



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

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: _____