



NEW YORK STATE MUNICIPAL WORKERS' COMPENSATION ALLIANCE

333 EARLE OVINGTON BOULEVARD, STE 505
UNIONDALE, NEW YORK 11553-3624
PHONE: 516-227-2300 FAX: 516-227-2352

APPLICATION FOR QUOTE

Date: _____

Municipality:		Tax ID #:	
Address:			
City/State/Zip:		County:	
Supervisor/Mayor:			
Phone:	Fax:	E-Mail:	
Claims Contact:			
Phone:	Fax:	E-Mail:	
Billing 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:	

ATTORNEY

Name & Address:			
Phone:	Fax:	E-Mail:	

AUDITOR

Name & Address:			
Phone:	Fax:	E-Mail:	

**COMPLETE THE NEXT TWO SECTIONS ONLY IF VOLUNTEER FIREFIGHTER AND/OR
VOLUNTEER AMBULANCE COVERAGE IS BEING REQUESTED**
VFF and VAW coverage cannot be written separately and cannot be written if filing status is 501C

VOLUNTEER FIRE

Fire Department Name:		
Contact Name:		
Phone:	Fax:	E-Mail:
Population Served:	# of Volunteer Fire Fighters:	

VOLUNTEER AMBULANCE

Ambulance Department Name:		
Contact Name:		
Phone:	Fax:	E-Mail:
# of Ambulances:		

**SUBMIT THE FOLLOWING INFORMATION WITH
YOUR APPLICATION:**

- 3-5 years currently valued loss runs
- Most recent approved budget
- Current/expiring Dec page (if available)

Be sure to review the termination/withdrawal provision of the current carrier. Many carriers require a minimum of 30 days notice, and failure to provide adequate notice could result in penalties and/or a delay in cancellation.

Please fax or mail your completed application:

NYS Municipal Workers' Compensation Alliance
333 Earle Ovington Blvd., Suite 505
Uniondale, NY 11553
Attn: Client Services Department

Fax: (516) 227-2352

