NEW YORK STATE MUNICIPAL
WORKERS' COMPENSATION ALLIANCE
900 Stewart Avenue, Suite 600
Garden City, New York 11530
Phone: 516-227-2300 Fax: 516-227-2352

APPLICATION FOR QUOTE

Today's Date: _____ **Effective Date:** _____

Public Entity:		**Tax ID #:**
Address:		
City/State/Zip:		**County:**
Administrative Contact:		
Phone:	**Fax:**	**E-Mail:**
Claims Contact:		
Phone:	**Fax:**	**E-Mail:**
Billing Contact:		
Phone:	**Fax:**	**E-Mail:**
Risk Management Contact:		
Phone:	**Fax:**	**E-Mail:**
Number of Full Time Employees:		**Number of Part Time and Volunteers:**
How would this municipality like to receive future program information and offerings?	**Fax:**	**E-Mail:**

AGENT

Agency:		**Agent:**
Address:		
Phone:	**Fax:**	**E-Mail:**

IF VOLUNTEER FIREFIGHTER AND/OR VOLUNTEER AMBULANCE COVERAGE IS BEING REQUESTED. PLEASE COMPLETE THE NEXT TWO SECTIONS AND THE VFF/AMBULANCE SUPPLEMENT ON PAGES 5 AND 6 OF THIS APPLICATION.

PLEASE INDICATE WHETHER THE ENTITY IS A FIRE DISTRICT, FIRE CORPORATION, FIRE PROTECTION DISTRICT OR FIRE COMPANY. IF ENTITY IS A FIRE PROTECTION DISTRICT, WHO PROVIDES THEIR COVERAGE?

VOLUNTEER FIRE

Fire Department Name:		**Fein Number:**
Contact Name:		
Address:		
Phone:	**Fax:**	**E-Mail:**
Population Served:	**# of Total Volunteers:** **# of First Responder Volunteers:**	**# of Paid Employees:**

ADDITIONAL VOLUNTEER FIRE

Fire Department Name:		**Fein Number:**
Contact Name:		
Address:		
Phone:	**Fax:**	**E-Mail:**
Population Served:	**Number or Active Volunteer First Responders:**	**# of Paid Employees:** **Who pays these salaries?**

VOLUNTEER AMBULANCE

Ambulance Department Name:		**Fein Number:**
Contact Name:		
Address:		
Phone:	**Fax:**	**E-Mail:**
# of Ambulances: **Number of Active Volunteer First Responders:**		**# of Paid Employees:** **Who pays these salaries?**

SUBMIT THE FOLLOWING INFORMATION WITH YOUR APPLICATION:

- 5 years currently valued detailed loss runs
- Please provide detailed information on any claim with an incurred value of $100,000 or more which occurred during the last 5 years or any claim involving death, dismemberment, severe burns, spinal cord injuries, paraplegia, quadriplegia or injuries involving multiple employees.
- Most recent approved budget (If budget is available on line, please provide the link)
- Current/expiring Dec page (if available)
- Employee Concentration Form
- VFF/Ambulance Supplement (if applicable)

IMPORTANT NOTE:

Be sure to review the termination/withdrawal provision of the current carrier. Many carriers require a minimum of 30 days' notice.

Failure to provide adequate notice could result in penalties and/or a delay in cancellation.

FAX, MAIL, or EMAIL COMPLETED APPLICATIONS:

New York State Municipal Workers' Compensation Alliance
900 Stewart Avenue, Suite 600
Garden City, NY 11530
Attn: Tricia Murphy
Fax: (516) 227-2352
Email: pmurphy@wrightinsurance.com

§114.1. Any person who knowingly and with intent to defraud presents, causes to be presented, or prepares with the knowledge of belief that it will be presented to or by an insurer or a purported insurer, or and agent thereof, any written statement as part of, or in support of, any application for the issuance of or the rating of an insurance policy for compensation insurance, or claim for payment of other benefit pursuant to a compensation policy which he or she knows to: (i) contain a false statement or representation concerning any fact material thereto, or (ii) omits any facts material thereto, shall be guilty of a class E felony. Upon conviction, the court in addition to any other authorized sentence, may order forfeiture of all rights to compensation or payments of any benefit, and may also require restitution of any amount received as a result of a violation of this subdivision.

_____/_____

Signature of Applicant *Date*

Employee Concentration Supplement

Applicant: _____

Effective Date: _____ Submission Date: _____

Total Employee Count: _____ Full Time: _____ Part Time: _____ Seasonal: _____

Section 1 (Physical Locations)

Location #	Address Street and #	Location Description	City	State	Zip	Employee Count (Complete Section 2 for each location over 100 employees)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						

Section 2 (Complete this section only for each physical location over 100 employees)

Location #	Building # Stories	# of Employees	Employee Count Shift 1	Employee Count Shift 2	Employee Count Shift 3	Year Built	Building Code #

Building Codes: 1 Wood Frame, 2 All Metal, 3 Steel Frame, 4 Reinforced Concrete, 5 Concrete Brick/Block, 6 Earthquake Resistant

VFF and Ambulance Supplement

Please complete this section if this submission includes coverage for volunteer fire and or ambulance.

Fire Department

Fire Company: yes ☐ no ☐ **Fire Department**: yes ☐ no ☐ **Fire District:** yes ☐ no ☐

Fire Protection District: yes ☐ no ☐ If yes, who provides the fire service?

_____

Volunteer Fire 1

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
Population Served:	# of Volunteer Firefighters	# of Paid Employees

Volunteer Fire 2 (if applicable)

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
Population Served:	# of Volunteer Firefighters	# of Paid Employees

Volunteer Fire 3 (if applicable)

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
Population Served:	# of Volunteer Firefighters	# of Paid Employees

Ambulance Department

Ambulance Company: yes ☐ no☐ **Ambulance Department**: yes ☐ no☐

Ambulance District: yes ☐ no☐

Ambulance 1

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
#of Ambulances:	# of Volunteer Workers	# of Paid Employees

Ambulance 2 (if applicable)

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
#of Ambulances:	# of Volunteer Workers	# of Paid Employees

Ambulance 3 (if applicable)

Name:		FEIN:
Contact Name:	Entity Type:	
Address:		
Phone:	Fax:	Email:
#of Ambulances:	# of Volunteer Workers	# of Paid Employees

Please be sure to attach additional sheets if more entities are utilized than provided.