



NYSIF DCC, 1 WATERVLIET AVE. EXT. ALBANY, NY 12206  
**nysif.com**

Attn: Underwriting Department

Policy Number: \_\_\_\_\_

Policyholder Name & Address: \_\_\_\_\_  
\_\_\_\_\_

In accordance with the provisions of the Workers' Compensation Law, we hereby give notice of our intention to withdraw from NYSIF. We are no longer need coverage under the Workers' Compensation Law because:

\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employer's Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Employer's Name (Print)

\_\_\_\_\_  
Title

Present Address: \_\_\_\_\_