NYSIF® **New York State Insurance Fund**

Workers' Compensation & Disability Benefits Specialists Since 1914

Document Control Center, 1 Watervliet Ave. Extension, Albany, NY 12206

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ATN#: _____

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APPLICATION FOR NEW YORK WORKERS' COMPENSATION

DOMESTIC HOUSEHOLD WORKER POLICY

Any person who willfully makes a false statement or representation, deliberately conceals any material fact, or engages in any other fraudulent scheme or device, for the purpose of obtaining or attempting to obtain, or for the purpose of aiding or abetting any person to obtain insurance in the New York State Insurance Fund at less than the proper rate for such insurance, or payment out of the New York State Insurance Fund to which such person is not entitled, is guilty of a crime. In addition, the New York State Insurance Fund shall have a right of action to recover civil damages equal to three times the amount wrongfully obtained, or five thousand dollars, whichever is greater. This right of action is in addition to any other remedy provided by law.

Applicant, please note:

With this application, you are applying for a policy insuring against liability under the New York Workers' Compensation Law for injuries to your employees that perform personal or domestic services in a private home. No coverage will be effected unless the required deposit premium is received along with this application and the New York State Insurance Fund accepts the application as evidenced by the inception date indicated in a policy. The terms and provisions of the policy will be binding on you. Any policy of insurance issued in response to this application will not cover non-occupational disability benefits or paid family leave benefits provided under Article 9 of the New York Workers' Compensation Law. You must submit a separate application to obtain a disability benefits/paid family leave policy.

You must answer all questions. Please print your answers.

(1) REQUESTED EFFECTIVE DATE OF INSURANCE: _____/_____/_____ **12:01 A.M.**, EASTERN STANDARD TIME.

(2) PLEASE LIST THE TYPE OF WORK AND DUTIES FOR ALL YOUR EMPLOYEES:

Description	Duties	# of Employees
DOMESTIC FULL TIME - INSIDE		
DOMESTIC FULL TIME - OUTSIDE		
DOMESTIC PART TIME - INSIDE		
DOMESTIC PART TIME - OUTSIDE		

Domestic Workers – Inside – are employees engaged in household work performed inside the residence. Examples include a cook, housekeeper, babysitter and nanny.
Domestic Workers – Outside – are employees engaged exclusively in household work performed outside the residence. Examples include a gardener or private driver.

Full Time - Any household worker who is employed more than 20 hours per work week.
Part Time - Any household worker who is employed 20 hours or less per work week.

(3) WHAT IS THE FULL NAME OF THE EMPLOYER?

First Name	M.I.	Last Name	Telephone	E-mail

3a. WHAT IS YOUR FEDERAL TAX ID NUMBER? _____

3b. WHAT IS YOUR NYS UNEMPLOYMENT INSURANCE NUMBER? _____

(4) PLEASE PROVIDE THE MAILING ADDRESS OF THE EMPLOYER:

FOR THE PURPOSE OF SERVING NOTICE OF CANCELLATION IN ACCORDANCE WITH SECTION 54(5) OF THE NEW YORK WORKERS' COMPENSATION LAW, THE INSURED(S) AGREE(S) THAT SERVICE OF NOTICE UPON THE PERSON OR ENTITY DESIGNATED AT THE ADDRESS SPECIFIED IS SERVICE OF NOTICE UPON ALL INSUREDS INSURED UNDER ONE INSURANCE POLICY. ALL BILLS, CORRESPONDENCE AND OTHER MAILED MATERIAL ALSO WILL BE SENT TO THAT PERSON OR ENTITY AT THAT ADDRESS. IF AN EMPLOYER IDENTIFIES A MAILING ADDRESS THAT IS DIFFERENT FROM THE WORK LOCATION ADDRESS, NYSIF WILL DEEM THE MAILING ADDRESS THE "LAST KNOWN PLACE OF BUSINESS" FOR CANCELLATION NOTICE PURPOSES.

Address

Address 2

City

State

Zip Code

(5) LIST ALL LOCATIONS TO BE COVERED IN NEW YORK STATE:

(P.O. BOX IS NOT ACCEPTABLE AS A LOCATION. ONLY NEW YORK STATE LOCATIONS CAN BE COVERED.)

Street Name	City	State	Zip Code	# Of Employees
		NY		
		NY		
		NY		
		NY		

(6) DO YOU HAVE A REPRESENTATIVE? ☐ YES ☐ NO

(6a) IF YES, PLEASE ENTER INFORMATION ON YOUR REPRESENTATIVE:

Representative Name

90

Group Number

Address

Address 2

City

State

Zip Code

Phone Number

Fax Number

E-mail Address

I UNDERSTAND THAT THE INFORMATION WHICH I HAVE PROVIDED ON THIS APPLICATION WILL BE USED TO CALCULATE MY WORKERS' COMPENSATION INSURANCE PREMIUM. I ALSO UNDERSTAND THAT I HAVE A CONTINUING OBLIGATION TO NOTIFY THE NEW YORK STATE INSURANCE FUND OF ANY CHANGES IN:

- ○ THE KINDS OF WORK WHICH THE BUSINESS IS DOING
- ○ THE SIZE OF OUR WORKFORCE
- ○ THE SIZE OF OUR PAYROLL
- ○ THE BUSINESS OWNERSHIP OR BUSINESS STRUCTURE

Print or Type Name of Owner, Partner or Officer

Signature of Owner, Partner or Officer

/ /

Date

PLEASE PRINT, SIGN AND MAIL YOUR COMPLETED APPLICATION ALONG WITH THE REQUIRED DEPOSIT

Applicant, please note:

INFORMATION YOU PROVIDE IS PROTECTED BY THE PERSONAL PRIVACY PROTECTION LAW

The authority to obtain the personal information requested herein is found in Section 83 of the Workers' Compensation Law as supplemented by Section 450.1, 450.3 and 450.5 of Chapter VI of Title 12(c) of the Official Compilation of Codes, Rules and Regulations of the State of New York. The principal purpose for which the information is sought is to assist the New York State Insurance Fund in processing your insurance coverage with the New York State Insurance Fund and its release is governed by the limitations of the Personal Privacy Protection Law. This information will be maintained by the Director of Underwriting, New York State Insurance Fund, 199 Church Street, New York, NY 10007.

To ensure prompt service and processing, please mail your fully completed and signed application along with your deposit premium check and supporting documentation to:

NEW YORK STATE INSURANCE FUND
DOCUMENT CONTROL CENTER - NEW BUSINESS
1 WATERVLIET AVENUE EXTENSION
ALBANY, NEW YORK 12206