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FOR OFFICE USE ONLY
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APPLICATION FOR NEW YORK VOLUNTEER FIREFIGHTERS' BENEFIT LAW AND EMPLOYERS' LIABILITY INSURANCE

Application is hereby made to THE STATE INSURANCE FUND for a policy insuring the applicant's liability for the payment of benefits to the applicant's volunteer firefighters under Chapter 64A of the Consolidated Laws of New York, known as the "Volunteer Firefighters' Benefit Law." Applicant understands that no liability shall attach to THE STATE INSURANCE FUND under this application and that insurance shall not be effective unless and until this application is accepted by THE STATE INSURANCE FUND 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 Ambulance Workers' 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 Ambulance Workers' 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

(2a) FEDERAL TAX ID NYS UNEMPLOYMENT ID

(3) APPLICANT IS ☐ COUNTY ☐ TOWN ☐ VILLAGE ☐ FIRE DISTRICT ☐ CITY
☐ OTHER SPECIFY

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

(Street) (City or Town) (State) (County) (Zip Code)

TELEPHONE NO. FAX E-MAIL ADDRESS

(5) LIST THE NAMES AND LOCATIONS OF ALL FIRE COMPANIES AND/OR FIRE DEPARTMENTS WITHIN THE APPLICANT'S BOUNDARIES

(6) LIST ALL ELECTED OR APPOINTED OFFICERS OF THE APPLICANT; IF THERE ARE NO ELECTED OR APPOINTED OFFICERS, LIST MEMBERS OF GOVERNING BOARD.

NAME	TITLE	HOME ADDRESS

(7) NAME, ADDRESS AND TELEPHONE NUMBER OF INSURANCE REPRESENTATIVE, IF ANY

(Name) (Street)

(City or Town) (State) (Zip Code) (Telephone) (Email)

(8) WHAT IS THE RESIDENTIAL POPULATION OF THE FIRE-PROTECTION AREA TO BE COVERED?

(Population of Applicant's Home Area)

(9) LIST SEPARATELY THE POPULATIONS OF EACH AND EVERY OUTSIDE AREA FOR WHICH THE APPLICANT HAS AGREED TO PROVIDE PROTECTION UNDER A FIRE-PROTECTION CONTRACT; IF THERE ARE NO OUTSIDE AREAS PROTECTED PURSUANT TO CONTRACT, WRITE "NONE."

Name of Outside Area	Population of Outside Area

(Attach an additional sheet if there are more Outside Areas.)

(10) THE POPULATION FIGURES WHICH APPLICANT PROVIDES ABOVE ARE BASED ON:

☐ U.S. CENSUS ☐ TAX ROLLS ☐ OTHER, SPECIFY

IF CENSUS FIGURES ARE USED, IN WHICH YEAR WAS THE CENSUS TAKEN

(11) PREVIOUS INSURANCE COMPANY

NAME AND ADDRESS	POLICY NUMBER	POLICY PERIOD	NUMBER OF ACCIDENTS	REASON FOR CANCELLATION

(12) HAS ANY INSURANCE COMPANY DECLINED TO OFFER COVERAGE TO YOU DURING THE LAST TWELVE MONTHS?

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? IF YES, WHAT IS THE NAME OF YOUR WORKERS' COMPENSATION INSURANCE COMPANY? POLICY NO.

(15) IF APPLICANT IS A FIRE DISTRICT, ARE FIRE DISTRICT OFFICERS AND EMPLOYEES COVERED FOR BENEFITS UNDER A WORKERS' COMPENSATION INSURANCE POLICY?

☐ YES ☐ NO - EXPLAIN

Section 54-6a of the Workers' Compensation Law requires a fire district to provide Workers' Compensation coverage for its officers and employees whether or not such persons are paid for their services. This policy, when issued, will not afford coverage for Workers' Compensation benefits for fire district officers or employees. A separate Workers' Compensation policy is needed for such coverage.

(16) THIS ITEM ONLY APPLIES IF APPLICANT IS PROVIDING GROUP INSURANCE PURSUANT TO SECTION 32 OF THE VOLUNTEER FIREFIGHTERS' BENEFIT LAW. PLEASE LIST AND GIVE THE POPULATION OF EACH CITY, TOWN, VILLAGE, ETC. TO BE COVERED UNDER GROUP INSURANCE.

Name of Outside Area	Population of Outside Area

(Attach an additional sheet if there are more Outside Areas.)

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.

(17)

(NAME OF AUTHORIZED OFFICER – PRINT OR TYPE) (SIGNATURE OF AUTHORIZED OFFICER - TITLE) (DATE)

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 AVE EXTENSION
ALBANY, NEW YORK 12206

For additional assistance, customer service and contact information:

Please visit our website – *NYSIF.COM* or telephone us at 1-888-875-5790.