NYSIF® **New York State Insurance Fund**

Workers' Compensation & Disability Benefits Specialists Since 1914

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APPLICATION FOR NEW YORK WORKERS' COMPENSATION AND EMPLOYERS' LIABILITY INSURANCE

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:
Application is hereby made to the NEW YORK STATE INSURANCE FUND for a policy insuring the applicant's liability for the payment of benefits to the applicant's employees under the New York Workers' Compensation Law. **No coverage will be effected unless the required deposit premium is received along with this application.** Applicant understands that no liability shall attach to the NEW YORK STATE INSURANCE FUND under this application and that insurance shall not be effective unless and until this application is accepted by the NEW YORK STATE INSURANCE FUND as evidenced by the inception date indicated in a policy, the terms and provisions of which will be binding upon the applicant. Applicant further understands that a policy of insurance issued pursuant to this application will not extend coverage under the Disability Benefits Law, the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law; any liabilities of the applicant under such laws to employees, executives or others must be separately insured under a Disability Benefits insurance policy, Volunteer Firefighters' Benefit Law policy or Volunteer Ambulance Workers' Benefit Law policy for which separate applications must be submitted.

PLEASE PRINT YOUR ANSWERS.

(1)* REQUESTED EFFECTIVE DATE OF INSURANCE: _____/_____/_____ 12:01 A.M., EASTERN STANDARD TIME.
The earliest effective date is the day after you submit a fully completed application and the required deposit premium.

(2)* PLEASE PROVIDE THE FOLLOWING INFORMATION ABOUT THE BUSINESS. WHEN APPROPRIATE, INCLUDE YOUR DOING BUSINESS AS NAME OR TRADING AS NAME.

Business Type:* _____

Business types: Sole Proprietor/Self Employed; Partnership; Corporation (For Profit); Corporation (Not For Profit); Corporation (Religious, Charitable, Educational and Veterans Organization); Political Subdivision; Limited Liability Company; Professional Service Liability Company; Registered Limited Liability Partnership; Limited Liability Partnership; or if Other-Specify.

Business Name:* _____

DBA or TA Name: _____
(Circle one)

Federal Tax ID:* _____ NYS Unemployment Ins. #: _____ NAICS CODE: _____

Business Telephone:* (_____)_____-_____ Business Fax #: (_____)_____-_____

WebSite: _____

Business E-mail: _____

(2a)* IS THIS A NEWLY FORMED BUSINESS? ☐ YES ☐ NO

(2b) IF YOU ARE A CORPORATION, IN WHAT STATE ARE YOU INCORPORATED AND THE DATE OF INCORPORATION?

State: _____ Date of incorporation: _____/_____/_____

(2c)* HOW LONG HAS YOUR COMPANY BEEN IN BUSINESS? Years: _____ Months: _____

* Required field

(3)* PLEASE PROVIDE INFORMATION ON THE SOLE PROPRIETOR, ALL EXECUTIVE OFFICERS, PARTNERS, ELECTED OR APPOINTED OFFICIALS, OR MEMBERS OF GOVERNING BOARDS, IF APPLICABLE. LIST ALL SUCH PERSONS, REGARDLESS OF WHETHER THEY WILL BE COVERED.

First Name:* _____ MI: _____ Last Name: *_____

Title: *_____
(President, Vice-President, Secretary, Treasurer, Member, Chairperson, Owner, Partner, Other-Specify)

Annual Salary:* $_____ % of Ownership / % of Partnership: _____ # of Shares Owned: _____

Duties:* _____

Home Address:* _____ Home Address 2: _____

City:* _____ State: *_____ Zip Code: *_____ - _____

Phone Number:* (_____)_____ - _____ E-mail Address:* _____

(3a)* COVER THIS INDIVIDUAL? ☐ YES ☐ NO

First Name: _____ MI: _____ Last Name: _____

Title: _____
(President, Vice-President, Secretary, Treasurer, Member, Chairperson, Owner, Partner, Other-Specify)

Annual Salary: $_____ % of Ownership / % of Partnership: _____ # of Shares Owned: _____

Duties: _____

Home Address: _____ Home Address 2: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone Number: (_____)_____ - _____ E-mail Address: _____

(3b) COVER THIS INDIVIDUAL? ☐ YES ☐ NO

First Name: _____ MI: _____ Last Name: _____

Title: _____
(President, Vice-President, Secretary, Treasurer, Member, Chairperson, Owner, Partner, Other-Specify)

Annual Salary: $_____ % of Ownership / % of Partnership: _____ # of Shares Owned: _____

Duties: _____

Home Address: _____ Home Address 2: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone Number: (_____)_____ - _____ E-mail Address: _____

(3c) COVER THIS INDIVIDUAL? ☐ YES ☐ NO

Attach a separate sheet if additional space is needed.

* Required field

(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 ADDRESSTHAT 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:* _____ - _____

(4a)* LIST ALL BUSINESS OR WORK LOCATIONS OF THE EMPLOYER TO BE COVERED IN NEW YORK STATE INCLUDING MAIN LOCATION: (P.O. BOX IS NOT ACCEPTABLE AS A LOCATION. ONLY NEW YORK STATE LOCATIONS CAN BE COVERED.)

Street Name (list main work location on the first line)	City	State	Zip Code	# Of Employees
		NY		
		NY		
		NY		
		NY		

Attach a separate sheet if additional space is needed.

(5)* ARE THERE ADDITIONAL BUSINESSES (ENTITIES) TO BE COVERED? ☐ YES ☐ NO

Business Type:* _____

Business types: Sole Proprietor/Self Employed; Partnership; Corporation (For Profit); Corporation (Not For Profit); Corporation (Religious, Charitable, Educational and Veterans Organization); Political Subdivision; Limited Liability Company; Professional Service Liability Company; Registered Limited Liability Partnership; Limited Liability Partnership; or if Other-Specify.

Business Name:* _____

DBA or TA Name: (Circle one) _____

Federal Tax ID:* _____ NYS Unemployment Ins. #: _____ NAICS CODE: _____

Business Telephone:* (_____)_____-_____ Business Fax #: (_____)_____-_____

WebSite: _____

Business E-mail: _____

For each additional employer listed, required forms establishing all such employers meet the requirements to be written under a single policy must be submitted.

(5a) LIST ALL BUSINESS OR WORK LOCATIONS OF THE ADDITIONAL ENTITIES (IF ANY):

(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		

Attach a separate sheet if additional space is needed.

* Required field

(6)* HAVE ANY OF THE PARTIES IDENTIFIED IN QUESTIONS 2, 3 AND/OR 5 EVER BEEN INSURED BY THE NEW YORK STATE INSURANCE FUND? ☐ YES ☐ NO

ANSWER YES TO INCLUDE IF ANY PERSON OR ENTITY WHICH OWNS, CONTROLS OR HAS A MAJORITY INTEREST IN ANY EMPLOYER IDENTIFIED IN QUESTIONS 2, 3 AND/OR 5, ALSO OWNED, CONTROLLED OR WAS AN OFFICER OF ANOTHER EMPLOYER THAT WAS PREVIOUSLY INSURED WITH THE NEW YORK STATE INSURANCE FUND.

IF ANY CURRENT RELATIONSHIP EXISTS, THE NY STATE INSURANCE FUND IS NOT REQUIRED TO ISSUE A POLICY UNTIL ALL UNPAID BILLED PREMIUM ON THE PRIOR POLICY IS PAID.

IF THE EMPLOYER HAD A PRIOR NY STATE INSURANCE FUND POLICY THAT WAS CANCELLED OR IS OTHERWISE NO LONGER IN EFFECT, THE NY STATE INSURANCE FUND IS NOT PERMITTED TO ISSUE ANOTHER POLICY WHILE ANY BILLED PREMIUM ON THAT PRIOR POLICY REMAINS UNCOLLECTED.

IF YES, PLEASE LIST ALL PREVIOUS NEW YORK STATE INSURANCE FUND POLICY NUMBERS:

Previous State Fund Policy Number(s)	Period(s) Of Coverage
	to
	to

(7)* HAVE THE EMPLOYER OR INDIVIDUAL(S) LISTED IN QUESTIONS 2, 3 AND/OR 5 BEEN INSURED FOR WORKERS' COMPENSATION BY A CARRIER OTHER THAN THE NY STATE INSURANCE FUND? ☐ YES ☐ NO

IF YES, PLEASE PROVIDE THE EMPLOYER'S WORKERS' COMPENSATION EXPERIENCE FOR THE LATEST 5 YEARS:

These amounts can be found on your loss runs from your current workers' compensation carrier.

A copy of loss runs and audit bills from prior insurers will be required.

Year	Insurer	Policy #	Annual Premium	# of Claims	Total Incurred Claims Cost	Amount Paid

(7a) IF KNOWN, PLEASE ENTER EMPLOYER'S NYCIRB NUMBER, NCCI NUMBER, LATEST EXPERIENCE MODIFICATION FACTOR AND THE EFFECTIVE RATING DATE:

NYCIRB #:_____ NCCI #:_____ Experience Mod Factor:_____ Effective Rating Date:_____

(8)* PLEASE DESCRIBE YOUR BUSINESS OPERATIONS INCLUDING THE PRODUCTS OR SERVICES SOLD:

IF THE EMPLOYER IS A MANUFACTURER INCLUDE THE RAW MATERIALS, PROCESS, PRODUCTS AND EQUIPMENT USED OR PRODUCED. IF THE EMPLOYER IS A CONTRACTOR OR ENGAGED IN CONSTRUCTION THEN DESCRIBE THE TYPE OF WORK PERFORMED INCLUDING THE WORK PERFORMED BY SUB-CONTRACTORS. IF ENGAGED IN MERCHANDISE, WHOLESALE OR RETAIL TRADE, DESCRIBE THE MERCHANDISE SOLD, TYPES OF CUSTOMERS AND DELIVERIES. IF ENGAGED IN A SERVICE BUSINESS DESCRIBE THE TYPE OF SERVICE PERFORMED AND LOCATION(S) OF SUCH SERVICE. IF ENGAGED IN FARMING INCLUDE ACREAGE, TYPES AND NUMBERS OF ANIMALS, MACHINERY USED AND SUB-CONTRACTS.

Business Description

Attach a separate sheet if additional space is needed.

* Required field

(9)* PLEASE LIST YOUR ESTIMATED ANNUAL PAYROLL BY THE TYPE OF WORK AND DUTIES FOR ALL YOUR EMPLOYEES. IF THE OFFICIAL(S) HAS ELECTED TO BE EXCLUDED FROM COVERAGE, DO NOT INCLUDE THEIR ANNUAL PAYROLL.

Type of Work	Duties	# of Employees	Annual Payroll
CLERICAL OFFICE EMPLOYEES			
SALESPERSONS / COLLECTORS / MESSENGERS			
EXECUTIVE OFFICERS / PARTNERS / MEMBERS / SELF-EMPLOYED			
OTHER-DESCRIBE			
OTHER-DESCRIBE			
OTHER-DESCRIBE			

Attach a separate sheet if additional space is needed.

When required, payroll verification should accompany this application. Acceptable verification consists of one of the following:

- Copies of Federal Tax Form 941 for the last four quarters
- Copies of New York State Tax Form NYS-45-MN for the last 4 quarters

(9a)* IF YOU HIRE OR LEASE AN EMPLOYEE WHO IS NOT COVERED BY A VALID WORKERS' COMPENSATION POLICY, YOU WILL BE LIABLE FOR THEIR COVERAGE. PLEASE LET US KNOW IF THERE ARE ANY SUCH WORKERS, REGARDLESS OF THEIR COVERAGE.

ARE SUB-CONTRACTORS, INDEPENDENT CONTRACTORS OR 1099 EMPLOYEES USED? ☐ YES ☐ NO

DO YOU LEASE EMPLOYEES TO OR FROM OTHER EMPLOYERS? ☐ YES ☐ NO

(10)* DO YOU HAVE A REPRESENTATIVE? ☐YES ☐ NO IF YES, PLEASE ENTER INFORMATION ON YOUR REPRESENTATIVE:

Representative Name: _____ Group Number: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone Number: (_____)_____-_____ E-mail: _____

(11)* IS THE MAIN LOCATION WHERE NYSIF SHOULD CONDUCT AN AUDIT OF YOUR RECORDS TO CONFIRM PAYROLL, OPERATIONS AND FINAL PREMIUM? ☐ YES ☐ NO IF NO, PLEASE ENTER THE PREMIUM AUDIT CONTACT:

Company Name: _____

Contact Name: _____

Address: _____ Address 2: _____

City: _____ State: _____ Zip Code: _____ - _____

Phone Number: (_____)_____-_____ E-mail: _____

* Required field

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

* Required field