FLEURY
RISK MANAGEMENT

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: Select One

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.

FLEURY
RISK MANAGEMENT

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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.

FLEURY
RISK MANAGEMENT

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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: Select One _____ Business Name: _____

Business Telephone: _____ Federal Tax ID: _____

Business Type: Select One _____ Business Name: _____

Business Telephone: _____ Federal Tax ID: _____

Business Type: Select One _____ 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.

FLEURY
RISK MANAGEMENT

Start a Workers' Compensation Quote

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*): _____

FLEURY
RISK MANAGEMENT

Additional Addresses and Locations

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: ______________

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: ______________

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: ______________

Additional Work Location

Street Address: ______________________ City: ______________________

State: NY Zip Code: ______________ Number of Employees: ______________

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RISK MANAGEMENT

Additional Payroll Information

Class Code	Number of Employees	Annual Payroll

FLEURY
RISK MANAGEMENT

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: _____