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

SCHOOL APPLICATION FOR QUOTE

Today's Date:________________ **Effective Date:____________________**

School Name:		Tax ID #:
Address:		
City/State/Zip:		County:
Business Official:		
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 the School like to receive future program information and offerings?	Fax: ___	E-Mail: ___

AGENT

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

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 w/salary information (If budget is available on line, please provide the link)
- Current/expiring Dec page (if available)
- Employee Concentration Form

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