NYSIF
New York State Insurance Fund

PO Box 66699; Albany, NY 12206
nysif.com

Office Use Only
ATN:
ICMS No.:

APPLICATION FOR NEW YORK VOLUNTEER AMBULANCE WORKERS' BENEFIT LAW AND EMPLOYERS' LIABILITY INSURANCE

Application is hereby made to NYSIF for a policy insuring the applicant's liability for the payment of benefits to the applicant's volunteer ambulance workers under Chapter 64B of the Consolidated Laws of New York, known as the "Volunteer Ambulance Workers' Benefit Law." Applicant understands that no liability shall attach to NYSIF under this application and that insurance shall not be effective unless and until this application is accepted by NYSIF as evidenced by the inception date indicated in a policy, the terms and provisions of which will be binding upon applicant. Applicant further understands that a policy of insurance issued pursuant to this application will not extend coverage under Workers' Compensation Law or Volunteer Firefighters' Benefit Law; any liability of the applicant under such laws to employees, executives or others must be separately insured under a Workers' Compensation insurance policy or Volunteer Firefighters' Benefit Law policy for which separate applications must be submitted.

PLEASE PRINT OR TYPE.

1. Requested effective date of insurance, 12:01 a.m., Eastern Standard Time: _____

2. Full name of applicant: _____

   Federal Tax ID: _____ NYS Unemployment ID: _____

3. Applicant is: ◯ County ◯ Town ◯ Village ◯ Ambulance District* ◯ Corporation
   ◯ Other Specify: _____

*If applicant is an Ambulance District, what is the name of your sponsoring town or village: _____

For the purpose of serving notice, the insured agrees that this address shall be considered the business address of this applicant or any representative upon whom notice may be served.

4. Mailing Address: _____

   Telephone: _____ Fax: _____ Email: _____

5. List all locations within the coverage area.

   _____

6. If applicant is a corporation, list all executive officers. If other than a corporation, list members of Governing Board.

Name	Title	Home Address

7. Contact information of insurance representative, if any.

   Name: _____ Company: _____

   Mailing Address: _____

   Telephone: _____ Fax: _____ Email: _____

Mail your fully completed and signed application along with your deposit premium check to:
NYSIF
PO Box 66699
Albany, NY 12206

8. List all ambulances and other first response vehicles registered to the applicant.

	Plate Number	Type of Vehicle
Vehicle 1		
Vehicle 2		
Vehicle 3		
Vehicle 4		

Attach additional sheets as necessary.

9. How many ambulance calls did you answer during the past year? _____

10. How many active volunteers do you have? _____ _____ _____
(Ambulance Workers) (Dispatchers) (Other: specify)

11. Previous insurance company:

Name, Address	Policy Number	Policy Period	Number of accidents	Reason for cancellation

How many of the accidents shown above involved a motor vehicle? _____

12. Has any insurance company declined to offer coverage to you during the last 12 months? ◯ Yes ◯ No

If yes, why was coverage declined? _____

13. If known, please enter your latest experience modification factor and effective rating date:

Experience Modification Factor: _____ Effective Rating Date: _____

14. Do you have any paid employees? ◯ Yes ◯ No

If yes, name of workers' comp insurance company: _____ Pol Number: _____

15. Is your ambulance company duly registered or certified pursuant to Article 30 of the Public Health Law?

◯ Yes ◯ No Please explain: _____

Only a registered or certified ambulance company, other than an ambulance company or emergency rescue and first aid squad affiliated with a fire department or fire company subject to Section 209-b of the General Municipal Law, is eligible to obtain insurance coverage under the Volunteer Ambulance Workers' Benefit Law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

16. _____ _____ _____
Print name: Authorized Officer Signature & Title: Authorized Officer Date

Mail your fully completed and signed application along with your deposit premium check to:
NYSIF
PO Box 66699
Albany, NY 12206