NYSIF New York State Insurance Fund
Workers' Compensation and Disability Benefits Specialist since 1914

FOR OFFICE USE ONLY
Seq. No.: ________________
C.M.S. No.: ________________
Policy No.: ________________

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

Any person who wilfully 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.

(2) WHAT IS THE FULL NAME(S) OF THE EMPLOYER(S) INCLUDING ANY TRADE NAME(S) OR DOING BUSINESS AS NAME(S)?

Name of Employer(s)	Trade Name(s) or Doing Business As Name(s)	*Business Type

Attach a separate sheet if additional space is needed.

***Business types:** Sole Proprietor/Self Employed; Partnership; Corporation; Political Subdivision; Limited Liability Company; Professional Service Liability Company; Registered Limited Liability Partnership; Limited Liability Partnership, or if Other-Specify.

(3) PLEASE PROVIDE THE MAIN NEW YORK STATE WORK LOCATION OF THE EMPLOYER:
(P.O. BOX IS NOT ACCEPTABLE AS A WORK LOCATION)

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.

Address:

City: State: NY Zip Code: -

Telephone: Fax: E-Mail:

NEW YORK STATE COUNTY FOR THE EMPLOYER'S MAIN WORK LOCATION

IS THE WORK LOCATION SHOWN ALSO THE EMPLOYER'S MAILING ADDRESS? ☐ YES ☐ NO

IF NO, PLEASE PROVIDE THE MAILING ADDRESS:

Address:

City: State: Zip Code: -

(4) DO YOU HAVE A REPRESENTATIVE? ☒ YES ☐ NO

(4a) IF YES, PLEASE ENTER INFORMATION ON YOUR REPRESENTATIVE.

Name: Sieger & Smith, Inc. Group No.: 495

Address: 700 White Plains Rd

City: Scarsdale State: New York Zip Code: 10583 -

Telephone: 914-472-6700 Fax: 914-472-6705 E-Mail: siegersmith@siegersmith.com

(5) HOW LONG HAS YOUR COMPANY BEEN IN BUSINESS? YEARS MONTHS

(6) HAVE YOU EVER BEEN INSURED FOR WORKERS' COMPENSATION? ☐ YES ☐ NO

(6a) IF YES, PLEASE PROVIDE INFORMATION ON YOUR WORKERS' COMPENSATION EXPERIENCE FOR THE PAST 5 YEARS:

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

Attach a separate sheet if additional space is needed.

(7) IF KNOWN, PLEASE ENTER YOUR LATEST EXPERIENCE MODIFICATION FACTOR AND EFFECTIVE RATING DATE.

Experience Modification Factor: Effective Rating Date: / /

(8) HAVE YOU BEEN DECLINED FOR COVERAGE DURING THE LAST 12 MONTHS? ☐ YES ☐ NO

(8a) IF YES, PLEASE COMPLETE:

Name of Insurance Company	Reason Coverage was Declined

Attach a separate sheet if additional space is needed.

(9) HAVE YOU EVER BEEN INSURED IN THE NEW YORK STATE INSURANCE FUND? ☐ YES ☐ NO

(You must answer "YES" if you or any person who directly or indirectly owns or controls or is the president, vice president, secretary or treasurer of an employer identified in Question (2) either directly or indirectly owns or controls or is president, vice president, secretary or treasurer of an employer that has had a workers' compensation policy with the State Insurance Fund that was cancelled, or directly or indirectly owned or controlled or was president, vice president, secretary or treasurer of an employer at the time that employer's workers' compensation insurance policy with the State Insurance Fund was cancelled. The Workers' Compensation Law prohibits any person from contracting for a subsequent policy with the State Insurance Fund while the billed premium on such a cancelled policy remains uncollected.)

(9a) IF YES, PLEASE COMPLETE.

Previous State Fund Policy Number(s)	Period(s) of Coverage
	From: / / To: / /
	From: / / To: / /

Attach a separate sheet if additional space is needed.

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

If you are a manufacturer, include the raw materials, processes, products, and equipment used or produced. If you are a contractor or engage in construction then describe the type of work performed including the work performed by sub-contractors. If engaged in mercantile, 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.)

(11) PLEASE LIST YOUR ESTIMATED ANNUAL PAYROLL BY TYPE OF WORK OR DUTIES FOR ALL YOUR EMPLOYEES:

If you are a corporation with one or two executive officers who collectively own 100% of the corporation's stock, you have the option to exclude the officers from coverage.

DO YOU WISH TO EXCLUDE THE OFFICER(S)? ☐ YES ☐ NO

If you are a partnership, LLP, PLLP, LLC, PLLC or Sole Proprietorship you can elect to bring partners, members or self-employed persons under coverage for a premium that is subject to a minimum and maximum annual remuneration.

DO YOU WISH TO INCLUDE PARTNERS, MEMBERS OR SELF-EMPLOYED PERSONS? ☐ YES ☐ NO

If yes, include remuneration for person(s) you wish to bring under coverage on the next page.

QUESTION (11) CONTINUED

Description	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.

(12) IF YOU ARE A CORPORATION, IN WHAT STATE ARE YOU INCORPORATED?

(12a) DATE OF INCORPORATION: / /

(13) LIST ALL BUSINESS 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		

Attach a separate sheet if additional space is needed.

(14) ADDITIONAL INFORMATION ON THE EMPLOYER(S) SEEKING COVERAGE, LISTED IN QUESTION (2).

Name of Employer(s)	Federal Tax ID	NYS Unemployment ID

Attach a separate sheet if additional space is needed.

(15) WHAT IS THE NAME AND ADDRESS OF YOUR BANK?

Bank Name:

Address:

City: State: Zip Code: -

(16) INFORMATION ON THE PERSON YOU WISH US TO CONTACT FOR A PREMIUM AUDIT:

Name:

Address:

City: State: Zip Code: -

Telephone: Fax: E-Mail:

(17) PLEASE PROVIDE INFORMATION ON THE SOLE PROPRIETOR, ALL EXECUTIVE OFFICERS, PARTNERS, ELECTED OR APPOINTED OFFICIALS, OR MEMBERS OF GOVERNING BOARDS, IF APPLICABLE:

First Name . MI. Last Name:

Title: Annual Salary:

Duties:

Address:

City: State: Zip Code: -

Telephone: Fax: E-Mail:

First Name . MI. Last Name:

Title: Annual Salary:

Duties:

Address:

City: State: Zip Code: -

Telephone: Fax. E-Mail:

First Name MI Last Name:

Title: Annual Salary:

Duties:

Address:

City: State: Zip Code: -

Telephone: Fax. E-Mail:

Attach a separate sheet if additional space is needed.

(17a) IF ANY OF THE PARTNERS OR CORPORATE OFFICERS LISTED IN QUESTION (17) IS A PARTNER OR CORPORATE OFFICER FOR A PARTNERSHIP OR CORPORATION OTHER THAN THE EMPLOYER(S) SPECIFIED IN QUESTION (2), LIST THE NAME OF ALL SUCH PARTNERSHIPS AND/OR CORPORATIONS WITH THE PRINCIPAL BUSINESS ADDRESS AND, FOR A CORPORATION, THE PERCENTAGE OF STOCK OWNERSHIP.

First Name: MI. Last Name:

Name of Partnership or Corporation: % of Stock:

Address:

City: State: Zip Code: -

First Name: MI. Last Name:

Name of Partnership or Corporation: % of Stock:

Address:

City: State: Zip Code: -

Attach a separate sheet if additional space is needed.

(18) PLEASE PROVIDE INFORMATION ON YOUR DISABILITY BENEFITS INSURANCE:

Disability Benefits Carrier: Disability Policy Number:

(18a) DO YOU WANT A DISABILITY BENEFITS INSURANCE QUOTE? ☐ YES ☐ NO

(19) PLEASE PROVIDE INFORMATION ON YOUR GENERAL LIABILITY INSURANCE:

General Liability Insurance Carrier: General Liability Policy Number:

(20) HAVE YOU EVER BEEN IN BUSINESS UNDER A DIFFERENT NAME? ☐ YES ☐ NO

(20a) IF YES, PLEASE COMPLETE:

Name(s) Used	**Trade Name(s) (if any)**	**Date Usage of Name was Stopped or Changed**

Attach a separate sheet if additional space is needed.

(21) IF YOU ARE INCORPORATED, HAVE THE PRINCIPALS OF THE CORPORATION PREVIOUSLY MANAGED A BUSINESS BY ANOTHER NAME? ☐ YES ☐ NO

(21a) IF YES, PLEASE COMPLETE:

Name(s) Used	**Trade Name(s) (if any)**	**Date Usage of Name was Stopped or Changed**

Attach a separate sheet if additional space is needed.

(22) IS YOUR BUSINESS OR COMPANY AN AFFILIATE OR A SUBSIDIARY OF ANY OTHER COMPANY? ☐ YES ☐ NO

(22a) IF YES, PLEASE COMPLETE

Name of Affiliate or Subsidiary:		Relationship:		Present Workers' Comp. Carrier:	
Address:					
City:		State:		Zip Code:	-

Attach a separate sheet if additional space is needed.

(23) ARE YOU ENGAGED IN ANY OTHER TYPE OF BUSINESS? ☐ YES ☐ NO

(23a) IF YES, PLEASE DESCRIBE OTHER BUSINESS OPERATIONS INCLUDING THE PRODUCTS AND SERVICES SOLD.

Business Description (Attach a separate sheet if additional space is needed.)

(24) ARE SUB-CONTRACTORS OR INDEPENDENT CONTRACTORS USED? ☐ YES ☐ NO

(25) PAYROLL VERIFICATION

(This requirement does not apply to employers of domestic workers or to municipalities or other political subdivisions.)

At least one of the following items of payroll verification MUST accompany this application. Failure to provide this information may increase your premium. Please attach at least one of the following items to your application:

- A copy of your previous insurance company's premium audit bill showing the classifications and payrolls for the most recent policy period
- Copies of Federal Tax Form 941 for the last four quarters
- Copies of New York State Tax Form NYS-45-MN quarterly combined withholding, wage reporting and unemployment insurance return for the last four quarters

If none of the foregoing documents are available because you are a new business or did not have employees, then check this box: ☐

(26) 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

Date: / /

Name of Applicant: (Print or Type)

Signature of Owner, Partner or Officer

PLEASE PRINT, SIGN AND MAIL YOUR COMPLETED APPLICATION

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 Sections 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.

District Offices of New York State Insurance Fund are located at:

1 Watervliet Ave. Ext.
Albany, NY 12206
(518) 437-6400

225 Oak Street
Buffalo, NY 14203
(716) 851-2000

8 Corporate Center Dr.
Melville, NY 11747
(631) 756-4000 Nassau
(631) 756-4300 Suffolk

199 Church Street
New York, NY 10007
(212) 312-9000

100 Chestnut Street
Rochester, NY 14604
(585) 258-2000

105 Corporate Park Drive
Suite 200
White Plains, NY 10604
(914) 701-2120

1045 7th North Street
Liverpool, NY 13088
(315) 453-6500

2001 Perimeter Rd. E.
Endicott, NY 13760
(607) 741-5055