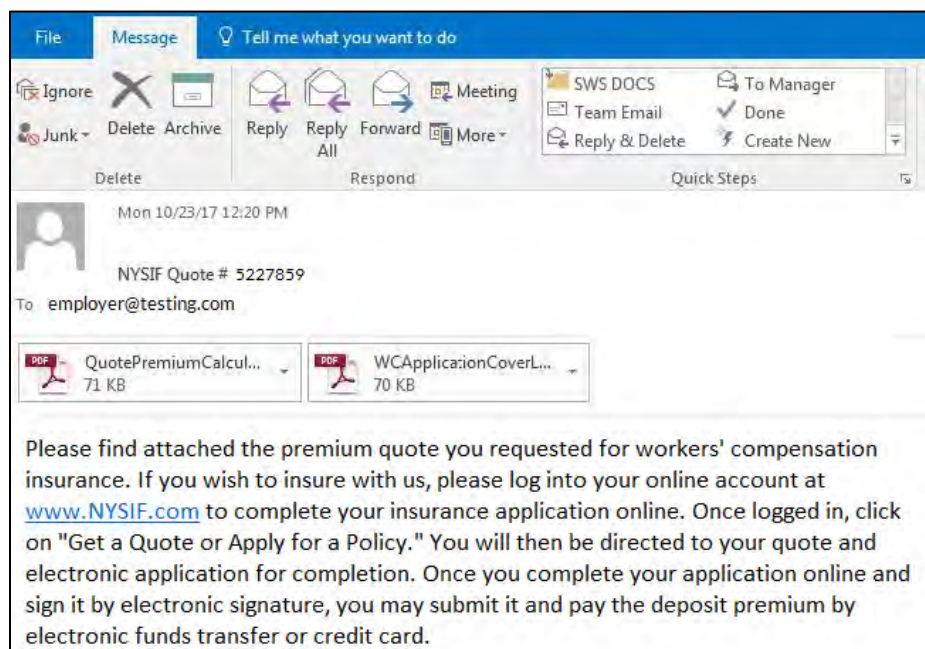
Once your quote is submitted, you will be able to view it via your online account. Visit [nysif.com](http://nysif.com), log in, and choose "Get a Quote" from your landing page. The quote will appear there.

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

### Request a Workers' Compensation Quote Ref #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](http://nysif.com) account to complete an online application.





# 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.

Quote #	Employer Name	...
<a href="#">5237565</a>	CUSTOMER APPLIED BROKER CORP	Status: Policy Created Received: 06/21/2019 Expires: 08/20/2019 Options: <a href="#">View Application</a>
<a href="#">5237477</a> 🏠	HOME OFFICE	Status: Quote Created Received: 06/19/2019 Expires: 08/18/2019 Options: <b>Continue to Online Application</b>

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.

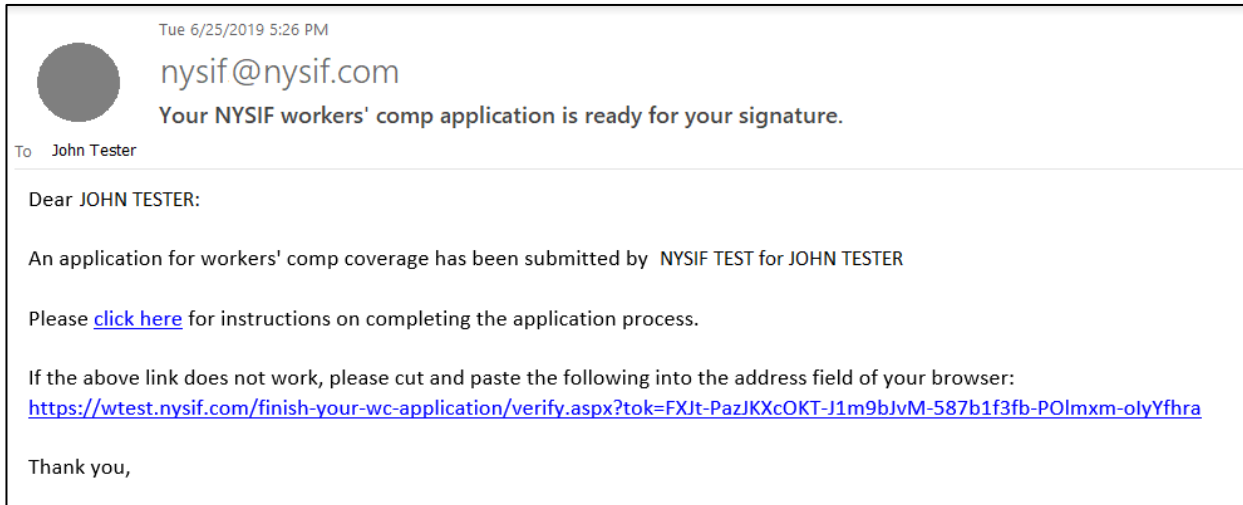
Identify the signing employer:

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.

The image shows a web form titled "Continue To Your Application". Below the title, it says "Please enter the five-digit ZIP Code of the primary business location:". There is a text input field containing "00000" and a "Submit" button.

The image shows a web form titled "Continue to Electronic Signature". Below the title, it says "ATN #: 2374659719 - Quote #: 5241475". There is a large button that says "Sign application with DocuSign".

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

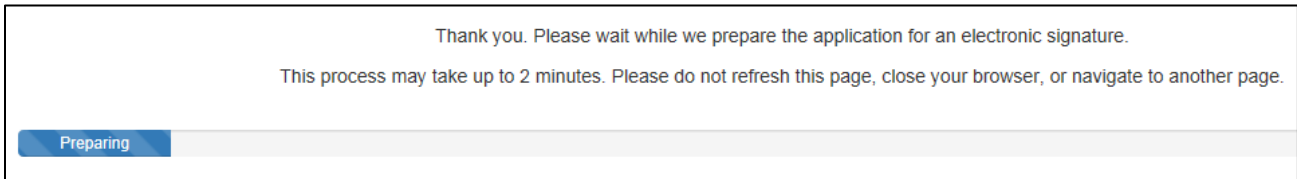
*TIP: We also recommend you download a copy from DocuSign prior to beginning the electronic signature process.*

## Application – Sign Online & Pay Online

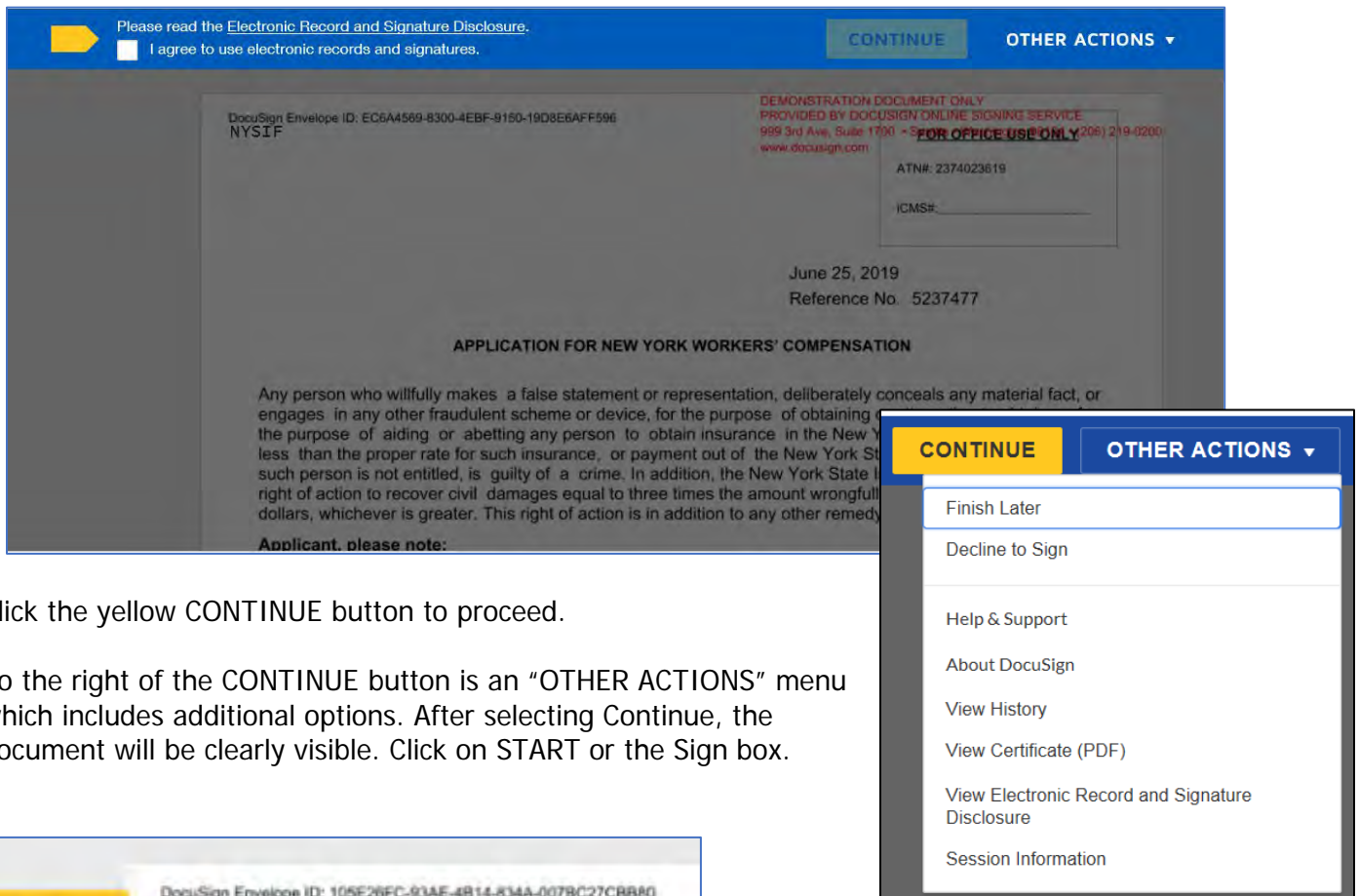
Once you've clicked submit, you will be redirected to DocuSign.

### 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.

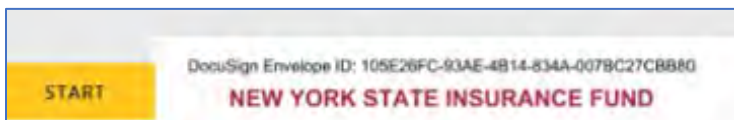


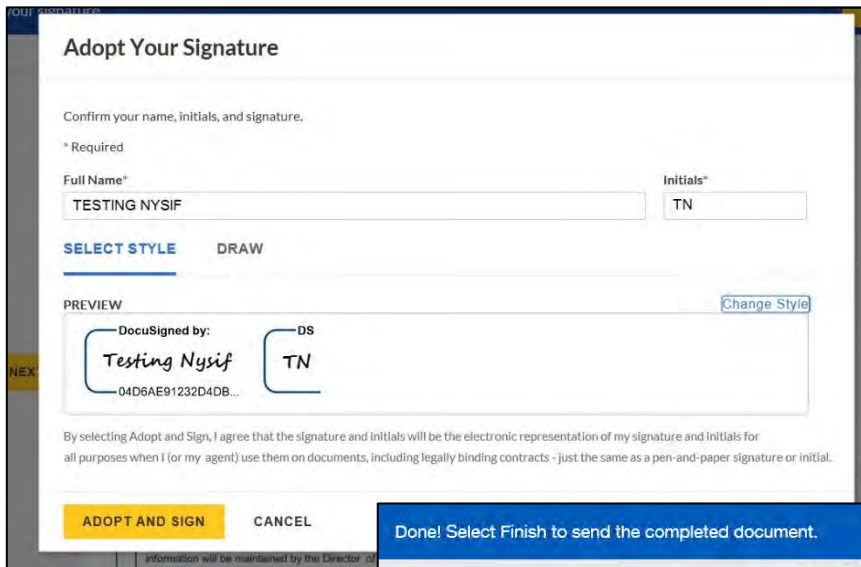
You must check the box to agree to use electronic records and signature.



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.



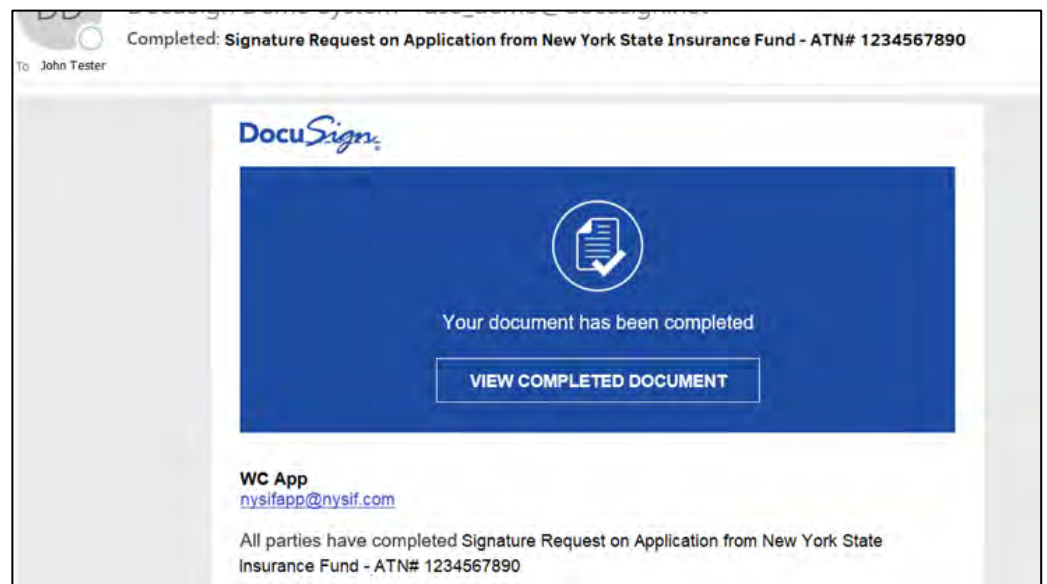


The screen will gray out the document, and a pop-up box will open with the user's name pre-populated. DocuSign will convert the name into a signature. There is also an option to create a free-hand signature by selecting the Draw option. Once a signature has been created, the user must choose **ADOPT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

DocuSign will insert the signature into the application.



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



## 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
<b>Total Payment</b>		<b>\$730.76</b>

[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
<b>Total</b>	<b>\$730.76</b>

[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 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 #

✓ 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
<b>Total Payment</b>				<b>\$747.20</b>

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   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
<b>Total Payment</b>				<b>\$747.20</b>

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 house. 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.



## Risk Control Resource Center

Our customizable, professionally designed, ready-to-print resources educate both employers and employees about workplace hazards. Help prevent injury and empower workers to take safety into their own hands.

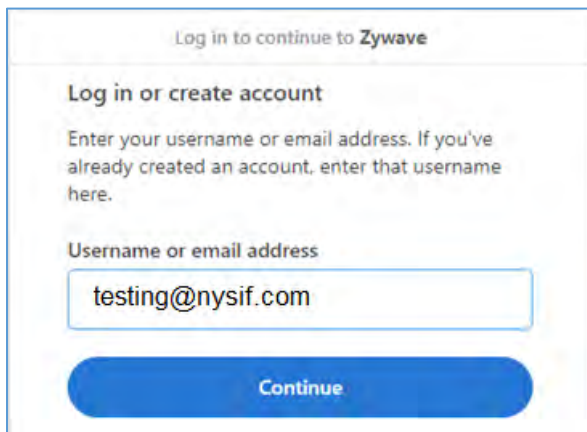
NYSIF provides thousands of downloadable resources that are right at your fingertips, including:

Newsletters	Safety Manuals
Safety Programs	Forms & Checklists
Safety Training Materials	Industry-Specific Resources
Workplace Posters	Online Safety Classes
Toolbox Talks	Hazard Communications Resources
Videos	Return-to-Work Materials

### LEARNING MANAGEMENT SYSTEM (LMS)

LMS enables you to assign safety training courses, stay compliant with safety requirements and generate course progress reports.

To access the Resource Center for the first time, choose the Risk Control link on your home page. You will be directed to our vendor, Zywave.



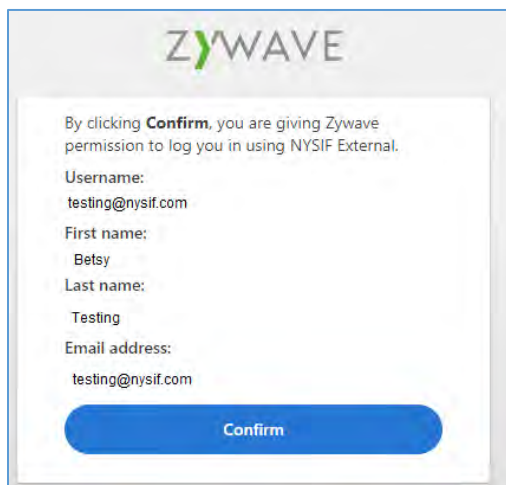
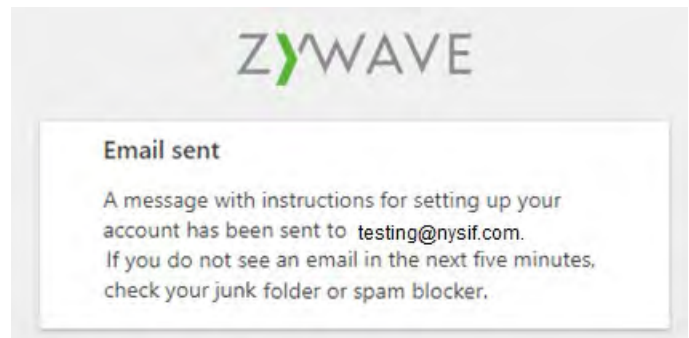
Log in to continue to Zywave

**Log in or create account**

Enter your username or email address. If you've already created an account, enter that username here.

Username or email address

**Continue**



**ZYWAVE**

By clicking **Confirm**, you are giving Zywave permission to log you in using NYSIF External.

Username:  
testing@nysif.com

First name:  
Betsy

Last name:  
Testing

Email address:  
testing@nysif.com

**Confirm**

Once you verify your address, register for an account and confirm your information.

**Remember to choose "Yes, remember me" so you won't be asked to log in again.**

## Forms

### Create a C-105 (Notice of Compliance)


Workers' comp law requires every covered employer to post a printed notice of compliance in each workplace notifying employees that the employer has workers' compensation coverage.

### C-105 Notice of Compliance

\*Policy Number(numbers only):

**Submit**

C-105 options for policy number: 0123456-7  
 Policy Status: Active  
 POLICYHOLDER POLICIES, INC  
 111 MAIN STREET  
 ANYTOWN, NY 00000

Form	Description	Print
C-105	To download Notice of Compliance - size 8 1/2" X 11" - As per <a href="#">Workers Compensation Law Section 51</a> , conspicuous posting of this notice is required by all employers in compliance with WCL rules & regulations stating they have secured the payment of compensation [insurance] to his/her employees and their dependents.	

## Prescription Benefits




Employers are required to provide an injured employee a Claimant Information Packet upon notification of a workplace injury. Included in that packet is a Prescription Services ID card the employee can use to obtain medication for the workplace injury.

### Prescription Benefits (PBM)

\*Policy Number(numbers only):

**Submit**

Prescription Benefits (PBM) Form options for policy number: 0123456-7  
 Policy Status: Active  
 POLICYHOLDER POLICIES, INC.  
 111 MAIN STREET  
 ANYTOWN, NY 00000

Form	Description	Print
Workers' Compensation Temporary Prescription Services ID	Employees injured at work under your policy should bring the completed form to any pharmacy participating in the CareComp Network of CVS Caremark, along with their prescription(s).	
Important Notification Concerning Workers' Compensation Pharmacy Benefits	<ul style="list-style-type: none"> <li>Post on employee accessible intranet or Internet website, or</li> <li>Post in the same location where the Notice of Workers' Compensation Coverage is posted, or</li> <li>Distribute a paper or electronic copy of the PBM Notice to all of your employees in New York State</li> </ul>	
Aviso Importante Referente A Beneficios de Farmacias Para Compensación Obrera	<ul style="list-style-type: none"> <li>Publicar en la intranet accesible para el empleado o en el sitio web en Internet,</li> <li>Publicar en el mismo lugar donde se coloca el Aviso de cobertura de Compensación de trabajadores, o</li> <li>Distribuir una copia electrónica o impresa del Aviso del PBM a todos sus empleados en el Estado de Nueva York.</li> </ul>	

## eSignature Forms

NYSIF has made its 10 most commonly-used workers' compensation forms available for electronic signature through DocuSign. This electronic process will expedite form submission.

Once a NYSIF underwriter initiates the electronic signature process in DocuSign, the policyholder will receive email notification that the online document is available to complete and sign electronically. In cases where more than one authorized signature is required, both signers will receive notification to complete the process. Once all recipients have successfully signed, both NYSIF and the policyholder will receive an email confirmation that the document has been executed, along with a link to the final form.

This table details the forms, a description of the form, and the signatures needed.

Title	Signers	Notes
[U-3] Assignment of Interest	1	This is a 1-signer workflow containing the U-3 (05/17) and U-3A (05/17) form. The sender must provide the Policy # reference for the form. Email Subj: NYSIF - Signed form required: [U-3] Assignment of Interest Agreement
[U-3] Assignment of Interest	2	This is a 2-signer workflow containing the U-3 (05/17) and U-3A (05/17) form. "Old firm signer" will sign first and fill in most of the fields on page one. "New firm signer" will sign afterwards and is responsible for most of the fields on page two. The sender must provide the Policy # reference for the form. Email Subj: NYSIF - Signed form required: [U-3] Assignment of Interest Agreement
[U-111] Inclusion of Additional Interest	1	This is a 1-signer workflow containing the U-111 and U-111A form. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U-111] Inclusion of Additional Interest
[U-431] Notice of election coverage of NY workers' compensation	1	This is a 1-signer workflow containing the U-431 Front and U-431 Reverse form. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U-431] Notice of election coverage of NY workers' compensation.
[U-445] Experience Rating Plan	1	This is a 1-signer workflow containing the U-445 (06/20/17) form. The sender must provide the Policy # reference for the form and the name of the assured. The applicant will complete all remaining fields. Email Subj: NYSIF - Signed form required: [U-445] Experience Rating Plan
[U-619] Corporate officer Exclusion form (1 officer ver w/U-617)	1	This is a 1-signer workflow containing the U-617, U-619, and U-619 Reverse form. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U 619] Corporate officer Exclusion form (1 Officer ver)
[U-619] Corporate officer Exclusion form (2 officer ver w/U-617)	2	This is a 2-signer workflow containing the U-617, U-619, and U-619 Reverse form. First officer will sign first and fill in most of the fields. The second officer will sign afterwards. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U 619] Corporate officers Exclusion form (2 Officers ver)
[U-627] Elective Coverage (w/U626 Letter)	1	This is a 1-signer workflow containing the U-627 and U-627 Reverse, with the U-626 cover letter. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U-627] Voluntary coverage for owners
[U-629] Notice of non-profit to exclude unsalaried executive officer	1	This is a 1-signer workflow containing the U-629 (C-105.52) form. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U-629] Notice of non-profit to exclude unsalaried executive officer
[U-765] Supplemental App for Roofing Contractors	1	This is a 1-signer workflow containing the 3 page U-765 (Rev. 6/17) form. The sender must provide the reference key for the form. Email Subj: NYSIF - Signed form required: [U-765] Supplemental Application for Roofing Contractors
[U-766] Certificate Request for Building Demolition	1	This is a 1-signer workflow containing the U-766 Rev. (06/17) form. The policy holder will provide all information, including the policy number. The sender must still click the "finish" button in docusign to send the document to the policy holder. Email Subj: NYSIF - Signed form required: [U-766] Building Demolition Questionnaire

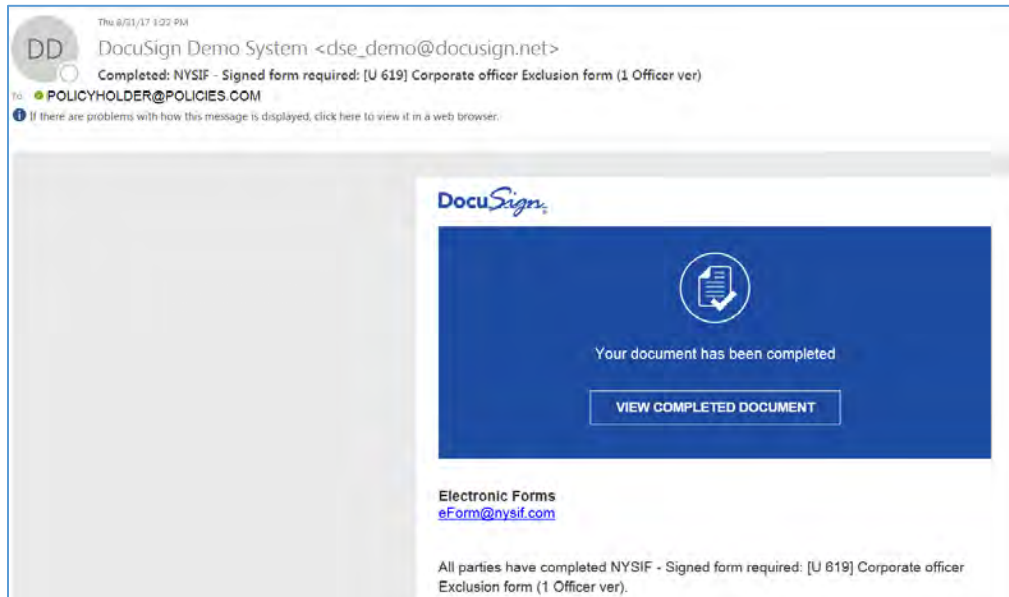


# You're done!

Thanks for using DocuSign.

After all recipients finish signing, you will receive an email with a link to the document.

(In the event two signatures are required, the first signer will receive the email form. Once they have completed their portion of the form, an email is automatically sent to the second signer.)





# Billing Menu

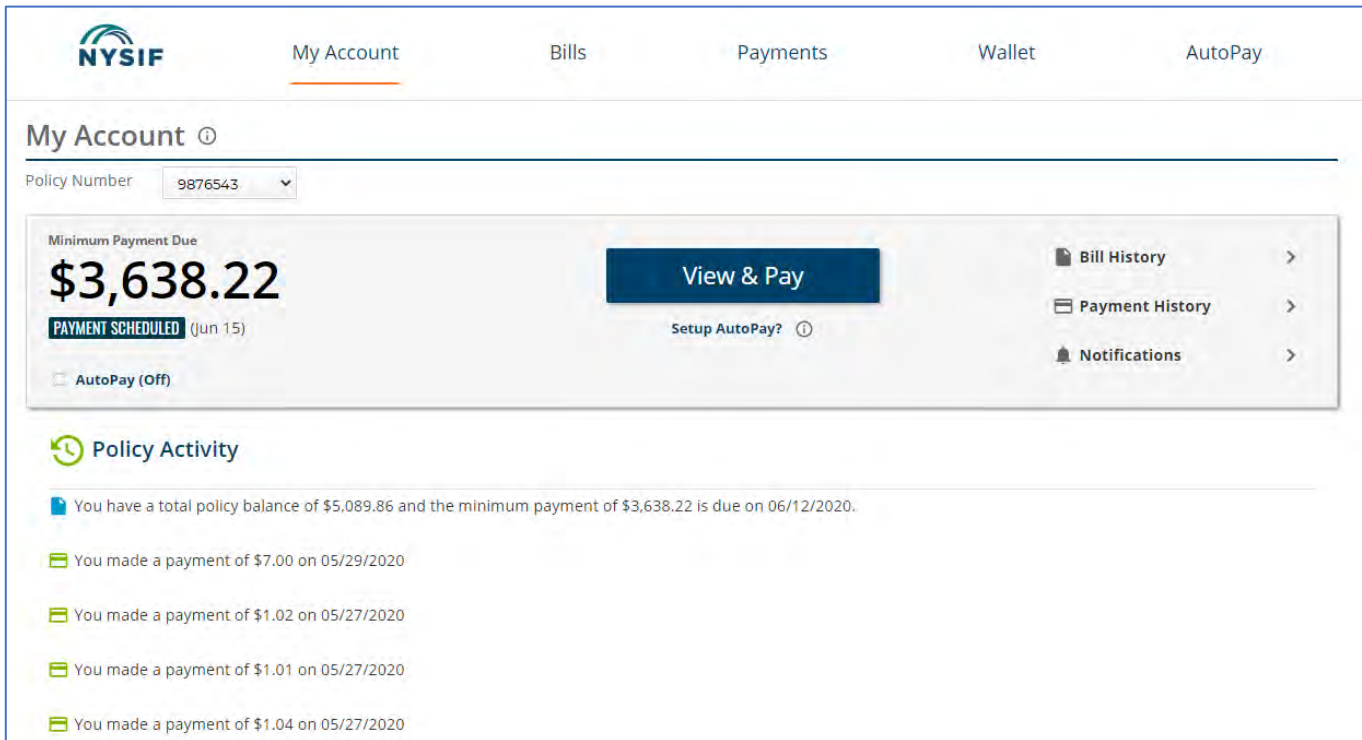
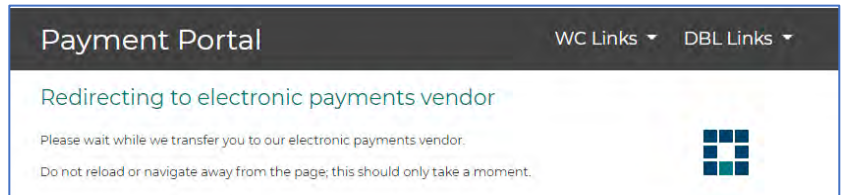
## Pay My Bill

Choose the Billing box to view the "Pay My Bill" link.

**Please note: choosing the "Pay My Bill" link when logged into your online account will allow for single sign-on (SSO) to our payment vendor. This means that your bill and payment information will be securely displayed on their site. Only the master account holder can make a payment using SSO.**

If you choose to make a one-time guest payment without being logged in to nysif.com, these features will not be available to you.

Choose **Pay My Bill**. You will be redirected to our electronic payments vendor, Kubra. Your Kubra landing page will display several options to you.



Your policy number will be displayed, along with the minimum amount due for that policy. (If you have more than one policy with NYSIF, click the drop down to access other policy numbers. The page will be updated to reflect the new minimum amount due.)

**View the KUBRA online payment [Terms and Conditions](#).**

## Make a one-time payment

Choose "View & Pay." Your latest bill for that policy will display, with a "Pay Now" button. Choose "Pay Now."

A screen will display with your choices. You can pay the minimum amount due, the total policy balance or another amount. Choose the date of payment and enter the credit card or bank account number. *KUBRA charges a 2.25% convenience fee for each credit card transaction.*

### Payment Details

Enter the details for this payment and click Continue

**Payment of**

Minimum Amount: \$3,638.22

Total Policy Amount: \$5,089.86

Other Amount: \$ \_\_\_\_\_

**Pay on**

Today \*

Due date (06/12/2020)

Select Date

**Pay with**

**Use a new card**

**Notes**

\_\_\_\_\_

\* Payments made before 2pm Eastern Time will post to your account today and payments made after 2pm ET will post to your account on the next business day.

### Add Card

**Card type**

Credit Card

Bank Account

Pinless Debit

**Bank account type:**

Select Account Type

**Account #**

Required

\_\_\_\_\_

**Routing #**

Required

\_\_\_\_\_

0000989430 0014409843

Routing Transit # Account #

**Nickname**

My Bank Account

**First name**

NYSIFTEST

**Last name**

NYSIFTEST

**Description (max 80 chars):**

\_\_\_\_\_

Save To Profile

Choose **Continue**.

Review your payment. Choose the "Pay \$XXX.XX (the amount)" button to complete your transaction.

### Payment Review

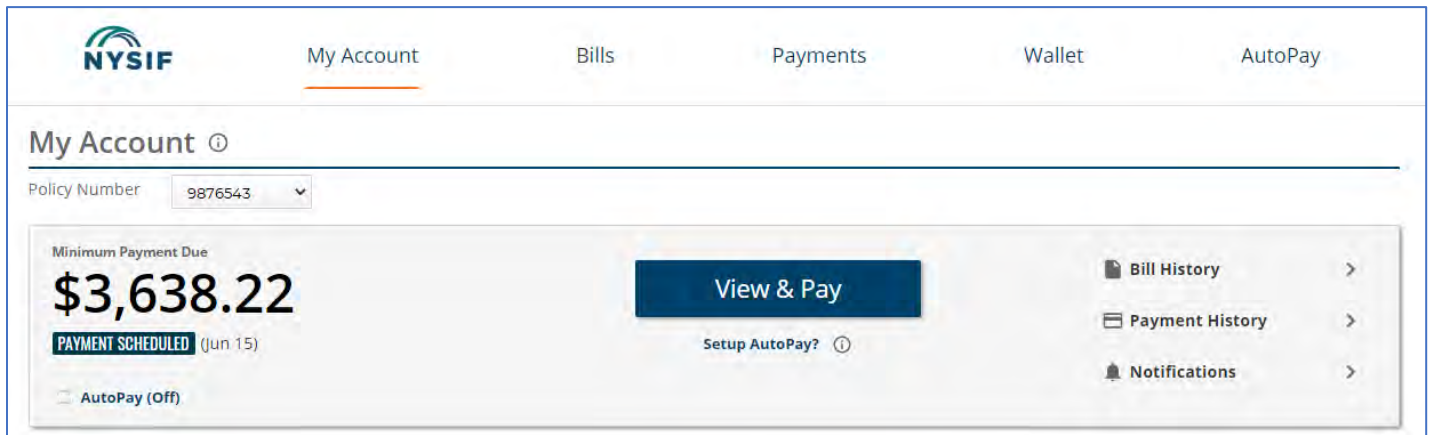
Please review your payment details

**Payment for Policy 12652988**

Pay On	Pay With	Payment Amount	Service Fee	Amount Charged	Edit details
Jun 19, 2020	Credit Card	\$3636.99	\$81.83	\$3718.82	<input checked="" type="checkbox"/>

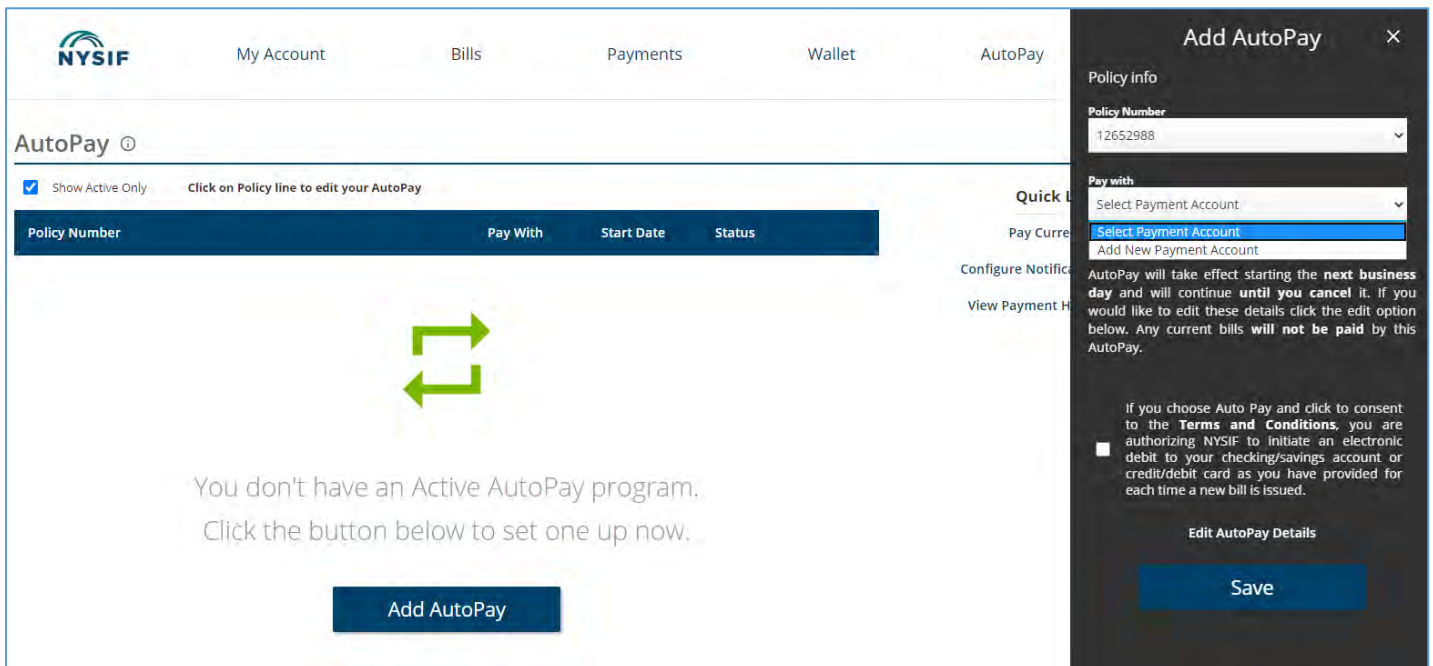
## Enroll in AutoPay

Choose either the “Set up AutoPay” link below the “View & Pay” button or choose it from the menu across the top.



The screenshot shows the NYSIF 'My Account' page. At the top, there is a navigation bar with 'My Account', 'Bills', 'Payments', 'Wallet', and 'AutoPay'. Below the navigation bar, the 'My Account' section displays the policy number '9876543' and a 'Minimum Payment Due' of '\$3,638.22'. A 'View & Pay' button is prominently displayed. To the right of the 'View & Pay' button, there are three menu items: 'Bill History', 'Payment History', and 'Notifications'. Below the 'View & Pay' button, there is a 'Setup AutoPay?' link. At the bottom left, there is a toggle switch for 'AutoPay (Off)'.

On this screen, choose **Add AutoPay**. A pop-up will appear on the right side. Choose the policy number you wish to enroll. If you have not yet added a payment method to your wallet, you can do that now. Choose **“Add New Payment Account.”**



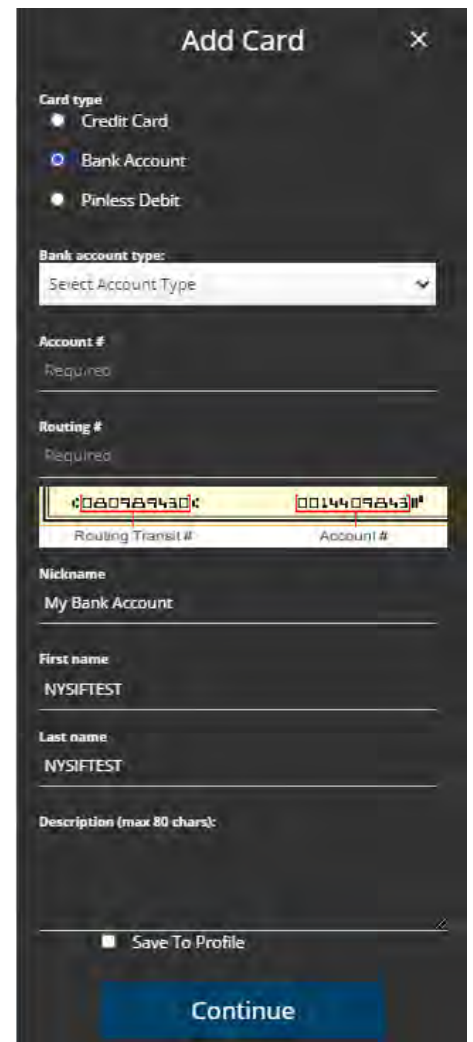
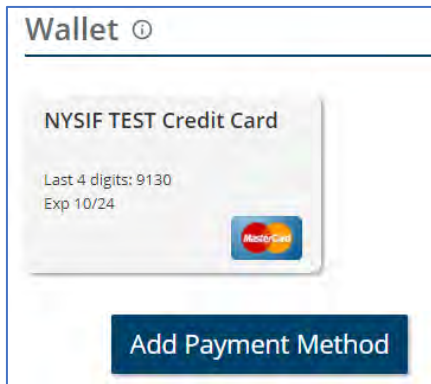
The screenshot shows the NYSIF 'AutoPay' page. The main content area displays a message: 'You don't have an Active AutoPay program. Click the button below to set one up now.' with an 'Add AutoPay' button. A pop-up window titled 'Add AutoPay' is overlaid on the right side. The pop-up contains a 'Policy Info' section with a 'Policy Number' dropdown menu. Below that, there is a 'Pay with' section with a 'Select Payment Account' dropdown menu and an 'Add New Payment Account' button. The pop-up also includes a 'Quick List' section with 'Pay Current' and 'Configure Notifications' options. At the bottom of the pop-up, there is a 'Save' button. The pop-up text explains that AutoPay will take effect starting the next business day and will continue until canceled. It also states that if you choose Auto Pay and click to consent to the Terms and Conditions, you are authorizing NYSIF to initiate an electronic debit to your checking/savings account or credit/debit card as you have provided for each time a new bill is issued.

You will be directed to your **Wallet** to add a payment method.

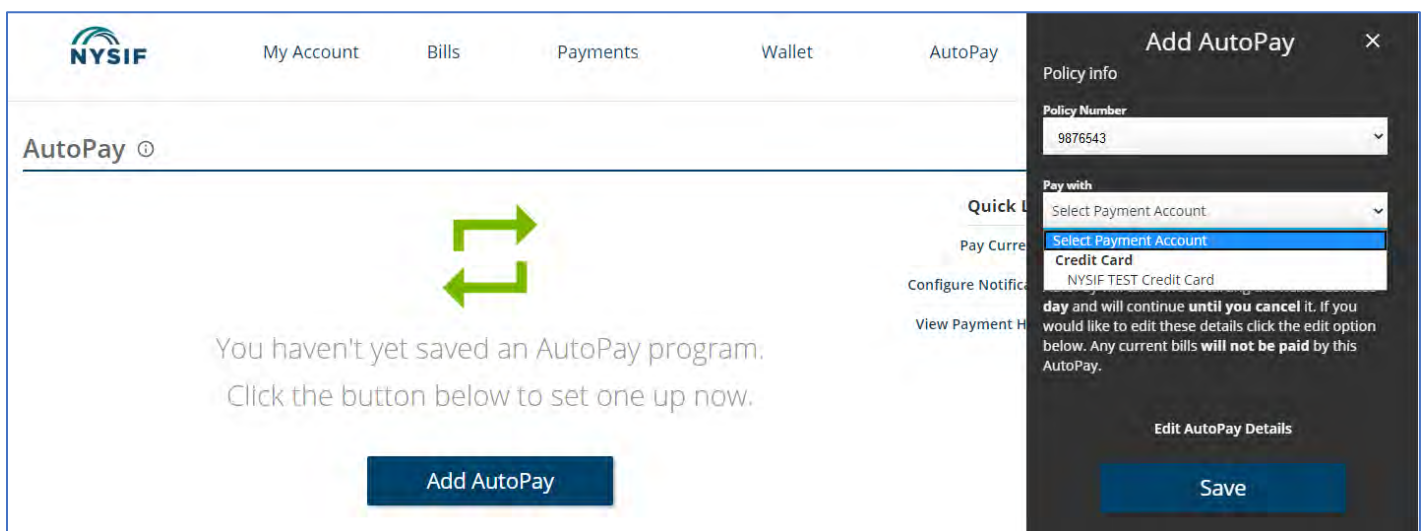
In Wallet, add the credit card or bank account you'd like to use. Please enter the digits carefully. You may add a nickname for the account, such as "Work credit card," etc.

Once you've added a payment method, it will appear in your Wallet. You can add other payment methods if necessary.

*KUBRA charges a 2.25% convenience fee for each credit card transaction.*



Return to the AutoPay screen. Choose **Add AutoPay**. Select the policy you wish to enroll and the payment method. **Click Save**.



A screen will appear to confirm your selection.

AutoPay ⓘ			
Policy Number	Pay With	Start Date	Status
1****2988	NYSIF TEST Credit Card	06/22/2020	Active >

## Set up the details for your AutoPayments

Double-click your policy number. This will take you to your details page where you can choose an end date, the amount of the AutoPayment and the date you'd like your payment made.

### Edit AutoPay ⓘ

Update the settings for AutoPay

Any current bills will not be paid by this AutoPay.

#### Policy info

Policy Number  
9876543

Pay With  
NYSIF TEST Credit Card

#### End Date

Remain Active

Until Further Notice

Until

For the next  payments

#### Payment Instructions

Pay

Minimum Payment Due  
Because your annual policy premium may change as the result of certain activities or transactions, please note that your minimum payment due may fluctuate each month.

On Due Date

Day(s) Before Due Date



## Notifications

If you use SSO to make a payment through Kubra, you can also take advantage of their notifications and reminders. These options are available for both email and text:

### Notifications ⓘ

Delivery Channels: Email (on) Text (off) Advanced Notifications

Notification	Email	Text
<b>Delivery Configuration</b>		
Notification Channels	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>New Bill and Payment</b>		
Notify me of a new bill by	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Remind me 5 days before due date	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Remind me 3 days after due date	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>Payment</b>		
Payment confirmations	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Cancelled payments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Rejected Payments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
<b>AutoPay</b>		
Scheduled AutoPay	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Aborted AutoPay	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Approved AutoPay	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Expired AutoPay	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Back
Save

Using the menu across the top of your Kubra home page, you can also view monthly bills and previous payments made via Kubra.

### Bills ⓘ

Policy Number 12652988 Apply filter? ☰

Policy No	Insurance Product	Due Date <span style="font-size: 0.8em;">▼</span>	Type	Total Policy Balance	Minimum Payment Due		
<input type="checkbox"/>	12652988	WORKERS' COMP	Jun 12, 2020	Bill	\$5,101.19	\$3,656.55	>
	12652988	WORKERS' COMP	May 13, 2020	Bill	\$5,106.34	\$2,939.36	>

### KUBRA Online And Phone Payments ⓘ

This page only shows payments made online or by phone. Payments by checks are not shown.

Policy Number 9876543 Apply filter? ☰

Date <span style="font-size: 0.8em;">▼</span>	Insurance Product	Type	Source	Status	Amount	
06/15/2020	WORKERS' COMP	Bank Account	EZ-PAY	Approved	\$1.23	>
06/11/2020	WORKERS' COMP	Bank Account	EZ-PAY	Approved	\$2.22	>
06/09/2020	WORKERS' COMP	Bank Account	EZ-PAY	Approved	\$1.11	>
06/01/2020	WORKERS' COMP	Bank Account	EZ-PAY	Approved	\$1.00	>
05/29/2020	WORKERS' COMP	Pinless Debit	e-Bill	Approved	\$7.16	>

## View Monthly Bills

Select this option to view premium bills associated with a policy. Click on the bill number to view details.

### Monthly Bills

Policy Number  
33333333

[Get Monthly Bills](#)

STATE INSURANCE FUND  
PRODUCTION CONTROL POLICY # 5, 199 CHURCH ST USWS-7TH FLOOR

Policy Status: Active

Bill Date	Previous Balance	Payment Received	Other Credits	New Charges	Other Debits	Balance Due	Minimum Due	Bill Number	Download
05/29/2020	\$ 2,939.36	\$ -5.15	\$ 0.00	\$ 722.34	\$ 0.00	\$ 3,656.55	\$ 3,656.55	58487823	<a href="#">Download</a>
04/30/2020	\$ 2,217.02	\$ 0.00	\$ 0.00	\$ 722.34	\$ 0.00	\$ 2,939.36	\$ 2,939.36	58359121	<a href="#">Download</a>
03/30/2020	\$ 1,494.68	\$ 0.00	\$ 0.00	\$ 722.34	\$ 0.00	\$ 2,217.02	\$ 2,217.02	58221819	<a href="#">Download</a>
02/28/2020	\$ 732.34	\$ 0.00	\$ 0.00	\$ 762.34	\$ 0.00	\$ 1,494.68	\$ 1,494.68	58074556	<a href="#">Download</a>
01/30/2020	\$ 1,494.68	\$ 0.00	\$ -1,494.68	\$ 732.34	\$ 0.00	\$ 732.34	\$ 732.34	57941872	<a href="#">Download</a>

[Pay My Bill](#)

# Policy Menu

## Account Summary

Choose "Account Summary" from the Policy menu.

### Account Summary

Policy Number: 01234567

[Get Summary Information](#)

ACME FENCE CO  
123 MAIN STREET  
ANYTOWN, NY 12345

Policy Status: Active

Summary Information for Policy Number : 01234567  
Current Policy Period 11/30/2017 - 11/30/2018

[Summary Information](#) [Previous Payments](#) go to [Monthly Bills](#) ➔

Policy No:	01234567
Policy Status:	ACTIVE
Current Balance:	25,550.99
Last Payment Posted:	
Last Payment Posted on:	
Minimum Amount Due Now	25,550.99
Information as of:	02/06/2018
Next Statement Date:	02/28/2018

Minimum Amount Due includes past due amount of \$24,681.09

Monthly Statement may or may not be mailed if you have a credit balance, or owe less than \$30.

[Pay your bill](#)

View previous payments and monthly bills using the top tabs.

[Summary Information](#) [Previous Payments](#) go to [Monthly Bills](#) ➔

Description	Date	Amount
Payment	01/24/2018	1,236.77 CR
Payment	12/21/2017	1,279.39 CR
Payment	11/20/2017	1,184.05 CR

## Earned Premium Audit (Audit Documents)

To view your policy's Premium Audit information, click the "Earned Premium Audit" link on your landing page. Your policy's audit history will be displayed. To review specific audits, the NYSIF Renewal Date may be selected as an additional filter. For each audit, the query displays:

- Audit Number
- Issue Date
- Status (of audit)
- Audit Period
- Group Number (of policy)
- Auditor
- Exit Interview Form (if available)
- Audit Worksheet (if available)

### Earned Premium Billing Audit Inquiry System

**Please Note:** Exit Interview Forms and Audit Worksheets, if available, are viewable on this portal for the last 4 Renewal Dates only.

\* NYSIF Policy Number

NYSIF Renewal Date

#### List Of Audits For Policy

**Policy Number:** 99999999  
**Renewal Date:** (All Renewal Dates)  
**Audit Number:** 8281446  
**Pay Plan:** Quarterly  
**Audit Count:** 1  
**Location Count:** 7  
**Rating Date:**

Audit Number	Issue Date	Status	Audit Period	Group Number	Auditor	Exit Interview Form	Audit Worksheet
<a href="#">8281446</a>	03/04/2022	Released to PAD	12/26/2021 - 02/24/2022	90	JOHN NYSIF	N/A	N/A
<a href="#">8244498</a>	12/27/2021	UW Review	12/26/2020 - 12/26/2021	90	UNDERWRITER	N/A	N/A
<a href="#">8071586</a>	12/28/2020	Released to PAD	12/26/2019 - 12/26/2020	90	MARY TESTER	N/A	N/A
<a href="#">8040861</a>	11/03/2020	Billed	12/26/2018 - 12/26/2019	90	AUDIT SUPERVISOR	N/A	N/A
<a href="#">7709661</a>	12/26/2018	Released to PAD	12/26/2017 - 12/26/2018	90	JOHN NYSIF	N/A	N/A

For details about an audit, click the audit number. A page will open displaying details about the audit.

Click close to go back to the previous screen.

### Audit Serial Number: 00022233

<b>Review Type</b>	N/A	<b>Audit Process Dates</b>	N/A
<b>Policy Name</b>	NYSIF	<b>Created</b>	03/04/2022
<b>Policy Number</b>	99999999	<b>Completed</b>	N/A
<b>Group Number</b>	90	<b>Payroll Audit Review</b>	N/A
<b>Renewal Date</b>	12/26/2021	<b>Underwriting Review</b>	N/A
<b>Rating Date</b>	N/A	<b>Billed</b>	
<b>Policy Status</b>	ACTIVE	<b>Auditor Name</b>	JOHN NYSIF
<b>Pay Plan</b>	Quarterly	<b>Auditor Number</b>	222
<b>Class Lines</b>	2	<b>History</b>	N/A
<b>Total Payroll</b>	\$0.00	<b>Audit Start Date</b>	12/26/2021
<b>Other Payroll</b>	N/A	<b>Audit End Date</b>	02/24/2022
<b>Audit Appointment Date</b>	N/A	<b>Period End Date</b>	12/26/2022
<b>Audit Status</b>	Retired	<b>Bill Code</b>	N/A
		<b>Location Count</b>	7
		<b>Audit Rating</b>	N/A

Line Number	Class Code	Region	Payroll	Rate
1	8742		\$0.00	\$0.34
2	8809		\$0.00	\$0.22

## Exit Interview Form

Click "View" under Exit Interview to view those documents.

### PREMIUM AUDIT EXIT INTERVIEW FORM

Policyholder:	ACME FENCE		
Policy Number:	1234567-8	Group Number:	90
Audit Number:	8255850	Policy Status:	Active
Audit Period:	01/01/2021 to 01/01/2022	Audit Date:	03/16/2022
Policy Period:	01/01/2021 to 01/01/2022	Auditor:	JOHN NYSIF

#### Payroll Information

Class Code	Class Description	Estimated Payroll	Verified Payroll
9028	BUILDING OPER DWELLING NOC ETC-U	\$795,300	\$799,485

Premium Billed at the Beginning of Period:	\$24,942.01
Premium for Period as a Result of the Audit:	\$25,071.95
Premium Change as a Result of Audit:	\$129.94

#### Please Note:

- Any credits or charges generated on the audit will be added to, or subtracted from, your current outstanding balance.
- If audited premium is significantly different from the current policy period renewal, your current policy premium may be subject to rebill adjustment.

#### Premium Audit Checklist

- |   |                                      |                                      |
|---|--------------------------------------|--------------------------------------|
| A. Payroll separations and employees' classification                      | <input checked="" type="radio"/> Yes | <input type="radio"/> N/A            |
| B. Changes in operation/classification/payroll                            | <input type="radio"/> Yes            | <input checked="" type="radio"/> N/A |
| C. Overtime Credit  | <input checked="" type="radio"/> Yes | <input type="radio"/> N/A            |
| D. Payroll Limitation Credit  | <input type="radio"/> Yes            | <input checked="" type="radio"/> N/A |
| E. Wrap-Up work   | <input type="radio"/> Yes            | <input checked="" type="radio"/> N/A |
| F. Casual Labor   | <input type="radio"/> Yes            | <input checked="" type="radio"/> N/A |
| G. Current policy renewal re-bill adjustment                              | <input type="radio"/> Yes            | <input checked="" type="radio"/> N/A |
| H. Audit Results & Policy Cost discussed with Policyholder/Representative | <input checked="" type="radio"/> Yes | <input type="radio"/> No             |

Gross Sales during the audit period

Largest number of employees during any one quarter of the audit period

#### Breakdown of Adjusted Audit Premium

Item #	Class	Description	Payroll	Rate	Premium
1	9028	BUILDING OPER DWELLING NOC ETC-U	\$799,485.00	\$4.06	\$32,459.09
2	<b>MANUAL PREMIUM</b>				\$32,459.09
3	EXPERIENCE RATING CREDIT 11 % OF (ITEM 2)				-\$3,570.50
4	<b>TOTAL MODIFIED PREMIUM</b>				\$28,888.59
5	NYSIF DISCOUNT 25 % OF (ITEM 4)				-\$7,222.15
6	EXPENSE CONSTANT				\$250.00
7	TERRORISM PREMIUM				\$455.71
8	NATURAL DISASTER AND CATASTROPHE PREMIUM				\$79.95
9	<b>TOTAL PREMIUM</b>				\$22,452.10
10	ASSESSMENT CHARGE 11.8 % OF (ITEM 9 LESS ITEM 6 )				\$2,619.85
11	<b>TOTAL PREMIUM + ASSESSMENTS</b>				\$25,071.95
	CREDIT FOR PREVIOUS DEPOSIT PREMIUM				-\$6,235.50
	CREDIT FOR PREVIOUS INSTALLMENTS				-\$18,706.51
A	<b>TOTAL CREDIT FOR PREVIOUS PREMIUM</b>				-\$24,942.01
B	<b>TOTAL PREMIUM + ASSESSMENTS (ITEM 11)</b>				\$25,071.95
C	<b>NET PREMIUM FOR THIS PERIOD (B LESS A)</b>				\$129.94



## Audit Worksheets

Click "View" under Audit Worksheet to view those documents.

THIS IS A COPY OF THE AUDIT COMPLETED BY A PADTEST1 ON 04/06/2017. WE VALUE YOU AS A CUSTOMER AND APPRECIATE YOUR BUSINESS. PLEASE CALL ME IF I CAN BE OF FURTHER ASSISTANCE.					
<b>Audit Number:</b> 987654			<b>Policy Number:</b> 12345678		
<b>Audit Period:</b> 07/01/2014 - 07/01/2015			<b>Policy Period:</b> 07/01/2014 - 07/01/2015		
<b>Assured Address:</b> Acme Fence Company 123 Main Street City, NY 11111 <b>Phone:</b> 518-555-1212			<b>Audit Address:</b> Johnson CPA 456 Elm Street Anytown, NY 00000 <b>Phone:</b> 518-222-5151		
<b>Entity:</b> Acme Fence Co Inc					
<b>EXECUTIVE OFFICERS</b>					
Title	Name	Gross Payroll	Amt. Included	Code	Description Of Duties
President		45,000	45,000	8809	Office Admin and Management.

<b>Audit No:</b> 666666-6		<b>Assured:</b> ACME FENCE COMPANY					
<b>Policy No:</b> 12345678		<b>Entity:</b> ACME FENCE CO INC.					
<b>PAYROLL DETAILS</b>							
A	B	C	D	E	F	G	H
(+/-) Total			(-)	(-)	(-)	(-)	(-)
Class Code		9501	8809	9501	8810	8742	8810
Territory		T9	T9	T9	T9	T9	T9
Title			President				
Name/Desc			JOHN ACME	reclassified from maNAGERS	managers	customer relation	admins
Jul/2014	\$512,399	\$0	\$19,320		\$46,123	\$21,244	\$19,204
Aug/2014	\$651,706	\$0	\$24,038		\$59,000	\$26,875	\$21,430
Sept 2014	\$654,602	\$0	\$41,665		\$59,577	\$24,576	\$24,722
october 2014	\$539,676	\$0	\$19,320			\$22,367	\$35,840
Total	\$2,358,383	\$0	\$104,343		\$164,700	\$95,062	\$101,196
Officers Adjust			\$34,200				
Other Adjust.				\$32,940	-\$32,940	-\$1,219	-\$28
Const. P.L.							
Charge		\$0	\$34,200	\$32,940	\$131,760	\$93,843	\$101,168

<b>Audit No:</b> 666666-6		<b>Assured:</b> ACME FENCE COMPANY						
<b>Policy No:</b> 12345678		<b>Entity:</b> ACME FENCE CO INC						
<b>RECONCILIATION</b>								
SUMMARY				RECONCILIATION		REPORTS		
Terr.	Code	Fed	Rated As	Payroll	Description	Values	Description	Values
9	9501	N		\$933,452	Total summary payroll	\$2,224,458	3q14	\$1,818,707
9	8809	N		\$34,200	Prior period	\$0	october 2014	\$539,676
9	8810	N		\$311,271	Subsequent period	\$0		
9	8742	N		\$93,843	Adjustment for Class [9501]	-\$7,606		
9	4511	N		\$434,708	John Acme, president	\$70,143		
9	3372	N		\$416,984	Adjustment for Class [8810]	\$32,968		
					Adjustment for Class [8742]	\$1,219		

## Endorsements

Clicking on the Endorsement Name will display the endorsement text.

List of All Endorsements

### Endorsements On A Policy

NYSIE Policy Number

Submit

**Policy Number:** 01234567  
**Assured Name:** ACME FENCE CO  
**Address:** 123 MAIN STREET  
 ANYTOWN, NY 11111  
**Issue Date:** 02/29/2018

End #	Name	Start Date	End Date	Terminate Date	Replacement End #	Seq #
99	SPECIAL ENDORSEMENT (EXCLUDING COVERAGE)	12/7/1999				1
106	Notice Of Terrorism Insurance Coverage.	11/30/2002	11/30/2003			1
109	NOTIFICATION ENDORSEMENT: TRIA-PLC.	11/30/2005	11/30/2006			1
90	INDIVIDUAL / CO-PARTNER INCLUSION	7/15/2010				1

**Endorsement Number:** 106  
**Endorsement Name:** Notice Of Terrorism Insurance Coverage.  
**Endorsement Text:**  
 Notice Of Terrorism Insurance Coverage (TRIA)

Coverage for acts of terrorism is already included in your current policy. You should know that, effective November 26, 2002, under your existing coverage, any losses caused by certified acts of terrorism would be partially reimbursed by the United States under a formula established by federal law. Under this formula, the United States pays 90% of covered terrorism losses exceeding the statutorily established deductible paid by the insurance company providing the coverage. The portion of your annual premium that is attributable to coverage for acts of terrorism is: .34

Choose the "List of All Endorsements" button to display the full list.

### List of All Endorsements

Endorsements

- 1 --- AUTO RACING
- 2 --- DOMESTIC SERVANTS
- 3 --- EXCLUDED LOCATION
- 4 --- EXTRATERRITORIAL
- 5 --- FOREIGN STATES EMPLOYEES- WORKING IN NYS
- 6 --- FARMS - EXCLUSION SPOUSE/MINOR CHILDREN
- 7 --- FARMS-ELECTV COVRG SPOUSE/MINOR CHILDREN
- 8 --- FARMS - LABOR CONTRACTOR
- 9 --- FLIGHT CREW
- 10 --- JOINT VENTURE
- 11 --- MANAGING AGENT
- 12 --- OFFICERS-EXCL CVG-MUNICPLS & POL SUB-DIV
- 13 --- OFFICERS/EXEMPT EMPLOYEE-EXCL COV,NON-PFT
- 14 --- ELECTIVE COVRG OFFICERS/EXEMPT EMPLOYEES
- 15 --- PAROLEE COVERAGE

Terminated Date:

Replacement Endorsement #:

Replacing Endorsement #:

Endorsement Text: ↵

## Monitor Subcontractor Coverage

Enter the FEIN of the subcontractor and click **SEARCH**.

NYSIF will display if they have current workers' compensation insurance. If they have current coverage, add them to your monitoring list, and you will be notified when there is a change in coverage.

### Monitor Subcontractor Coverage

Please note that the subcontractor information below is updated every 24 hours.  
If you need more recent information, you may search for employer coverage on the [Workers' Compensation Board's](#) website.

FEIN  
 123456789

Search

---

Search Results

FEIN	Active Coverage	Employer Name	Employer Address	Policy
XXXXX 6789	Y	ACME CONSTRUCTION	123 MAIN ST; ALBANY, NY 12240	33221100

Add To List

Employers will remain on your monitoring list until or unless you remove them. (Subcontractors with no active coverage for 365 days will be automatically deleted.) Policyholders can also export their subcontractor monitoring list to Excel.

### Your Subcontractor List

Click on a column header to sort

FEIN	Active Coverage	Employer Name	Policy	Monitor Start Date	
XXXXX 3052	Y	ADIRONDACK PORTABLE CUSTOM	UB2T8618892214G	04/25/2022	<a href="#">Delete</a>
XXXXX 1769	Y	BARBAROTTO INTERNATIONAL SALESCORP	UBIT4105222242G	04/27/2022	<a href="#">Delete</a>
XXXXX 6896	N	CERASIA & DEL REY-CONE LLP		05/11/2022	<a href="#">Delete</a>
XXXXX 8732	N <span style="color: red;">❗</span>	DEVON THOMAS MINKLER-CHORNEY		05/11/2022	<a href="#">Delete</a>
XXXXX 4174	Y	GOURMET FOOD OF NEW YORK INC	76WEGAR8P51	05/11/2022	<a href="#">Delete</a>

❗ This symbol indicates that a subcontractor has not had active coverage for at least 90 days. If you no longer need to monitor this subcontractor, please delete them from your list. Subcontractors with no active coverage for 365 days will be automatically deleted.

23 Record(s)

[Download list](#)

Dear Policyholder,

There has been a change in workers' compensation coverage for the following subcontractor(s) on your monitor list:

Employer Name	New Status
PATRICK SCHULZ	Potential coverage lapse - confirm coverage at <a href="#">wcb.ny.gov</a>
GAP TESTING CORP.	Potential coverage lapse - confirm coverage at <a href="#">wcb.ny.gov</a>

Employers will remain on your monitoring list until or unless you remove them. However, subcontractors without active workers' compensation coverage for 365 days will automatically be removed from your monitor list.

# NYCIRB Rating Data

Enter the policy number.

Click the Sheet # to view the NYCIRB data for that entity and time period.

### New York State Compensation Insurance Rating Board Information

Policy Number: 0123456-7

[Submit](#)

Policy #	Board #	Sheet #	Risk Name	ISSUED Date	Eff Date	Exp
01234567	600086	<a href="#">1505603</a>	ACME FENCE COMPANY	10/03/2015	07/01/2014	1.08
01234567	600086	<a href="#">1483551</a>	ACME FENCE COMPANY	08/04/2015	07/01/2014	1.08
01234567	600086	<a href="#">1482231</a>	ACME FENCE COMPANY, INC. DBA ACME	07/01/2015	07/01/2014	1.08
01234567	600086	<a href="#">1408544</a>	ACME FENCE CO., INC.	02/03/2014	07/01/2014	1.12
				10/03/2015	07/01/2013	0.94
				02/02/2013	07/01/2013	0.94

### NY CIRB RATING DATA

07/01/2014  
EFF. Date of Rtg

**INSURED and LOCATION**

ACME FENCE CO  
123 MAIN STREET  
ANYTOWN, NY 00000

R. 0000000  
Board File No.  
10/03/2015  
Issue Date

CODE NO.	CLASSIFICATION	MANUAL RATE
0000	Governing Classification to Apply	0.00
3372	Galvanizing or Tinning	0.00
3372	Electroplating	0.00
3372	Electroplating	0.00
4511	Analytical Chemist	0.00
9501	Painting-Shop Only-B Drivers	0.00
14	RATING TERM: EXPERIENCE MODIFICATION: 1.08	

Part I	1) POLICY YR	2) CLAIM NO.	3) ACTUAL INCURRED LOSSES	4) PRIMARY ACTUAL LOSSES
Exhibit of Actual Losses	Total by Policy Year of All Cases Equal To Or Less Than \$10000		2012: 9675	9675
			2011: 17359	17359
			2010: 6462	6462
	Individual Cases Greater Than \$10000		2012: 66471.244	32000
			2012: 65833.477	15500
			2011: 65697.831	10038
			2010: 64752.71	18001
			(a)	(b)
(c) ACTUAL EXCESS (a) - (b) = 35539			Total 109035	Total 73496

PART II	5) CLASS CODE	6) POLICY YR	7) PAYROLL	8) EXP LOSS RATE	9) EXP LSS 7)X8)/100	10) D RATIO	11) PRI EXP LSS 9)X10)
Exhibit of Expected Losses	3372	2012	1096092				
		2011	1171459				
		2010	1153817	2.06	70480	0.20	14096
	4511	2012	1011485				
		2011	1086285				
	8742	2010	979600	0.38	11694	0.23	2689
		2012	194780				
	8809	2011	229690				
		2010	280289	0.17	1197	0.21	252
	8810	2012	189800				
		2010	189800	0.08	450	0.23	104
	9501	2012	995388				
		2011	987543				
	9501	2010	907910	0.08	2312	0.26	601
		2012	2607406				
	2011	2544897					
	2010	1830777	1.28	89384	0.29	25922	
			(d)			(e)	
(f) EXPECTED EXCESS (d) - (e) = 131853			Total 175517	Total 43664			

PART III	12) PRIMARY LOSSES	13) B VALUE + WX(c) COL 16	14) (I-W)X(f) BOTH COL'S	15) TOTALS	16) ACTUAL	17) EXPECTED	18) EXP MOD
Rating Procedure	(12) PRIMARY LOSSES				W		
	(13) B VALUE + WX(c) COL 16				(b)	73496	(e) 43664
	B VALUE + WX(f) COL 17	0.12				62365	73922
	(14) (I-W)X(f) BOTH COL'S	0.88				116031	116031
	(15) TOTALS	I-W	(g)	251892	(h)	233617	(g)/(h) 1.08



## Payroll Reporting

Most policies are audited by a NYSIF auditor. In certain cases, a policyholder may submit an underwriting payroll verification instead of an actual audit. A policyholder who receives a payroll verification notification letter should be sure to follow the instructions on the letter to access the form and complete and return it to NYSIF within 30 days.

NYSIF reserves the right to perform an actual audit to verify the data submitted by the employer.

Eligible policyholders can submit a payroll report online at <https://www.nysif.com/wcpayroll/>. Follow the instructions below. If you are unable to verify your payroll online, you may obtain a paper form at [nysif.com/verifyprint](https://www.nysif.com/verifyprint).

To submit a Payroll Report or Self-Audit Report with a Document Number in letter/number format such as A1B2C3D4E5F6, please email the fully completed form to your policy rep or mail it to NYSIF; PO Box 66699; Albany, NY 12206

**STEP 1. Enter the policy number and the report number from your paper payroll report. Click NEXT.**

The screenshot shows the 'Workers' Compensation Online Payroll Report' interface. At the top right is a 'Login' button. Below the header is a light blue banner with the text: 'Need Help? Call your Policy Representative at 1-800-865-4714 Monday - Friday 8am - 5pm'. A progress bar below the banner shows seven steps: Step 1 (Start), Step 2 (Verify Policyholder Info), Step 3 (Ownership Info), Step 4 (Worker Info), Step 5 (Other Worker Info), Step 6 (Review & Submit), and Step 7 (Successfully Submitted). Step 1 is currently selected and highlighted in blue. The main content area is titled 'Start' and contains the following text: 'Please provide the following information which can be found on the letter you recently received requesting your payroll information. Your actual payroll is needed to ensure your final premium is accurate.' Below this is a yellow box with the text: 'If you received a **PAYROLL REPORT** or **SELF AUDIT REPORT** with a Document Number in letter/number format such as A1B2C3D4E5F6, please [click here](#) to report your payroll'. There are two text input fields: 'Policy Number' and 'Report Number'. Below these are two checkboxes: the first is 'I read and accept NYSIF's [User Agreement and Privacy Policy](#)' and the second is 'I verify that all the information provided here is true, complete and accurate.' At the bottom left is a green 'Next' button.



Policy Number 00112233 Report Number 99999999 Report Period 12/27/2018 - 12/27/2019

### Verify Policyholder Information

Policyholder Name  
NYSIF WIDGET SELLERS

Address Line 1  
123 MAIN STREET

Address Line 2

City ANYTOWN State NY Zip Code 00001

Phone  
222-555-1212

Email  
TESTINGWIDGETS@NYSIF.COM

Legal Business Structure  
CORPORATION

Business Description  
8810 - CLERICAL OFFICE EMPLOYEES

Federal Employer Identification Number (FEIN)  
00-1112223

[Edit](#) [Confirm](#)

[Previous](#) [Next](#)

**STEP 2. Confirm (or edit, if necessary) your business information. Click NEXT.**

**STEP 3. Enter Ownership information. Click NEXT.**

### Owner/Officer/Member/Partners Information

Enter Owner/Officer/Member/Partners gross wages below (if none, enter 0). We need this information to properly adjust and process the payroll for the individuals listed below.

Name	Title	Work Type Description	Total Gross Wages for the Period	Actions
Ranji	Developer	8810 - Clerical Office Employees	\$130,00	<a href="#">Edit</a> <a href="#">Delete</a>
<input type="text" value="John"/>	<input type="text" value="Owner"/>	9060 - Clubs: Golf, Fishing or Yacht	<input type="text" value="\$200,00"/>	<a href="#">Save</a> <a href="#">Delete</a>

[+ Add Owner/Officer/Member/Partner\(s\) if Applicable](#)

[Previous](#) [Next](#)

**STEP 4. Enter Worker Information.** (Depending on your Class Code, this screen could display slightly differently.) **Click NEXT.**

## Worker Information

Enter below the total gross wages (**all employees including Owner/Officer/Member/Partners**) by work type.

If your policy covers multiple businesses (covered entities), please provide the total gross payroll for all businesses below.

Work Type Description	# of Employees	Total Gross Wages for the Period	Overtime Included in Total Gross Wages	Actions
8810 - Clerical Office Employees (No...	66	\$66	\$666	 Edit
9060 - Clubs: Golf, Fishing or Yacht ▾	<input type="text" value="4"/>	<input type="text" value="\$44"/>	<input type="text" value="\$444"/>	 Save  Delete

Entering the Amount of **Overtime included in Total Gross Wages** enables us to lower your premium by reducing gross wages to account for overtime

[+ Add Additional Work Type if Applicable](#)

**STEP 5. Enter any additional wage information, if applicable. Click NEXT.**

## Other Wage Information

Did you issue 1099's to individuals who performed work for you?

Yes  No

Please enter total 1099 payments  
\$1,000

1099 Employee Payments include payments to individuals who work primarily for you and are not paid through your regular payroll process.

Did you use casual labor for the report period?

Yes  No

Please enter total casual labor payments  
\$2,000

Casual Labor includes cash or check payments to individuals for short duration work or day labor who are not paid through your regular payroll process.

Did you lease employees to or from other employers for the report period?

Yes  No

Employee Leasing occurs when an employer contracts with another firm for some or all of its employees.

Did you employ any unpaid individuals (Relatives, Volunteers, Interns, etc.) for the report period?

Yes  No

Unpaid individuals are persons who perform work or services for an employer who receive no compensation.

Did you use any subcontractors for the report period?

Yes  No

A subcontractor is a business or person that carries out work for a company as part of a larger job or contract.

## Business Revenue Information

Please tell us your total gross revenue.

Gross Revenue: Total gross revenue includes gross sales or gross receipts for the report period.

**STEP 6. Review and Submit. Review all information carefully.**

**Summary**

**Employer Information**

<b>Policyholder Name</b>	NYSIF WIDGET SELLERS	<b>Legal Business Structure</b>	CORPORATION
<b>Policyholder Address</b>	123 MAIN STREET	<b>FEIN</b>	00-1112223
<b>City</b>	ANYTOWN	<b>Business Description</b>	8810 - CLERICAL
<b>State</b>	NEW YORK	<b>Total Gross Revenue</b>	\$150,000
<b>Zip Code</b>	00001		
<b>Phone</b>	222-555-1212		
<b>Email</b>	TESTINGWIDGETS@NYSIF.COM		

**Owner/Officer/Member/Partners gross wages**

Name	Title	Work Type Description	Total Gross Wages for the Period
Ranji	Developer	8840 - Religious House of Worship: Professional Employees	\$200
John	Owner	9060 - Clubs: Golf, Fishing or Yacht	\$30

**Total Gross Wages (all employees including Owner/Officer/Member/Partners) by work type**

Work Type Description	Number of Employees	Total Gross Wages for the Period	Overtime Included in Total Gross Wages
8810 - Clerical Office Employees (Not Otherwise Classified)	66	\$6,006	\$666
9060 - Clubs: Golf, Fishing or Yacht	4	\$4,004	\$404

**Other Wage Information**

<b>Did you have 1099 employees for the period?</b>	Yes
<b>1099 Payments</b>	\$1,000
<b>Did you use casual labor for the period?</b>	Yes
<b>Casual Labor Payments</b>	\$2,000
<b>Did you lease employees to or from other employers?</b>	No
<b>Did you employ any unpaid individuals (Relatives, Volunteers, Interns, etc.)?</b>	No
<b>Did you utilize any subcontractors for the period?</b>	No



### Chargeable Payroll Summary

Work Type Description	Total Amount of Gross Wages	Overtime Adj	Owner / Partner / Member / Officer Adj	1099 Payments	Casual Labor Payments	Chargeable Payroll
8810 - CLERICAL OFFICE EMPLOYEES -U	\$6,006	-\$222	\$0	\$0	\$0	\$5,784
9060 - CLUBS-COUNTRY, GOLF, FISHING&CLER-U	\$4,004	-\$135	\$37,670	\$0	\$0	\$41,539
Total Gross Wages	\$10,010					

Complete the "Preparer" information at the bottom of the page. Click **SUBMIT PAYROLL**.

### Preparer Information

Preparer's Name

Preparer's Email

Relationship to Insured

Other

Other Description

Prepared Date

7/10/2020

By checking this box, I hereby certify that I am the preparer named above, and to the best of my knowledge all of the information contained in this payroll verification is true and accurate. Further, I acknowledge that willfully falsifying this record constitutes a violation of New York State law.

Previous

Submit Payroll

### STEP 7. Confirmation.

**Step 1** Start    **Step 2** Verify Policyholder Info    **Step 3** Ownership Info    **Step 4** Worker Info    **Step 5** Other Worker Info    **Step 6** Review & Submit    **Step 7** Successfully Submitted

## Successfully Submitted

Thank you for completing and successfully submitting your workers' compensation online payroll verification.

[Save a Copy for Your Records](#)

We would appreciate your feedback, please click below to take a short survey.

[Take Survey](#)

[Go back to Nysif.com](#)

## Policy Information

The policy information screen will display all pertinent details regarding the business. Additional tabs along the top menu provide the following information:

- Policy Info
- Period
- Pay Class
- Entity
- Active Entity
- Location
- Active Location
- Location excluded
- Active Location Excluded

### Policy Information System

Policy Number:

Rating Board Number:

Policy Number	Business Name	Principal Name	Telephone Number	Rating Board Number	Policy Status	Cancellation Reason	Group Number
01234567	ACME FENCE CO	John Brown	518-555-1212	0	ACTIVE		90

[Policy Info](#) | [Period](#) | [Pay Class](#) | [Entity](#) | [Active Entity](#) | [Location](#) | [Active Location](#) | [Location Excluded](#) | [Active Location Excluded](#)

**Policyholder's Address:**

ACME FENCE CO  
 123 MAIN STREET  
 ANYTOWN, NY 12345  
  
 518-555-1212

**Representative Information:**

NYSIF / PHS / STATEWIDE SVCS  
 199 CHURCH STREET 7TH FL  
 NEW YORK NY 10007

**Premium:**

NYSIF Premium	\$9,108.23
Current Account Balance	\$25,550.99
Last Bill #	N/A
Current Deposit Bill Type	Renewal
Current Deposit Bill #	N/A
Future Renew Experience MOD	N/A
Governing Class Code	8810

**Policy Profile:**

Policy #	01234567
Status	ACTIVE
Group	90
Principal's Name	JOHN BROWN
Industry Group	Others (A)
Active Entities	1
Active Locations	1
Excluded Locations	0
County	New York (Lower Manhattan) (10)
State Fund District	L
Rated	N/A
Rating Board File #	N/A
Combinable Policy Count	0
FEIN	9999999999
SSN	N/A
Unemployment ID	N/A
Audit Plan	Yearly (14)
Bill Plan	Quarterly 9 Installments (11)
Certificates	1
Payroll Audit District	N/A
Business Type	Political Subdivision (08)
Account Status	C Estimate (Bill Type 7)
Contract Code Number	N/A

**Date:**

Inception Date	11/30/1999
Original Inception Date	11/30/1999
Current Renewal Start Date	11/30/2017
Last Billing Cycle Date	01/30/2018
Current Account Balance Date	01/30/2018
Current Period Start Date	11/30/2017
Current Period End Date	11/30/2018
Anniversary Date	11/30/2018
WCB Cancellation Date	N/A
SIF Cancellation Date	N/A
Cancellation Reason	N/A
Name Change	12/23/2003 Count[1]
Address Change	12/30/2003 Count[2]

**Indicator:**

Credit	No Special Conditions
Policy Name Type	MAIL and ENTITY
Policy Address Type	MAIL and LOCATION



## Report Requests

Select a report from the Report Name list.

### Report Request

To request a report, fill out the information below and click "Search." All fields are required unless otherwise stated. Some requests will open in a new window

Report Name:  
 <Select a Report>
 

- <Select a Report>
- Certificate List for a Policy
- Accident Analysis Report
- Loss Run Report
- Recap Sheet
- Test Rating
- DP203
- Enhanced Loss Run Report

**View Requested Reports**

If you received an email notification that your report is available, it will display the table below. Some reports will download and others will open in a new window.

[Refresh](#)

Report ID	Created Date and Time	Group Number/Policy Number	Report Name	Open Report	Download CSV
-----------	-----------------------	----------------------------	-------------	-------------	--------------

- Some reports will download and others will open in a new window.
- Once saved, the file can be re-opened in a browser or other application (Excel, for example) for printing or review.
- Some reports may take up to two hours to generate and will be emailed to the user.

Running a report of **Certificate List of a Policy** will generate a table with the following headings:

NEW YORK STATE INSURANCE FUND CERTIFICATES OF A POLICY									
Policy No : 01234567		Policy Holder : ACME FENCE CO				Report Date : 02/08/2018			
CERT. #	ENTITY	LOC	M T D L	FROM	TO	DAYS	CERTIFICATE HOLDER NAME & ADDRESS	JobID	Hide Flag
234233	00000	00000	0 1 1 0	11/30/2017	11/30/2018	0	KPK W21 CERT TEST 15 COMPUTER DR W NYSIF SYSTEMS TESTING ALBANY NY 12205		0
Total # Of Certificates for this Policy: 1									

## Accident Analysis Report

NEW YORK STATE INSURANCE FUND Accident Analysis Report											
ASSURED ACME FENCE CO 123 MAIN STREET ANYTOWN, NY 11111 TEL: (518) 555-1212				POLICY # 01234567 POL. DTE 07/01/2014 COUNTY Suffolk LOCATIONS 2 ENTITIES 1				GOV CLASS 9501 GROUP 90 PLAN Annual Audit Plan		PROCESS DATE 02/05/2018 REPRESENTATIVE BROKERS, INC.	
ACCIDENT ANALYSIS FROM 07/01/2013 TO 07/01/2014 for 01234567											
KIND OF INJURY	COUNT	KIND OF INJURY	COUNT	KIND OF INJURY	COUNT	KIND OF INJURY	COUNT	KIND OF INJURY	COUNT		
Contusion	4	Swelling	1	Sprain/Strain	2						
TOTAL	7										
CAUSE OF INJURY	COUNT	CAUSE OF INJURY	COUNT	CAUSE OF INJURY	COUNT	CAUSE OF INJURY	COUNT	CAUSE OF INJURY	COUNT		
Fall/Slip/Trip	1	Struck Against/Caught	1	Struck (By)	2	Lifting	2				
Snow/Ice/etc.	1										
TOTAL	7										
PART OF BODY	COUNT	PART OF BODY	COUNT	PART OF BODY	COUNT	PART OF BODY	COUNT	PART OF BODY	COUNT		
Back	5	Shoulder, Right	1	Thigh, Left	1						
TOTAL	7										
OCCUPATION	COUNT	OCCUPATION	COUNT	OCCUPATION	COUNT	OCCUPATION	COUNT	OCCUPATION	COUNT		
ELECTROPLATE, GALVANIZE, DETINNING	6										
UNCLASSIFIED	1										
TOTAL	7										
MONTH	COUNT	MONTH	COUNT	MONTH	COUNT	MONTH	COUNT	MONTH	COUNT		
JAN.	2	FEB.	1	MAR.	1	APR.	0	MAY.	0		
JUL.	1	AUG.	0	SEP.	2	OCT.	0	NOV.	0		
TOTAL	7										

## Loss Run Reports

NEW YORK STATE INSURANCE FUND Loss Run Report by Policy															
WCLAIM/180/01 POLICY INQUIRY 01234567				ACME FENCE CO.				Accidents Occurred Between 01/01/2005 And 01/01/2017 ALL CLAIMS				AS OF 02/08/2018 CYCLE NO. 14779			
CLAIM NO.	UNIT	CLAIMANT	ACC DATE	JCK	COMP INC	MED INC	Status	COMP PD	MED PD	POL DATE	GRP	PAYCLASS	INC	PAYT	C. DOC
1111111111			07/10/2015	Z	.00	.00	0	.00	.00	07/01/2015	7380		01/2016	00/0000	0
0000000000			06/24/2016	X	.00	210.00	0	.00	210.00	07/01/2015	4558		02/2018	07/2017	0
NO OF CLAIMS FOR THIS POLICY: 2					.00	210.00		.00	210.00						

## Recap Sheet

The recap sheet will provide information in the following categories for period you choose:

- Summary of policy information
- Reported payroll for the period
- Endorsements
- Claims
- Included locations
- Excluded locations
- Entities
- Certificates sent

SUMMARY OF POLICY INFORMATION					
<b>ISSUED: 02/08/2018</b>		<b>POLICY PERIOD :02/04/2014 to 02/06/2018</b>			<b>POLICY NO: 01234567</b>
<b>Assured</b>		<b>Audit at</b>			
ACME FENCE CO 123 MAIN STREET ANYTOWN, NY 12345 518-555-1212		NYSIF TESTING & CPAs	<b>Group</b>	90	<b>Inception</b>
			<b>Industry Code</b>	A	<b>Next Ann</b>
			<b>Governing Code</b>	8810	<b>Est. Premium</b>
			<b>RB Mod</b>	N/A	<b>Billing Plan</b>
			<b>SIF Mod</b>	95	25% Down, 9
			<b>Construction Mod</b>	N/A	Monthly
			<b>Policy is</b>	Not Rated	Installments
			<b>Bill to</b>	11/30/2016	of 1/12 of
					annual
<b>Principal</b>		JOHN BROWN			premium
<b>FEIN</b>		9999999999	<b>Representative</b>		<b>Audit Plan</b>
<b>SIF District</b>		L	NYSIF / PHS / STATEWIDE SVCS		Annual Audit
<b>PAD Unit</b>		L	199 CHURCH STREET 7TH FL		Plan
<b>Rating Date</b>		N/A			<b>Cancel Bill</b>
					N/A
					<b>Cancel Board</b>
					N/A
					<b>Reason Canc.</b>
					N/A
<b>PERIODS</b>					
<b>PRESENT BILL:</b>					
<b>Class</b>	<b>Description</b>	<b>Rate</b>	<b>Payroll</b>		
8810	CLERICAL OFFICE EMPLOYEES NOC-U	\$0.20	\$3,072,000.00		
<b>PRIOR FULLY BILLED PERIOD WAS REPORTED : 11/30/2015 to 11/30/2016</b>					
<b>Class</b>	<b>Description</b>	<b>Rate</b>	<b>Payroll</b>		
8810	CLERICAL OFFICE EMPLOYEES NOC-U	\$0.25	\$2,048,000.00		
<b>ENDORSEMENTS</b>					
<b>Number</b>	<b>Start Date</b>	<b>End Date</b>	<b>Endorsement Text</b>		
99	12/07/1999		SPECIAL ENDORSEMENT (EXCLUDING COVERAGE) COVERAGE UNDER THIS POLICY IS EXCLUDED FOR ANY AND ALL ENTITIES. THE DOCUMENTS ISSUED UNDER THIS POLICY NUMBER ARE FOR TEST PURPOSES ONLY AND PROVIDE NO INSURANCE COVERAGE WHATSOEVER.		
90	07/15/2010		INDIVIDUAL / CO-PARTNER INCLUSION NEW YORK SOLE PROPRIETORS, PARTNERS AND MEMBERS OF LIMITED LIABILITY COMPANIES COVERAGE ENDORSEMENT YOU HAVE ELECTED TO MAKE EACH PERSON NAMED IN THE SCHEDULE SUBJECT TO THE NEW YORK WORKERS' COMPENSATION LAW. THIS POLICY COVERS YOU WITH RESPECT TO BODILY INJURY SUSTAINED BY SUCH PERSONS UNDER "PART ONE - WORKERS' COMPENSATION INSURANCE" BUT NOT UNDER "PART TWO - EMPLOYERS' LIABILITY INSURANCE". THE PREMIUM BASIS OF THE		

# Test Rating

<b>EFF RATING DATE</b> 10/24/2014	<b>INSURED AND ADDRESS</b> NYSIF TESTING, INC. 123 MAIN STREET ALBANY, NY 12206	<b>BOARD FILE NUM</b>	<b>POLICY NUMBER</b> G 999999-1
<b>TEST RATING</b>		<b>ACTUAL LOSSES</b>	
<b>POLICY YEAR</b>	<b>CLAIM NO</b>	<b>ACTUAL INCURRED LOSSES</b>	<b>PRIMARY ACTUAL LOSSES</b>
01/01/2011	64722796	50,591	10,000
<b>ACTUAL EXCESS</b>	40,591	50,591	10,000
<b>EXPECTED LOSSES</b>			
<b>CLASS CODE</b>	<b>POLICY YEAR</b>	<b>PAYROLL</b>	<b>EXPECTED LOSS RATE</b>
5538	01/01/2012	46,637	
	01/01/2011	62,975	5.36
			5,875
			0.29
			1,704
5545	01/01/2012	130,250	
	01/01/2011	106,014	11.43
			27,005
			0.15
			4,051
5547	01/01/2012	8,308	
	01/01/2011	4,920	9.07
			1,200
			0.14
			168
5645	01/01/2012	2,223	
	01/01/2011	796	5.32
			161
			0.19
			31
<b>EXPECTED EXCESS</b>	28,976		35,150
			6,174

# DP-203 Report

## NEW YORK STATE INSURANCE FUND DP203 Report for Policy # 12345678

ASSURED  
 ACME FENCE COMPANY  
 123 MAIN STREET  
 ANYTOWN, NY 10000  
 TEL: 518-555-1111  
 ESTIMATED ANNUAL PREMIUM: 85,466.19

POLICY # 12345678  
 POL. DATE 04/01/2015  
 COUNTY Nassau  
 LOCATION 1  
 ENTITY 1

GOV CLASS 5022  
 GROUP 90  
 AUD / BIL 14 / 14  
 IND GRP Y

PROCESS DATE 12/08/2017  
 REPRESENTATIVE NASSAU BROKERS, INC.  
 123 ELM STREET  
 ANYTOWN, NY 10000  
 516-555-1212

CLAIM NUMBER	CLM UNIT	PAY CLASS	NAME OF CLAIMANT	ACCIDENT DATE	BODY PART	CAUSE ACC	INJ TYPE	P A Y M E N T S		I N C U R R E D C O S T S		STATUS
								COMP	MEDICAL	COMP	MEDICAL	
9876543	127	5022	SMITH, MICHAEL	09/27/2013	29	2	14	.00	889.96	.00	889.96	0
			CLAIMS BATCHED 2					.00	329.71	.00	329.71	
			CLAIMS SUMMARY 3					.00	1,219.67	.00	1,219.67	

P E R I O D		E A R N E D P R E M I U M		EXP	SIF	N O . O F C L A I M S		I N C U R R E D L O S S E S		TOTAL	LOSS
FROM	TO	R.B. LEVEL	S.F. LEVEL	MOD	MOD	COMP	NC	COMP	MEDICAL	LOSSES	RATIO
04/01/2015	04/01/2016	95,271	74,958	121	80	0	0	0	0	0	.00
04/01/2014	04/01/2015	102,566	80,201	119	80	0	0	0	0	0	.00
* 04/01/2013	04/01/2014	95,150	80,714	98	75	0	1	0	890	890	.01
04/01/2012	04/01/2013	59,849	49,905	89	75	0	1	0	330	330	.01
<b>Totals:</b>		<b>352,836</b>	<b>285,778</b>			<b>0</b>	<b>2</b>	<b>0</b>	<b>1,220</b>	<b>1,220</b>	<b>AVG:.00</b>

\*For this period and all prior periods, the assessment charge is included in the SIF Level Earned Premium. All future periods will not include the assessment charge.

START DT	END DT	CLASS	DESCRIPTION	PAYROLL
THE FOLLOWING PAYROLL INFORMATION IS FROM AN AUDIT BILL				
04/01/2013	04/01/2014	5022	MASONRY N.O.C.	499,142
04/01/2013	04/01/2014	9127	TERRITORY 2 DIFFERENTIAL 0.0%	0
04/01/2013	04/01/2014	8809	EXECUTIVE OFFICERS N.O.C. ETC-U	156,000
04/01/2013	04/01/2014	7380	DRIVERS CHAUFF HELPERS-COMML-U	131,667
THE FOLLOWING PAYROLL INFORMATION IS FROM AN AUDIT BILL				
04/01/2012	04/01/2013	5022	MASONRY N.O.C.	338,277
04/01/2012	04/01/2013	9127	TERRITORY 2 DIFFERENTIAL 0.0%	0
04/01/2012	04/01/2013	8809	EXECUTIVE OFFICERS N.O.C. ETC-U	156,000
04/01/2012	04/01/2013	7380	DRIVERS CHAUFF HELPERS-COMML-U	122,410

**THIS POLICY INCLUDES THE FOLLOWING ACTIVE LOCATIONS:**

LOC#	ADDRESS	START DT
1	123 MAIN STREET ANYTOWN, NY 10000	08/13/1996

**THIS POLICY INCLUDES THE FOLLOWING ACTIVE ENTITIES:**

ENT#	ENTITY NAME	BUSINESS TYPE	EFFECTIVE DT
1	ACME FENCE COMPANY	Corporation	03/28/2000

**THE ABOVE POLICY IS COMBINED WITH THE FOLLOWING ACTIVE POLICIES:**

22222222 FARM FENCING, INC.

# Enhanced Loss Run Report

Enter your parameters. You must choose either "Loss Run" or "Percentage Analysis" for the report output.

Loss Run, No Totals Example:

CLAIM NO	CLAIMANT	ACC DT	JCK	COMP INC	MED INC	S	COMP PD	MED PD CLASS	INC	PAYT
1111111111	NEW YORK STATE INSURANCE FUND Loss Run and Analysis Report ACME FENCE CO	06/17/2010	T	880.00	1,094.09	0	880.00	1,094.09 8810	03/11	10/10
Accidents Occurred Between 2/2/2010 And 2/8/2018 AS OF 02/08/2018 Sorted By Accident, CLAIM# OPEN&CLOSED Claims Found YES										
WCB NUM: CLAIMANT AGE: 51 TYPE OF INJURY: Breathing Dif PART OF BODY: Unknown										
2222222222		07/12/2010	X	.00	628.58	0	.00	628.58 3372	02/11	09/10
WCB NUM: CLAIMANT AGE: 39 TYPE OF INJURY: Sprain/Strain PART OF BODY: Back										
3333333333		12/22/2010	X	.00	53.43	0	.00	53.43 9501	01/13	01/13
WCB NUM: CLAIMANT AGE: 34 TYPE OF INJURY: Laceration PART OF BODY: Hand, Left										
4444444444		01/28/2011	X	.00	291.89	0	.00	291.89 9501	10/11	07/11
WCB NUM: CLAIMANT AGE: 50 TYPE OF INJURY: Sprain/Strain PART OF BODY: Wrist, Right										

## Report Request

Report Name: Enhanced Loss Run Report

### Enhanced Loss Run Report

Parameter: Policy Number

Policy Number: 01234567

Must be numeric

Start date: mm/dd/yyyy

(mm/dd/yyyy)

End date: mm/dd/yyyy

(mm/dd/yyyy)

### Report Output

Required. Choose either Loss Run or Percentage Analysis.

1.  Loss Run

Claimant Information

Accident Information

Address

Totals: No Totals

Sort By Fields: <- None ->

Sort By Policy

Break up Report Into Separate Periods

2.  Percentage Analysis

Grand Totals Only

### Optional

Report Parameters

Submit

Percentage Analysis Example:

NEW YORK STATE INSURANCE FUND		Accidents Occurred Between 2/2/2010 And 2/8/2018										AS OF 02/08/2018			
Loss Run and Analysis Report		Sorted By Accident, CLAIM# OPEN&CLOSED										Claims Found YES			
Policy#	01234567														
Cause of Accident		COMP	% PD	COMP	% IC	MED	% PD	MED	% IC	TOTAL	% PD	TOTAL	% IC	NO OF CLAIMS	% TOT CLMS
Description		PAID		INC		PAID		INC		PAID		INC			
Struck Against/Caught		2064.71	2.34	2064.71	2.34	5696.94	8.15	5696.94	8.15	7761.65	4.91	7761.65	4.91	4	12.5
Fall/Slip/Trip		60000	68.13	60000	68.13	20677.83	29.58	20677.83	29.58	80677.83	51.07	80677.83	51.07	3	9.38
Material Handling		8285.09	9.41	8285.09	9.41	4551.91	6.51	4551.91	6.51	12837	8.13	12837	8.13	3	9.38
Tools		0	0	0	0	317.19	.45	317.19	.45	317.19	.2	317.19	.2	2	6.25
Snow/Ice/etc.		2663.68	3.02	2663.68	3.02	7625.53	10.91	7625.53	10.91	10289.21	6.51	10289.21	6.51	1	3.13
Part of Body		COMP	% PD	COMP	% IC	MED	% PD	MED	% IC	TOTAL	% PD	TOTAL	% IC	NO OF CLAIMS	% TOT CLMS
Description		PAID		INC		PAID		INC		PAID		INC			
Back		6045.1	6.86	6045.1	6.86	13742.71	19.66	13742.71	19.66	19787.81	12.53	19787.81	12.53	9	28.13
Knee, Right		0	0	0	0	420.93	.6	420.93	.6	420.93	.27	420.93	.27	2	6.25
Eye, Left		0	0	0	0	471.95	.68	471.95	.68	471.95	.3	471.95	.3	2	6.25
Unknown		880	1	880	1	1278.69	1.83	1278.69	1.83	2158.69	1.37	2158.69	1.37	2	6.25
Hand, Left		0	0	0	0	53.43	.08	53.43	.08	53.43	.03	53.43	.03	1	3.13
Arm, Right		60000	68.13	60000	68.13	20457.94	29.27	20457.94	29.27	80457.94	50.93	80457.94	50.93	1	3.13
Ankle, Left		0	0	0	0	0	0	0	0	0	0	0	0	1	3.13
Type of Injury		COMP	% PD	COMP	% IC	MED	% PD	MED	% IC	TOTAL	% PD	TOTAL	% IC	NO OF CLAIMS	% TOT CLMS
Description		PAID		INC		PAID		INC		PAID		INC			
Sprain/Strain		66603.32	75.62	66603.32	75.62	35219.54	50.39	35219.54	50.39	101822.86	64.46	101822.86	64.46	13	40.63
Laceration		1536.72	1.74	1536.72	1.74	806.15	1.15	806.15	1.15	2342.87	1.48	2342.87	1.48	3	9.38
Other		7576.2	8.6	7576.2	8.6	8115.6	11.61	8115.6	11.61	15691.8	9.93	15691.8	9.93	3	9.38
Foreign body		0	0	0	0	198.11	.28	198.11	.28	198.11	.13	198.11	.13	1	3.13
Payclass		COMP	% PD	COMP	% IC	MED	% PD	MED	% IC	TOTAL	% PD	TOTAL	% IC	NO OF CLAIMS	% TOT CLMS
Description		PAID		INC		PAID		INC		PAID		INC			
9501		7779.81	8.83	7779.81	8.83	20744.88	29.68	20744.88	29.68	28524.69	18.06	28524.69	18.06	12	37.5
4511		3221.9	3.66	3221.9	3.66	2930.76	4.19	2930.76	4.19	6152.66	3.89	6152.66	3.89	1	3.13
8810		60880	69.12	60880	69.12	21552.03	30.83	21552.03	30.83	82432.03	52.18	82432.03	52.18	2	6.25
3372		13527.61	15.36	13527.61	15.36	17043.43	24.38	17043.43	24.38	30571.04	19.35	30571.04	19.35	16	50
0		2663.68	3.02	2663.68	3.02	7625.53	10.91	7625.53	10.91	10289.21	6.51	10289.21	6.51	1	3.13
Open/Closed Case		COMP	% PD	COMP	% IC	MED	% PD	MED	% IC	TOTAL	% PD	TOTAL	% IC	NO OF CLAIMS	% TOT CLMS
Description		PAID		INC		PAID		INC		PAID		INC			
Closed		88073	100	88073	100	69896.63	100	69896.63	100	157969.63	100	157969.63	100	32	100
Total		88,073.00		88,073.00		69,896.63		69,896.63		157,969.63		157,969.63		32	



## Statement of Account

Your statement of account displays billing transactions, including the latest renewal bill and deposit premium of a period.

### Policy Bill Inquiry

\*Policy Number

\*Select One  
 Statement Of Account  
 Statement Of Account  
 Dep. Prem. Bill of a Period  
 Latest renewal Bill of a policy  
 Statement of Premiums Due  
 Other Options

## Policy Bill Inquiry - Statement Of Account

\*Policy Number

\*Select One  
 Statement Of Account

Name: ACME FENCE CO  
 Rep: BROKERS, INC  
 Current Policy Period: 10/19/2017-10/19/2018  
 Policy Status: ACTIVE  
 SIF Office Code: Q - Queens  
 GR.#: 90

[More Records](#) Records: 1-25

Tran Date	Tran Code	Bill Number	Tran Description	Period Date	Tran Amount	Balance
02/02/2018	542	<a href="#">016491487</a>	Experience Modification Endorsement	07/01/2018		910.01
02/01/2018	900	<a href="#">54672984</a>	Monthly Statement			910.01
02/01/2018	464	016436890	Service Charge	07/01/2017	10.00	910.01
02/01/2018	562	<a href="#">P10002600126</a>	Installment	07/01/2017	900.01	900.01
01/22/2018	312	5238	Cash		775.74CR	0.00
12/29/2017	900	<a href="#">54497885</a>	Monthly Statement			775.74

Choose **Other Options** to search and view by transaction code. Common transaction codes include:

- 312: Payment
- 464: Service Charge
- 532: Rebill
- 542: Experience Modification Endorsement
- 560: Audit
- 562: Installment billed
- EP: Earned premium transactions
- AP: Advanced premium transactions
- Factor: Experience modification transaction

\*Select One  
 All Trans  
 Trans Code  
 EP Trans  
 AP Trans  
 Factor Trans  
 All Trans  
[More Records](#)



## Disability Benefits Policyholders

DB policyholders should visit [nysif.com](https://nysif.com) to create an account and enroll in enhanced security as explained beginning on [page 3](#). To view Account Management and add authorized users, please follow the instructions in the [online account management section](#).

### Disability Benefits Policy Summary

Policy Info	Policy Entity	Policy Entity Contact
<b>Policy Number</b> 9876543	<b>Entity Name</b> BANANAS, INC.	<b>Address</b> 111 BROADWAY
<b>Account Status</b> ACTIVE	<b>DBA or T/A</b>	<b>City,State,Zip</b> NEW YORK NY 10016
<b>Inception Date</b> 11/02/2013	<b>Business Type</b> DOMESTIC EMPLOYER	<b>Email</b> TESTING@NYSIF.COM
<b>Renewal Date</b> 11/02/2021	<b>FEIN</b> 012345678	<b>Telephone Number</b>
	<b>UIER</b>	<b>Fax Number</b>

Pay My Bill
[View all Policy Entities](#)

### Disability Benefits Links

**Policyholder Services** -

- [Policy Entities](#)
- [Claims Payment Report](#)

**\$ Get a Quote** -

- [Obtain a Quote for Disability Benefits Insurance](#)

**Billing** -

- [Pay My Bill](#)
- [View Bills](#)

**Premium Calculator** -

- [Enter Payroll for a DB Premium Estimate](#)

**Certificates of Insurance** -

- [Validate a Certificate](#)
- [Create a Certificate](#)

**Report Payroll** -

- [Report Your DB Payroll Electronically](#)

**Documents** -

- [Document Retrieval](#)

**? Need Help?** -

- [Get Policy Help](#)
- [Get Claims Help](#)
- [Policyholder Online User Guide](#)
- [DB Policyholder Handbook](#)

Once successfully logged in, expand the boxes by clicking the + sign. The boxes will expand to display further menu choices. You can view a claims payment report, monthly bills, info pages and also create a certificate of insurance.







Clicking the “DBL Links” drop-down in the upper right corner will show you the same menu items as shown in the boxes.

## Notification Center

Choose “**Email Notifications**” from your Administration Console to view your Notification Center and enroll in paperless for bills and Info Pages. The Notification Center also allows you to manage email notifications by policy or user for bills, Info Pages or Audits.

### Administration Console

Manage your NYSIF account using the links below.

 <b>Profile Management</b> Review and update your account information at any time. <a href="#">Update Your Profile</a>	 <b>Consolidate Accounts</b> To achieve single sign on please consolidate your accounts. <a href="#">Consolidate</a>
 <b>User Management</b> Add new authorized users and manage existing users. <a href="#">Manage Users</a>	 <b>Link Account</b> Here you can add a new Disability Benefits Policyholder account to the current account. <a href="#">Link Account</a>
 <b>Help</b> Need technical help? Please contact the NYSIF Service Desk. 1-877-435-7743	 <b>Email Notifications</b> Set email addresses for audit/infopage notifications. <a href="#">Notifications</a>

Authorized User accounts will have access to **only** the Notification Management and Messages tabs.

## Paperless Enrollment

To enroll in paperless billing, choose the Paperless tab.

**Only the master account holder can enroll in paperless for the policy.**

Paperless    **Notification Management**    Enrollments    Messages

### Go Paperless with NYSIF!

Select to go paperless with NYSIF and receive email notifications when policy documents and your premium bill are available online.

**Step 1: Verify your email address.**

We will send email notifications to the email address associated with your policyholder account. Please note your email address must be verified to receive communications from NYSIF.

Step 1: Verify your email address if needed.

### Step 1: Verify your email address.

We will send email notifications to the email address associated with your policyholder account. Please note your email address must be verified to receive communications from NYSIF.

Your email address (**testing@nysif.com**) has been verified. Please continue to step 2.

## (To unenroll, uncheck the box in Step 2 and save.)

In Step 2, check the box(es) to go paperless and receive email notifications for your workers' compensation policy. Be sure to click "Save Changes."

**Step 2: Update your paperless options.**

Check the box(es) below to go paperless and receive email notifications for your workers' compensation and disability benefits policies. Once you have enrolled, if you would like to revert to receiving paper copies, uncheck the boxes and click Save Changes.

WC Bills

WC Policy Documents ?

DB Bills

DB Policy Documents ?

By going paperless, you agree to NYSIF's [Terms and Conditions](#)

**Save Changes**

**NOTE: If a policy chooses to go paperless, the master account holder will automatically receive all paperless email notifications. The master account holder cannot opt-out of email notifications without unsubscribing from paperless.**

## Notification Management

In the Notification Management tab, master account holders can enroll and manage notifications for authorized user accounts. Use the dropdown to choose a user and click "Go." Make your choices and Choose "Save Changes" to finish.

**Notification Management**

**User selection**

In addition to your master online account, you can enroll and manage notifications for your authorized user accounts here. Use the dropdown to choose a user and click "Go". Please note, if you switch users without saving, any unsaved changes will be lost.

STANDARDQUOTE Go

underwriting (self)  
STANDARDQUOTE  
CHILDQUOTETWO  
QUOTECHILDTHREE  
jsunderwriting

In addition to your master online account, you can enroll and manage notifications for your authorized user accounts here. Use the dropdown to choose a user and click "Go". Please note, if you switch users without saving, any unsaved changes will be lost.

STANDARDQUOTE Go

**Email Notification Settings (STANDARDQUOTE)**

	For Accounts
Audit Notifications	Nothing selected
Workers' Comp Bills	01234567, 0000089
WC Policy Documents	0000089 <span>?</span>
Disability Benefits Bills	12345, 6789
DB Policy Documents	12345 <span>?</span>

**Save Changes**

**NOTE: If a policy chooses to go paperless, the master account holder will automatically receive all paperless email notifications. The master account holder cannot opt-out of email notifications without unsubscribing from paperless. This means that on the Notification Management tab, the master account holder will not see an option to choose a policy number for Bills or Policy Documents.**

## Enrollments

The Enrollments page allows the master account holder to manage email preferences for workers' comp bills, policy documents and audits by policy designated on the Notification Management tab. If a policy has chosen to go paperless, the master account holder will receive all paperless notifications.

**If a master account holder chooses to unsubscribe to paperless notifications, NYSIF will preserve the notification choices made for authorized users should the policyholder choose to re-enroll. These choices will still appear in Enrollments, but authorized users will not receive email notifications while the policy is unsubscribed.**

To add or remove a notification to an authorized user account, go to the Notification Management page or click the "Edit" icon in the table.

The screenshot shows the 'Enrollments' page under the 'Notification Management' tab. It includes a table with columns for Notification Type, Account, Username, Email Address, and Edit. Below the table are filters for Notification Type, Account, Username, and Email Address, along with a search box and a 'Show 10 entries' option.

Notification Type	Account	Username	Email Address	Edit
Audit Notification	01234567	chld_nysiftest3	TESTING@NYSIF.COM	
Audit Notification	01234567	nysiftest_chld	WTEST@NYSIF.COM	
Workers' Comp Bills	01234567	chld_nysiftest3	TESTING@NYSIF.COM	
Workers' Comp Bills	01234567	nysiftest_chld	WTEST@NYSIF.COM	

## Messages

When bills or policy documents are issued and you receive an email notification, you are also notified in your Message Center. You can access these by choosing "Messages" at the top of your landing page or in the Notification Center.

The screenshot shows the top navigation bar with the 'Messages' menu item highlighted in a red box. Other items include 'nysiftest' with a dropdown arrow and 'Logout' with a lock icon. Below the navigation bar are links for 'Online Services' and 'Account Management'.



## Request a DB/PFL Quote

Choose Obtain a Quote. (While NYSIF offers a gender-neutral price for disability benefits coverage, statutory reporting mandates require NYSIF collect this information.) Enter the required information and proceed from page to page.

# 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)\*

City, State, Zip, Country\*

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 \$82917.64, per employee)*

#### \*Females

Number of Covered Female Employees

0

Total Wages for All Covered Female Employees

\$ 0

*(Subject to an annual cap of PFL \$82917.64, per employee)*

\*Information by Gender is required by the Department of Financial Services

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

## New York State Disability and Paid Family Leave Benefits Application

**1. Employer Information**

Your reference number is 012345.

Legal Business Name\*  
NYSIF TESTING, INC.

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.\*  
15 COMPUTER DRIVE WEST

City, State, Zip, Country\*  
Albany NY 12206 USA

Contact Information\*  
MARY TESTER 1234567890 TESTING@NYSIF.COM

Mailing Address (if different than above)

Select Country  
Select A Country

Address

City, State, Zip, Country  
City Select A State Zip Select A Country

Policy Inception Date

Future Inception Date\*  
12/06/2017

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  LLP  Union  Other

Are you a Not For Profit Corporation\*  
 Yes  No

Nature Of Business  
Testing software

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: 90%; border: 1px solid #ccc;" type="text" value="3"/>	<p>Number of Covered Employees</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="8"/>
<p>Total Wages for All Employees</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="53040"/> <p><small>Subject to an annual cap of 17680 per employee</small></p>	<p>Total Wages for All Employees</p> <input style="width: 90%; border: 1px solid #ccc;" 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: 90%; border: 1px solid #ccc;" type="text" value="500000"/>	<p>Total Gross Annual Payroll</p> <input style="width: 90%; border: 1px solid #ccc;" type="text" value="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 \$82917.64, per employee)

### \*Females

Number of Covered Female Employees

0

Total Wages for All Covered Female Employees

\$ 0

(Subject to an annual cap of PFL \$82917.64, per employee)

[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](#)

### 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  
USA

Home Address (P.O. Box is not acceptable)  
123 MAIN STREET

City, State, Zip, Country\*  
ALBANY NEW YORK 12208 USA

Contact Information\*  
MARY TESTER CEO TESTING@NYSIF.COM

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

**Please note that if your mailing address is outside the US, you must print your application and mail it to NYSIF.**

**NYSIF**  
**PO Box 66699**  
**Albany, NY 12206**



**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: \_\_\_\_\_

City: \_\_\_\_\_

State: \_\_\_\_\_

Zip: \_\_\_\_\_

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

**CONTINUE**

**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.

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

I agree to use electronic records and signatures.

**CONTINUE**

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
<b>Total Payment</b>		<b>\$282.90</b>

[Go to Checkout](#) 

### Payment Options

Cart Items	Payment Amount
1	\$282.90

Application Number	Deposit Due
6640784	\$282.90
<b>Total</b>	<b>\$282.90</b>

[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 Check Out 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

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

MEMO  
⑆331674485⑆ 1456874801 1⑆ 3321⑆  
Routing Number Account Number Check #

Back Next

### Enter Card Information

Card Number

Card Holder Name  
Enter card holder's 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  
Enter your Name

Phone Number  
Enter your phone number

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

Email  
Enter your email address

+ 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: **\$289.27**      Payment Date: **Aug 19, 2020**

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

**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](#).

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

Look Up   Add   Check Out   Done

## Your payment was successful

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

Policy Number	Confirmation #	Details	Status	Amount
000999888777	123456789	Processed successfully		\$289.27
<b>Total Payment</b>				<b>\$289.27</b>

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



## Policyholder Services

### View Entities

Choose the "View all Policy Entities" link in the middle of your home page.

Disability Benefits Online Services				
Please click the "View Details" icon to view the details for that policy entity.				
Entity Name	Policy Number	Effective Date	FEIN	View Details
ACME WIDGETS	9876543	11/02/2013	999999999	
ACME FOUNDATION	9876544	11/02/2013	999999998	

### Certificates

Expand the Certificate box to validate or print a certificate.



**NOTE:** There is no longer the need to wait until your policy period renews to create a DB certificate of insurance. You can now generate NYSIF DB certificates online for your upcoming policy period **up to 45 days in advance** of your renewal date.

To create a certificate, select "Entity Name" from the drop down. If a DBA is listed on the policy and you would like it listed on the certificate, please select DBA from the DBA dropdown. Enter name and address of the certificate holder. Click "Preview Certificate." If all information is correct, save or print.

**Employer's Application for Certificate of Insurance under the Disability Benefits Law**

Complete the following fields and click to view a printable version of the certificate.

Policy Number: DBL 9876 54-3

Select Entity Name:

Select DBA:

A PO Box alone is not acceptable.  
A street address must be included.

Entity Address: 100 TESTING LANE, ALBANY NY 12206

FEIN: 999-99-9999

Phone Number: 555-555-1512

**Certificate Holder Information**


Name:


Street:

City:

State:   - plus 4 digit zip (optional)

(If you do not see the certificate after choosing "Preview," please minimize the current window as it may have displayed behind your open browser.)

		<b>CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW</b>	
<b>PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier</b>			
1a. Legal Name & Address of Insured (use street address only)  POLICYHOLDER, INC. DBA PREMIER TESTING 100 TESTING LANE ALBANY, NY 12208  <i>Work Location of Insured (Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)</i>		1b. Business Telephone Number of Insured (518) 555-1212  1c. NYS Unemployment Insurance Employer Registration Number of Insured  1d. Federal Employer Identification Number of Insured or Social Security Number 000000000	
2. Name and Address of Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)  ABC CONTRACTING, INC. 111 MAIN STREET ANYTOWN, AK 11111		3a. Name of Insurance Carrier <b>New York State Insurance Fund (NYSIF)</b>  3b. Policy Number of Entity Listed in Box "1a" DBL 00000-6  3c. Policy effective period <u>03/13/2009</u> to <u>03/13/2018</u>	
4. Policy covers: <ul style="list-style-type: none"> <li><input checked="" type="checkbox"/> A. All of the employer's employees eligible under the New York Disability Benefits Law</li> <li><input type="checkbox"/> B. Only the following class or classes of employer's employees:</li> </ul>			

EMPLOYER	CLAIMANT	INSURAN REPRESEN
<ul style="list-style-type: none"> <li> Review My Account</li> <li>Validate/Subscribe to a Workers' Comp Certificate</li> <li style="border: 2px solid green; padding: 2px;">Validate a Disability Benefits Certificate</li> </ul>		

To validate a certificate, visit [nysif.com](https://www.nysif.com), choose Employer, and choose Validate a Disability Benefits Certificate. You can also save this link as a bookmark for direct access: <https://www.nysif.com/DBL/Tools/Validate/Certificate.aspx>.

### Disability Certificate Validation

To validate a Certificate of Insurance, enter the Policy Number and Certificate Number, as shown on the Certificate.

Policy Number:

Certificate Number:

A certificate of Insurance was issued under this policy number with the following information:

**Policyholder:** ACME FENCE CO  
**Issue Date:** 1/1/2019

If the policy is not valid, a message will be returned stating:

The certificate cannot be validated. Please check that the policy and certificate numbers are correct.

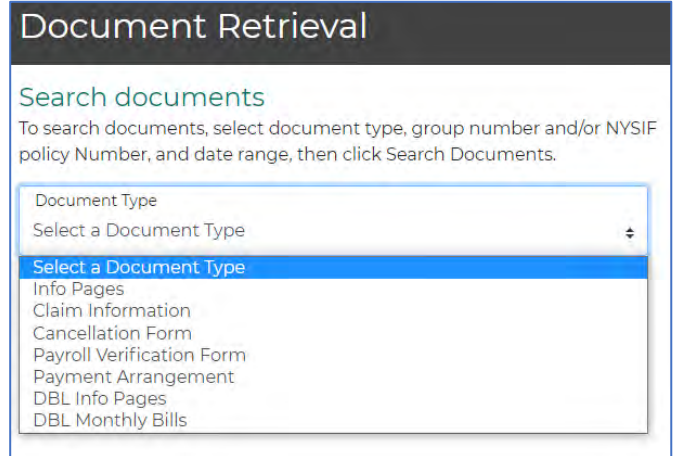
## Pay My Bill

Choose the Billing box to view the “Pay My Bill” link. (There is also a link to “View Bills” which will take you to Document Retrieval, described next.)

For instructions on how to make a one-time payment or enroll in AutoPay, [please view the step-by-step instructions](#) in the worker’s comp section.

## Documents

Expand the Documents box to view the Document Retrieval link. Choosing this link will direct you to a drop-down that will display your DB Info Pages and DB monthly bills. (**If you have a consolidated online account**, go to the WC Online Services Menu and choose Document Retrieval from there. You will then see both sets of documents in the dropdown, as in the example shown.)



## Info Pages:

To search documents, select document type, group number and/or NYSIF policy Number, and date range, then click Search Documents.

Document Type  
DBL Info Pages

Policy Number  
9876543

The date range is limited to three years for search by policy and displays up to the current day, if no date range is specified.

Start Date(optional)  
mm/dd/yyyy

End Date(optional)  
mm/dd/yyyy

**Search Documents**

Envelope ID	Transaction Date	Category	Details	Description
<a href="#">67074960</a>	11/04/2019	DB Payroll Reports	DB Online Payroll Report Reminder v.2	DBL Payroll Reports
<a href="#">66836365</a>	10/22/2019	DB Endorsement	DBL Standalone Endorsement v.2	DBL Endorsements ASD
<a href="#">66232080</a>	09/18/2019	DB Renewals	DBL Information Page - Endorsement v.2 DBL Interest and Service Charge Endorsement v.3 DBL Information Page - Schedule v.2 DBL Return of Premium Endorsement V.3 DBL Rate Endorsement v.2 DB-120 - Notice of Compliance DB PFL Notice of Compliance (PFL-120) DBL Renewal Information Page v.2 DBL Selection of Coverage Cover Letter DBL Renewal v.4	DBL Info - Renewals ASD
<a href="#">66232080</a>	09/18/2019	DB New Policy	DBL Information Page - Endorsement v.2 DBL Interest and Service Charge Endorsement v.3 DBL Information Page - Schedule v.2 DBL Return of Premium Endorsement V.3 DBL Rate Endorsement v.2 DB-120 - Notice of Compliance DB PFL Notice of Compliance (PFL-120) DBL Renewal Information Page v.2 DBL Selection of Coverage Cover Letter DBL Renewal v.4	DBL Info - Renewals ASD

## DB Bills

### Search documents

To search documents, select document type, group number and/or NYSIF policy Number, and date range, then click Search Documents.

Document Type  
DBL Monthly Bills

Policy Number  
9876543

The date range is limited to three years for search by policy and displays up to the current day, if no date range is specified.

Start Date(optional)  
mm/dd/yyyy

End Date(optional)  
mm/dd/yyyy

Search Documents

Envelope ID	Transaction Date	Category	Details	Description
<a href="#">71276729</a>	06/02/2020	Other	DBL Monthly Bill v3	DBL Bills Sample Monthly
<a href="#">66540376</a>	10/02/2019	Other	DBL Monthly Bill v3	DBL Bills Sample Monthly
<a href="#">61574968</a>	02/02/2019	Other	DBL Monthly Bill v1	DBL Monthly Bill
<a href="#">60954558</a>	01/02/2019	Other	New Bills "Its Here" Flyer DBL Monthly Bill v1	DBL Monthly Bill
<a href="#">59081720</a>	10/02/2018	Other	DBL Monthly Bill v1	DBL Monthly Bill

## Estimate Premium

Use our premium calculator to estimate a policy's premium.

### 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 wage to the first \$17,680 each employee earns during a policy period. If an employee is expected to earn less than \$17,680 policy period, then the lower amount should be provided. If an employee is expected to earn more than \$17,680, \$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 2022, annual wages are limited to the first \$82917.64 each employee earns. If an employee is expected to earn less than \$82917.64 annually, then the lower amount should be provided. If an employee is expected to earn more than \$82917.64 annually, then only the first \$82917.64 of their wages should be provided.

Calculate Premium

Reset

## Report Payroll

Choose Report Payroll from the right column menu. Choose the policy period and click "View Report." You will be directed to DocuSign to complete the report.

Examples shown on next page. Enter information for employees working in New York State only.

## Payroll Report

Please select an outstanding report date from the list below.

Outstanding Report Dates:

11/02/2020 - 03/31/2021

11/02/2019 - 11/02/2020

[View Report](#)

## INSTRUCTIONS (example prepared for 2021 policy period)

### PART A: DISABILITY BENEFITS

1. Enter the total number of employees covered on your policy. Covered employees should include all individuals who were on your company's payroll throughout the reporting period.
2. Enter the total wages capped at \$17,680 for all covered employees for the period indicated.\*
3. Enter the total wages capped at \$75,408 for all covered employees for the period indicated.\*
4. Enter the total gross wages for all covered employees for the period indicated. Gross wages are a total of actual wages for all covered employees (without any cap).
5. If your employees contribute to DB premium (FICA), please check yes.

### PART B: PAID FAMILY LEAVE BENEFITS

1. Enter the total number of employees covered on your policy. Covered employees should include all individuals who were on your company's payroll throughout the reporting period.
2. Enter the total wages capped at \$75,408 for all covered employees for the period indicated.\*
3. Enter the total gross wages for all covered employees for the period indicated. Gross wages are a total of actual wages for all covered employees (without any cap).

### \*Calculating Capped Wages

Part A, Question 2: The capped wage for an employee is limited to a maximum of \$17,680 per year. If an employee's annual wage is less than \$17,680, please use the employee's actual wages. If the employee's annual wage is greater than \$17,680, use \$17,680 as their wages. If your policy has enriched disability benefit coverage, multiply \$17,680 by the enrichment factor (1.5, 2, 2.5, 3,4 or 5) for the limited capped wage amount.

Part A, Question 3 and Part B, Question 2: The capped wage for an employee is limited to a maximum of \$75,408 per year. If an employee's annual wage is less than \$75,408, please use the employee's actual wages. If the employee's annual wage is greater than \$75,408, use \$75,408 as their wages.

**This cap changes every year in accordance with the NYS Average Weekly Wage. Be sure you are using the correct cap for the policy period being reported.**

**2023: \$87,786**

**2022: \$82,917**

**2021: \$75,408**

**2020: \$72,860**

**2019: \$70,569**



**Example:**

**Policyholder Name:** EXAMPLE POLICYHOLDER  
**Policy Number:** 123123  
**Reporting Period:** 2/11/2021 to 2/11/2022

---

**PART A: DISABILITY BENEFITS**  
 Please complete information for Disability Benefits only

	Male	Female
1. Enter the number of covered employees	_____	_____
2. Enter wages, capped at \$17,680 per employee	_____	_____
3. Enter wages, capped at \$75,408 per employee	_____	_____
4. Enter total gross wages, with no cap	_____	_____
5. Do your employees contribute to premium?	<input type="checkbox"/> Yes <input type="checkbox"/> No	

---

**PART B: PAID FAMILY LEAVE BENEFITS**  
 Please complete information for Paid Family Leave only

	Male	Female
1. Enter the number of covered employees	_____	_____
2. Enter wages, capped at \$75,408 per employee	_____	_____
3. Enter total gross wages, with no cap	_____	_____

**Claims Services**

**Claims Payment Report**

DB policyholders can access a claims summary for a policy by choosing "Claims Payment Report" from the DBL links drop-down. Enter the beginning and end dates for the period needed, and run the report with a single click. A spreadsheet will be generated containing claimant and payment data, including start and end dates.

Claims payment information is provided to DB policyholders so that the employer can report the appropriate FICA information in its quarterly and annual tax filings as required by the IRS.

**Claims Payment Report**

Policy Number: 0987654

Select Payment Info: Claims Payment Spreadsheet

Start Date:  Note: The start date for the date range can only go as far back as the beginning of the year, 7 years ago.

End Date:  Note: The date range cannot be more than 4 year(s).

[Download Sheet](#)

DB Claims Payment Report													
Claim Number	Claimant Name	SSN	Payment to	Paid date	Draft Number	Start Date	End Date	Gross Amount	Net Amount	FICA Amount	SSFICA Amount	MedFICA Amount	Taxable Amount
XD3/2/05	John Nysif	XXX-XX-4XX4	Claimant	11/13/14	X311X8	6/10/14	9/2/14	\$2,040.00	\$1,773.94	\$156.06	\$126.48	\$29.58	\$2,040.00
XD3/603	Mary Nysif	XXX-XX-4XX4	Claimant	11/12/14	X31025	10/21/14	10/28/14	\$170.00	\$156.99	\$13.01	\$10.54	\$2.47	\$170.00
XD3/603	Mary Nysif	XXX-XX-4XX4	Claimant	11/3/14	X29998	10/28/14	11/4/14	\$170.00	\$156.99	\$13.01	\$10.54	\$2.47	\$170.00
XD3/603	Mary Nysif	XXX-XX-4XX4	Claimant	11/12/14	X31026	11/4/14	11/18/14	\$340.00	\$313.99	\$26.01	\$21.08	\$4.93	\$340.00
XD3/603	Mary Nysif	XXX-XX-4XX4	Claimant	11/21/14	X3218X	11/18/14	11/24/14	\$136.00	\$125.60	\$10.40	\$8.43	\$1.97	\$136.00