



## Start a Workers' Compensation Quote

Requested Effective Date: \_\_\_\_\_

### **Business Information**

Business Name: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: NY Zip Code: \_\_\_\_\_

Business Email: \_\_\_\_\_ Business Telephone: \_\_\_\_\_

Is this a newly formed business?      Yes\*      No      *\*Indicates the business has no prior coverage and/or reported payroll history of any kind & has not operated under any other entity.*

Federal Tax ID: \_\_\_\_\_ Age of Business: \_\_\_\_\_ yr. \_\_\_\_\_ months

State of Incorporation: \_\_\_\_\_ Date of Incorporation: \_\_\_\_\_ Type of Business: \_\_\_\_\_

### **Addresses & Work Locations**

Please list **all** New York business locations to be covered only where employees physically work. A post office box (P.O. Box) is **not** an acceptable location.

#### Main Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

Is this the location where NYSIF should conduct an audit?\*      Yes      No      *\*Payroll, tax, and ownership documents must be present at audit.*

#### Additional Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

#### Additional Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

**Click here to access a supplemental page to list additional work locations.**



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### Governing Board Or Ownership Information

List **all** executive officers, board members, or owners regardless of whether they will be covered.

**NOTE: The first contact listed must be the individual that would electronically sign the application if the applicant elects to bind coverage.**

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Cover this Individual?: Yes No Duties: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Cover this Individual?: Yes No Duties: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Cover this Individual?: Yes No Duties: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Cover this Individual?: Yes No Duties: \_\_\_\_\_

First Name: \_\_\_\_\_ MI: \_\_\_\_\_ Last Name: \_\_\_\_\_

Title: \_\_\_\_\_ Email: \_\_\_\_\_ Phone: \_\_\_\_\_

Annual Salary: \$ \_\_\_\_\_ Cover this Individual?: Yes No Duties: \_\_\_\_\_

**Please attach an additional copy of this sheet if your organization has more executive officers, board members, or owners they wish to include.**



## Start a Workers' Compensation Quote

### Other Businesses (Entities)

List all other businesses (employers) that you are seeking to cover under this policy. This means any business requiring coverage under this policy that operates under a different FEIN (Federal Employer Identification Number) and/or a separate set of payroll records. For each additional business listed, required forms must be submitted to determine whether it meets the requirements to be written under a single policy.

Are there additional entities to be covered?      Yes      No

Business Type: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_

Business Type: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_

Business Type: \_\_\_\_\_ Business Name: \_\_\_\_\_

Business Telephone: \_\_\_\_\_ Federal Tax ID: \_\_\_\_\_

### Payroll Information

Please list the number of employees and annual payroll for each class code used by your organization.

Class Code	Number of Employees	Annual Payroll

**Need to list more class codes? Click here to access the supplemental Payroll Information page.**

**Does your organization need VFBL or VAWBL coverage? Click to access the supplemental VFBL and VAWBL Coverage Information page.**



## Start a Workers' Compensation Quote

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### **Subcontractor and Other Employee Information**

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.

**YES**, our organization uses subcontractors, independent contractors, or 1099 employees.

**OR**

**NO**, our organization **does not** use subcontractors, independent contractors, or 1099 employees.

### **Workers' Comp History**

Have the employer(s) seeking coverage or their executive officers, partners, elected or appointed officials, or members of governing boards been insured for workers' compensation? If yes, please provide the employer's workers' compensation experience for the latest five years.

**YES**, our organization has previously been insured for workers' compensation.

**OR**

**NO**, our organization **has not** previously been insured for workers' compensation.

Policy Year: \_\_\_\_\_ Annual Premium: \_\_\_\_\_

Total Incurred Cost or Number of Claims (*Optional*): \_\_\_\_\_

Policy Year: \_\_\_\_\_ Annual Premium: \_\_\_\_\_

Total Incurred Cost or Number of Claims (*Optional*): \_\_\_\_\_

Policy Year: \_\_\_\_\_ Annual Premium: \_\_\_\_\_

Total Incurred Cost or Number of Claims (*Optional*): \_\_\_\_\_

Policy Year: \_\_\_\_\_ Annual Premium: \_\_\_\_\_

Total Incurred Cost or Number of Claims (*Optional*): \_\_\_\_\_

Policy Year: \_\_\_\_\_ Annual Premium: \_\_\_\_\_

Total Incurred Cost or Number of Claims (*Optional*): \_\_\_\_\_

## **Additional Addresses and Locations**

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### Additional Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

### Additional Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_

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Street Address: \_\_\_\_\_ City: \_\_\_\_\_

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### Additional Work Location

Street Address: \_\_\_\_\_ City: \_\_\_\_\_

State: NY Zip Code: \_\_\_\_\_ Number of Employees: \_\_\_\_\_



### Additional Payroll Information

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Class Code	Number of Employees	Annual Payroll



## VFBL and VAWBL Coverage Information

If your organization requires **VFBL coverage**, please list the population of your coverage area(s):

VFBL Coverage Area	Population

If your organization requires **VAWBL coverage**, please list the number of first responder vehicles: \_\_\_\_\_