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FOR OFFICE USE ONLY
ATN
ICMS NO.

APPLICATION FOR NEW YORK VOLUNTEER AMBULANCE WORKERS' 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 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 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 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

(2a) 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

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

TELEPHONE NO. FAX E-MAIL ADDRESS

(5) LIST ALL LOCATIONS

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

(Name) (Street)

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

(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 an additional sheet if there are more vehicles.)

(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 AND 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 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) IS YOUR AMBULANCE COMPANY DULY REGISTERED OR CERTIFIED PURSUANT TO ARTICLE 30 OF THE PUBLIC HEALTH LAW?

☐ YES ☐ NO - 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) ____ (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.