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Marshall & Sterling Insurance
 300 Route 23 B
 Leeds, NY 12451

 800-724-0695
 518-943-7440, fax
www.marshallsterling.com/leeds

Workers' Compensation Insurance Program

GENERAL INFORMATION:

Named Insured:			
Mailing Address:			
			Zip:
Effective Date:		# of Years in Operation:	
Executive Director:			
Contact Name:			
Telephone #:		Fax#:	
Email Address:			
NYS Agency applicant is licensed or certified by:			
Primary Funding Sources:			
Annual Budget: \$		Payroll: \$	
Is audit /review conducted by a CPA? <input type="checkbox"/>yes <input type="checkbox"/>no			
Briefly describe services provided (please attach newsletters and/or brochures:			
Description	# Full Time	# Part Time	# Independent Contractors
Staffing			
Volunteers			

WORKERS COMPENSATION

EFFECTIVE DATE: _____

Employers Liability BI Limits	Statutory Limits: \$100,000 each accident/\$500,000 policy limit/\$100,000 each employee Other \$
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Coverage State	Class Codes	Annual Payroll
		\$
		\$
		\$
		\$
Experience Mod:	Federal Empl. ID#:	Bureau ID#:

COVERAGE INCLUSIONS/EXCLUSIONS		
Name:	Title:	<input type="checkbox"/> Include <input type="checkbox"/> Exclude
Name:	Title:	<input type="checkbox"/> Include <input type="checkbox"/> Exclude
Name:	Title:	<input type="checkbox"/> Include <input type="checkbox"/> Exclude

UMBRELLA

EFFECTIVE DATE: _____

This type of liability insurance provides excess liability protection over the "underlying" liability insurance you carry.

<input type="checkbox"/> \$1,000,000	<input type="checkbox"/> \$2,000,000	<input type="checkbox"/> \$3,000,000	<input type="checkbox"/> \$4,000,000	<input type="checkbox"/> \$5,000,000
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OPERATIONS

Does your organization do any of the following? (If so, please explain below)

1. Provide any regulatory, inspection, certification accreditation, setting or reviewing standards of similar services? Yes No
2. Engage in lobbying or political action? Yes No
3. Provide any publications, internet or broadcasting services? Yes No
4. Do you own or manage any property other than offices & contents? Yes No
5. Provide any type of medical or health related services? Yes No
6. Provide any counseling, support, intake, referral services, crisis intervention, hot lines or other direct client services? Yes No
7. Conduct any special events or fund raisers off premises? Yes No

Expanations/comments: _____

THE FOLLOWING MUST BE COMPLETED TO PROPERLY QUOTE YOUR COVERAGE.

5 Year Loss Information: Property, Liability, Crime, Automobile, Workers Comp, & Umbrella
 (Company loss runs may be attached in lieu of completing loss information). check here if none

Loss Date	Loss Description	Paid/Reserved

Please provide carrier and premium information for your current coverage:

Property/Liability	
Automobile	
Workers Comp	
Umbrella	

I understand that this application provides coverage highlights only and that I must read my policy(ies) to determine full coverages and exclusions provided. I hereby declare that the statements made in this application are complete and true. The signing of this application does not bind the application for coverage.

Applicant	Applicant/Title	Date