NYSIF® New York State Insurance Fund

MAIL TO:

NYSIF DOCUMENT CONTROL CENTER
1 WATERVLIET AVENUE EXTENSION
ALBANY, NY 12206

Attn: Underwriting Department

Policy Number: _____

Policyholder Name & Address: _____

_____

Please be advised that we will only require workers' compensation insurance to cover our temporary employees for the following time period:

Start Date: _____ to End Date: _____

To perform the following operations:

_____

_____

Please cancel this coverage effective 12:01 a.m. as our operations will be completed, and we will no longer have employees.

_____ _____
Employer's Signature Date

_____ _____
Employer's Name (Print) Title

Present Address: _____