NYSIF
New York State Insurance Fund

PO Box 66699; Albany, NY 12206
nysif.com

Policyholder: _____ Policy #: _____

Policyholder address: _____

_____

Entity Number, if applicable: _____

We are no longer in need of workers' compensation coverage as required by the New York State Workers' Compensation Law.

In accordance with the provisions of the Workers' Compensation Law, we hereby give notice of our intention to withdraw from the New York State Insurance Fund.

We no longer need coverage under the Workers' Compensation law because:

◯ No employees ◯ Out of Business ◯ Insurance Elsewhere ◯ Other

Other: _____

_____

_____

_____

If you are replacing coverage elsewhere, including if coverage is being provided through an employee leasing agreement, and you have determined the new carrier, please provide the carrier details below:

Carrier: _____ Effective Date: _____

Reason for Replacing Coverage: _____

_____

_____ _____
Employer's Signature Date

_____ _____
Employer's Name (Print) Title