



APPLICATION FOR VOLUNTEER AMBULANCE WORKERS' BENEFIT LAW AND EMPLOYERS' LIABILITY INSURANCE

ATN \_\_\_\_\_
ICMS No. \_\_\_\_\_

Application is hereby made to THE STATE INSURANCE FUND for a policy insuring the applicant's liability for the payment of benefits to the applicant's volunteer ambulance workers under Chapter 64B of the Consolidated Laws of New York, known as the "Volunteer Ambulance Workers' Benefit Law."

PLEASE PRINT OR TYPE.

(1) REQUESTED EFFECTIVE DATE OF INSURANCE, 12:01 A.M., Eastern Standard Time \_\_\_\_\_

(2) FULL NAME OF APPLICANT \_\_\_\_\_

(2a) FEDERAL TAX ID \_\_\_\_\_ NYS UNEMPLOYMENT ID \_\_\_\_\_

(3) APPLICANT IS ( ) COUNTY ( ) TOWN ( ) VILLAGE ( ) AMBULANCE DISTRICT ( ) CORPORATION ( ) OTHER SPECIFY \_\_\_\_\_

\* If applicant is an Ambulance District what is the name of your sponsoring town or village: \_\_\_\_\_

(4) MAILING ADDRESS \_\_\_\_\_
(Street) (City or Town) (State) (County) (Zip Code)

For the purpose of serving notice the insured agrees that this address shall be considered the business address of this applicant or any representative upon whom notice may be served.

(5) TELEPHONE NUMBER \_\_\_\_\_

(6) LIST ALL LOCATIONS \_\_\_\_\_

(7) IF APPLICANT IS A CORPORATION, LIST ALL EXECUTIVE OFFICERS. IF OTHER THAN A CORPORATION, LIST MEMBERS OF GOVERNING BOARD.

Table with 3 columns: NAME, TITLE, HOME ADDRESS. Multiple rows for listing officers.

(8) NAME, ADDRESS AND TELEPHONE NUMBER OF INSURANCE REPRESENTATIVE, IF ANY
(Name) (Street)
(City or Town) (State) (Zip Code) (Telephone)

(9) LIST ALL AMBULANCES REGISTERED TO THE APPLICANT
VEHICLE 1 PLATE NUMBER TYPE OF VEHICLE
VEHICLE 2
VEHICLE 3
VEHICLE 4

(Attach an additional sheet if there are more vehicles.)

(10) HOW MANY AMBULANCE CALLS DID YOU ANSWER DURING THE PAST YEAR? \_\_\_\_\_

(11) HOW MANY ACTIVE VOLUNTEERS DO YOU HAVE \_\_\_\_\_  
(Ambulance Workers) (Dispatchers) (Other - Specify)

(12) PREVIOUS INSURANCE COMPANY NAME AND ADDRESS	POLICY NUMBER	POLICY PERIOD	NUMBER OF ACCIDENTS	REASON FOR CANCELLATION
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

HOW MANY OF THE ACCIDENTS SHOWN ABOVE INVOLVED A MOTOR VEHICLE? \_\_\_\_\_

(13) HAS ANY INSURANCE COMPANY DECLINED TO OFFER COVERAGE TO YOU DURING THE LAST TWELVE MONTHS? \_\_\_\_\_  
IF YES, WHY WAS COVERAGE DECLINED?  
\_\_\_\_\_

(14) DO YOU HAVE ANY PAID EMPLOYEES? IF YES, WHAT IS THE NAME OF YOUR WORKERS' COMPENSATION INSURANCE COMPANY? \_\_\_\_\_ POLICY NO. \_\_\_\_\_

(15) IS YOUR AMBULANCE COMPANY DULY REGISTERED OR CERTIFIED PURSUANT TO ARTICLE 30 OF THE PUBLIC HEALTH LAW:  
( ) YES  
(..) NO EXPLAIN \_\_\_\_\_

Only a registered or certified ambulance company, other than an ambulance company or emergency rescue and first aid squad affiliated with a fire department or fire company subject to Section 209-b of the General Municipal Law, is eligible to obtain insurance coverage under the Volunteer Workers' Benefit Law.

Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance containing false information or conceals, for the purpose of misleading, information concerning any facts material thereto, commits a fraudulent act, which is a crime, and shall also be subject to a civil penalty not to exceed five thousand dollars and the stated value of the claim for each such violation.

(16) DATE: \_\_\_\_\_  
\_\_\_\_\_  
(Name of Applicant - Print or Type)  
\_\_\_\_\_  
(Signature of Authorized Officer - Title)

**To ensure prompt service and processing, please mail your fully completed and signed application along with your deposit premium check and supporting documentation to:**

NEW YORK STATE INSURANCE FUND  
DOCUMENT CONTROL CENTER - NEW BUSINESS  
1 WATERVLIET AVE EXTENSION  
ALBANY, NEW YORK 12206

**For additional assistance, customer service and contact information:**  
Please visit our website – [WWW.NYSIF.COM](http://WWW.NYSIF.COM) or telephone us at - 888-875-5790.