

**QUARTERLY UNIFIED EMPLOYER ASSESSMENT
Municipal Self-Insurers Remittance Form
State of New York - Workers' Compensation Board**

A. Municipal Self-Insurer Information: * Indicates a Required Field

GA-4 Instructions

1. *WCB Identification Number: W867188

2. *FEIN (12-3456789): 11-6001701

3. *Name of Municipal Self-Insured Employer: SPRINGS UNION FREE SCHOOL DISTRICT

4. *Mailing address

Number and Street: 48 SCHOOL STREET

City: EAST HAMPTON State: New York Zip Code: 11937

B. Reporting Period:

1. Calendar Year	2016	Q1	Payroll for period January 1- March 31	Form & Payment postmarked by April 30
2. *Quarter Ending	<u>Q2</u>	Q2	Payroll for period April 1- June 30	Form & Payment postmarked by July 31
		Q3	Payroll for period July 1-September 30	Form & Payment postmarked by October 31
		Q4	Payroll for period October 1- December 31	Form & Payment postmarked by January 31

C. Basis for Assessment:

* (1) Payroll Class Code	(2) Description	* (3) Quarterly Payroll Dollars	(4) Less Cost Per Hundred Dollars of Payroll	(5) Total Loss Cost (3) x (4) divided by \$100
Various	School Districts - All Employees	\$3,313,685.47	\$0.55	\$18,225.27
Various	All Other Municipal Employees	\$0.00	\$2.00	\$0.00
	(6) Subtotal Payroll	\$3,313,685.47		
	(7) Excluded Payroll Not Subject to Assessment (if applicable)	\$0.00		
	(8) Total Payroll = (6) + (7)	\$3,313,685.47		
			(9) Total Loss Cost	\$18,225.27
			(10) Assessment Rate	12.9%
			(11) Total Assessment Due	\$2,351.06

D. Certification:

By submitting this form via e-mail, the sender certifies that the information presented herein including all applicable addendums, has been examined and is a true, correct and complete report made in good faith.

<u>JULIE BISTRAN</u> *Name	<u>SENIOR ACCOUNT CLERK</u> *Title
<u>JBISTRAN@SPRINGSSCHOOL.ORG</u> * e-mail Address	<u>631-324-0144 EXT.127</u> Phone - ext.
<u>7/15/2016</u> *Date (MM/DD/YYYY)	

Note: Additional employers covered under the same W number shown must be reported on the *Quarterly Unified Employer Assessment Municipal Self-Insurers Remittance Form - Payroll by FEIN Addendum (GA-4.1)*

* Are additional employers covered under this W Number? Yes No

E-mail this form to Assessments@wcb.ny.gov by selecting the E-mail Form button or by saving the form and sending it as an attachment in an e-mail. Please enter your WCB Identification Number (W#) in the subject line of the email, before "Quarterly Assessment Reporting"

QUARTERLY UNIFIED EMPLOYER ASSESSMENT
Municipal Self-Insurers Remittance Form
State of New York - Workers' Compensation Board

If you selected to Email Form, you will receive an email from the Workers' Compensation Board confirming receipt of your form.

If you do not receive a confirmation email, then the Board did not receive your form. Please try to attach a saved version of this form to an email to Assessments@wcb.ny.gov. If you still do not receive an email confirmation, please contact the Board by sending an email to WCBFinanceOffice@wcb.ny.gov

Please e-mail the GA-4 and then print this page and mail with your check to:

New York Workers' Compensation Board
328 State Street
Finance Unit, Room 331
Schenectady, NY 12305-2318

Self-Insurer Information:

WCB Identification Number W867188

Name of Self-Insured Employer SPRINGS UNION FREE SCHOOL DISTRICT

Reporting Period:

Calendar Year 2016 Quarter Ending Q2

Total Assessment Due \$2,351.06

Date Form Certified 7/15/2016

Contact Information:

Name JULIE BISTRAN

Phone 631-324-0144 EXT.127

eMail Address JBISTRAN@SPRINGSSCHOOL.ORG