NYSIF
New York State Insurance Fund

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 the New York State Insurance Fund.

Company Name: _____

Company Name: _____

Company Name: _____

We no longer need coverage under the Workers' Compensation law because:

☐ No employees ☐ Out of Business ☐ Insurance Elsewhere ☐ Other

_____

_____

_____

_____ _____
Employer's Signature Date

_____ _____
Employer's Name (Print) Title

Present Address: _____