



**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

2. \*Quarter Ending: Q2

|    |   |   |
|----|---|---|
| Q1 | Payroll for period January 1- March 31    | Form & Payment postmarked by April 30   |
| 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><br>*Name                         | <u>SENIOR ACCOUNT CLERK</u><br>*Title        |
| <u>JBISTRAN@SPRINGSSCHOOL.ORG</u><br>* e-mail Address | <u>631-324-0144 EXT.127</u><br>*Phone - ext. |
| <u>7/15/2016</u><br>*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](mailto: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](mailto: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](mailto: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