Checklist for Insurance Requirements for Security Guard Companies 55 RCNY § 14-05

1. Workers Compensation Insurance.	
☐	The Security Guard Company submitted a certificate of workers' compensation insurance or an exemption. (Exhibit A)
	If not exempt . . .
☐	A Form C-105.2 or Form U-26.3 was submitted
☐	The form names the Security Guard Company
☐	Certificate holder is the City and/or DCAS
☐	The policy effective period is current
☐	The date of the form is within the past year
	If exempt . . .
☐	A Form CE-200 was submitted
☐	The "Workers' Compensation Exemption Statement" is filled in
☐	The form names the Security Guard Company
☐	The form lists the City and/or DCAS
☐	The date of the form is within the past three months
2. Disability Benefits Insurance.	
☐	The Security Guard Company submitted a certificate of disability benefits insurance or an exemption. (Exhibit B)
	If not exempt . . .
☐	A Form DB-120.1 was submitted
☐	The form names the Security Guard Company
☐	Certificate holder is the City and/or DCAS
☐	The policy effective period is current
☐	The date of the form is within the past year
	If exempt . . .
☐	A Form CE-200 was submitted
☐	The "Disability Benefits Exemption Statement" is filled in
☐	The form names the Security Guard Company
☐	The form lists the City and/or DCAS
☐	The date of the form is within the past three months

3. Commercial General Liability Insurance.		
☐	The Security Guard Company submitted a certificate of liability insurance. (Exhibit C)	
	☐	The "insured" is the Security Guard Company
	☐	The top quarter of the form is complete
	☐	The CGL insurer has an acceptable rating (see table below)
	☐	Under Commercial General Liability, "occur" is checked off
	☐	Under Commercial General Liability, there is a policy number
	☐	Under Commercial General Liability, the expiration date has not passed
	☐	Under Commercial General Liability, the "occurrence" limit is $1 million or more
	☐	Under Commercial General Liability, the "aggregate" limit is $2 million or more
	☐	The description of operations box lists the name of the school and the "City of New York, including its officials and employees" as an additional insured. [Note: Small changes in wording ok, so long as the additional insured endorsement is correct.]
	☐	The Certificate Holder is DCAS and/or the City and/or the school
	☐	The form is signed
☐	The Security Guard Company submitted a completed "Certification of Insurance Broker or Agent" (Exhibit D)	
☐	The Security Guard Company submitted an additional insured endorsement (Exhibit E)	
	☐	The additional insured endorsement lists "The City of New York, including its officials and employees" and the school (If it does not, ask counsel if it is ok as is)
	☐	The additional insured endorsement is "at least as broad as" ISO Form CG 20 26 (ask counsel if you are not sure)

Ratings Company	**Acceptable Ratings**
A.M. Best ➢ http://ratings.ambest.com	A-, A, A+, A++ *together with . . .* VII, VIII, IX, X, XI, XII, XIII, XIV, XV
Standard & Poor's ➢ https://www.standardandpoors.com/en_US/web/guest/home	A, A+, AA-, AA, AA+, AAA
Moody's Investor Service ➢ https://www.moodys.com/page/lookuparating.aspx	A3, A2, A1, Aa3, Aa2, Aa1, Aaa
Fitch Ratings ➢ https://www.fitchratings.com	A-, A, A+, AA-, AA, AA+, AAA-, AAA, AAA+

Workers' Compensation Requirements under Workers' Compensation Law §57

To comply with coverage provisions of the Workers' Compensation Law (WCL), businesses must:

a) be legally exempt from obtaining workers' compensation insurance coverage; or
b) obtain such coverage from insurance carriers; or
c) be a Board-approved self-insured employer; or
d) participate in an authorized group self-insurance plan.

To assist State and municipal entities in enforcing WCL Section 57, businesses requesting permits or licenses, or seeking to enter into contracts **MUST provide ONE** of the following forms to the government entity issuing the permit or entering into a contract:

A) Form CE-200, *Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage*;

Form CE-200 can be filled out electronically on the Board's website, www.wcb.ny.gov. Click on the button entitled "WC/DB Exemptions Form CE-200" (In bright yellow letters). Applicants filing electronically are able to print a finished Form CE-200 immediately upon completion of the electronic application. Applicants without access to a computer may obtain a paper application for the CE-200 by writing or visiting the Customer Service Center at any district office of the Workers' Compensation Board. Applicants using the manual process may wait up to four weeks before receiving a CE-200. Once the applicant receives the CE-200, the applicant can then submit that CE-200 to the government agency from which he/she is getting the permit, license or contract; or

B) Form C-105.2, *Certificate of Workers' Compensation Insurance* (the business's insurance carrier will send this form to the government entity upon request). **Please Note**: The State Insurance Fund provides its own version of this form, the U-26.3; or

C) Form SI-12, *Certificate of Workers' Compensation Self-Insurance* (the business calls the Board's Self-Insurance Office at 518-402-0247), or GSI-105.2, *Certificate of Participation in Worker's Compensation Group Self-Insurance* (the business's Group Self-Insurance Administrator will send this form to the government entity upon request).

Disability Benefits Requirements under Workers' Compensation Law §220(8)

To comply with coverage provisions of the WCL regarding disability benefits, businesses may:

a) be legally exempt from obtaining disability benefits insurance coverage; or
b) obtain such coverage from insurance carriers; or
c) be a Board-approved self-insured employer.

Accordingly, to assist State and municipal entities in enforcing WCL Section 220(8), businesses requesting permits or licenses, or seeking to enter into contracts **must** provide one of the following forms to the entity issuing the permit or entering into a contract:

A) CE-200, *Certificate of Attestation of Exemption from NYS Workers' Compensation and/or Disability Benefits Coverage* (see above);

B) DB-120.1, *Certificate of Disability Benefits Insurance* (the business's insurance carrier will send this form to the government entity upon request); **or**

C) DB-155, *Certificate of Disability Benefits Self-Insurance* (the business calls the Board's Self-Insurance Office at 518-402-0247).

NYS Agencies Acceptable Proof: Letter from the NYS Department of Civil Service indicating the applicant is a New York State government agency covered for workers' compensation under Section 88-c of the Workers' Compensation Law and exempt from NYS disability benefits.

Please note that **for building permits only**, certain homeowners of 1, 2, 3 or 4 family owner-occupied residences serving as their own General Contractor may be eligible to file Form BP-1 (The homeowner obtains this form from either the Building Department or on the Board's website, http://www.wcb.ny.gov/content/main/forms/bp-1.pdf)

(c) Insurance Requirements. Upon retention by the school of a Security Guard Company from the Qualified Provider List or a Security Guard Company licensed pursuant to Article 7-A of the General Business Law, the Security Guard Company must maintain throughout the term of its agreement with the school commercial general liability ("CGL") insurance, which shall:
(i) be issued by a company that may lawfully issue the CGL policy. The company must have an A.M. Best rating of at least A-/VII or a Standard & Poor's rating of at least A;
(ii) insure the Security Guard Company, the school, and the City of New York and protect them from any claims for injury (including death) or property damage that may arise from or allegedly arise from operations under the agreement with the school;
(iii) provide coverage of at least one million dollars ($1,000,000) per occurrence and two million dollars ($2,000,000) aggregate;
(iv) provide coverage at least as broad as that provided in the most recently issued edition of Insurance Services Office ("ISO") Form CG 00 01 and be "occurrence" based rather than "claims-made"; and
(v) name the school and the City of New York as an Additional Insured with coverage at least as broad as the most recent edition ISO Form CG 2026.
(1) The Security Guard Company shall provide the endorsement(s) naming the school and the City as an Additional Insured and proof of CGL insurance by submission of a certificate of insurance that:
A. satisfies the requirements of this rule;
B. identifies the insurance company that issued such insurance policy, the policy number, limit(s) of insurance, and expiration date; and
C. is accompanied by a sworn statement in a form prescribed by the Department from a licensed insurance broker or agent certifying that the certificate of insurance is accurate in all material respects.
(2) A Security Guard Company must ensure that its policies are current and is required to submit an updated certificate of insurance and certification by broker or agent within five days of the expiration date of the current policy.
(3) A Security Guard Company shall maintain workers' compensation insurance, disability benefits insurance and employer's liability insurance in accordance with the laws of the State of New York on behalf of, or with regard to, all employees providing services to a school, and must produce proof of such coverage within 10 days of its retention by the school, or upon demand by the Department. Satisfactory proof shall mean:
A. C-105.2 Certificate of Workers' Compensation Insurance;
B. U-26.3 -- State Insurance Fund Certificate of Workers' Compensation Insurance;
C. Request for WC/DB Exemption (Form CE-200);
D. Equivalent or successor forms used by the New York State Workers' Compensation Board; or
E. Other proof of insurance in a form acceptable to the City.

Exhibit A
Sample Workers' Compensation Insurance Certificates and Proof of Exemption

Form C-105.2

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)	3a. Name of Insurance Carrier 3b. Policy Number of entity listed in box "2" 3c. Policy effective period 4. The Proprietor, Partners or Executive Officers are ☐ included. (Only check box if all partners/officers included) ☐ excluded or certain partners/officers excluded.

This certifies that the insurance carrier listed above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To be valid, this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation and employers liability insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are any reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate. (Such notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the Insurance Carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or construction contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: _____
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ _____
(Signature) (Date)

Title: _____

Telephone Number of authorized representative or licensed agent of insurance carrier: _____

Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it.

Form U-26.3

New York State Insurance Fund
Workers' Compensation & Disability Benefits Specialists Since 1914
199 CHURCH STREET, NEW YORK, N.Y. 10007-1100
Phone: (212) 312-9000

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

****** 146013200
STATE INSURANCE FUND
PRODUCTION CONTROL POLICY #1
199 CHURCH ST USWS-7TH FLOOR
NEW YORK NY 10007

POLICYHOLDER	CERTIFICATE HOLDER
STATE INSURANCE FUND PRODUCTION CONTROL POLICY #1 199 CHURCH ST USWS-7TH FLOOR NEW YORK NY 10007	SAMPLE CERTIFICATE 123 NEW YORK ROAD NEW YORK NY 10001

POLICY NUMBER	CERTIFICATE NUMBER	PERIOD COVERED BY THIS CERTIFICATE	DATE
L 1265 328-3	029707	12/26/2[illegible] TO 12/[illegible]	6/17/2010

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1265 328-3 UNTIL 12/26/200[illegible], COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT [illegible] INDICATED [illegible].

IF SAID POLICY IS CANCELLED, OR CHANGED PRIOR TO 12/26/200[illegible] IN SUCH MANNER AS TO AFFECT THIS CERTIFICATE, 10 DAYS WRITTEN NOTICE OF SUCH [illegible] WILL BE GIVEN TO THE CERTIFICATE HOLDER ABOVE. NOTICE BY REGULAR MAIL SO ADDRESSED SHALL BE SUFFICIENT COMPLIANCE WITH THIS PROVISION. THE NEW YORK STATE INSURANCE FUND DOES NOT ASSUME [illegible] LIABILITY IN THE EVENT OF FAILURE TO GIVE SUCH NOTICE.

THIS CERTIFICATE DOES NOT APPLY TO THOSE JOB SITES WHICH ARE COVERED BY OTHER INSURANCE AND ARE SPECIFICALLY EXCLUDED BY ENDORSEMENT.

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIMITED COMPANY.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

SAMPLE

NEW YORK STATE INSURANCE FUND
John Manetti
DIRECTOR,INSURANCE FUND UNDERWRITING

This certificate can be validated on our web site at https://www.nysif.com/cert/certval.asp or by calling (888) 875-5790
VALIDATION NUMBER: 591780737

U-26.3

Form CE-200

Certificate of Attestation of Exemption
From New York State Workers' Compensation
and/or Disability Benefits Insurance Coverage

This form cannot be used to waive the workers' compensation rights or obligations of any party.

The applicant may use this Certificate of Attestation of Exemption ONLY to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may NOT use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

In the Application of (Legal Entity Name and Address):	Business Applying For:
JOHN SMITH 123 MAIN STREET ALBANY, NY 12207 111-111-1111 Federal ID Number: XXXXXX6789	BUILDING PERMIT From: CITY OF ALBANY, DEPT OF BUILDING AND CODES The location of where work will be performed is 123 ACME AVENUE, ALBANY, NY 12203. Estimated dates necessary to complete work associated with the building permit are from October 14, 2008 to March 31, 2009. The estimated dollar amount of project is $25,001 - $50,000

Workers' Compensation Exemption Statement:

The above named business is certifying that it is NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE for the following reason:

The business is owned by one individual and is not a corporation. Other than the owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) or subcontractors.

Disability Benefits Exemption Statement:

The above named business is certifying that it is NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY BENEFITS INSURANCE COVERAGE for the following reason:

The business is owned by one individual or is a partnership (LLC, LLP, PLLP or a RLLP) under the laws of New York State and is not a corporation; or is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation (in a two person owned corporation, each individual must be an officer and own at least one share of stock) or is a business with no NYS location. In addition, the business does not require disability benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

I, JOHN SMITH, am the Sole Proprietor with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE	Signature:	Date:

Exemption Certificate Number
2008-00197

Received
October 2, 2008
NYS Workers' Compensation Board

CE-200 (Draft 06/02/08)

NYSIF **New York State Insurance Fund**

Workers' Compensation & Disability Benefits Specialists Since 1914

199 CHURCH STREET, NEW YORK, N Y 10007-1100

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

****** 481438505
STEADFAST PROTECTION LLC
10 DOREEN DRIVE
STATEN ISLAND NY 10303

Scan to Validate

POLICYHOLDER	CERTIFICATE HOLDER
STEADFAST PROTECTION LLC 10 DOREEN DRIVE STATEN ISLAND NY 10303	YESHIVA HAR TORAH 250-10 GRAND CENTRAL PKWY JAMAICA NY 11426

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
V2278 684-2	916448	06/06/2016 TO 06/06/2017	10/25/2017

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2278 684-2, COVERING THE ENTIRE OBLIGATION OF THIS POLICYHOLDER FOR WORKERS' COMPENSATION UNDER THE NEW YORK WORKERS' COMPENSATION LAW WITH RESPECT TO ALL OPERATIONS IN THE STATE OF NEW YORK, EXCEPT AS INDICATED BELOW, AND, WITH RESPECT TO OPERATIONS OUTSIDE OF NEW YORK, TO THE POLICYHOLDER'S REGULAR NEW YORK STATE EMPLOYEES ONLY

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING SAID POLICY, INCLUDING ANY NOTIFICATION OF CANCELLATIONS, OR TO VALIDATE THIS CERTIFICATE, VISIT OUR WEBSITE AT HTTPS://WWW.NYSIF.COM/CERT/CERTVAL.ASP THE NEW YORK STATE INSURANCE FUND IS NOT LIABLE IN THE EVENT OF FAILURE TO GIVE SUCH NOTIFICATIONS

THIS POLICY DOES NOT COVER THE SOLE PROPRIETOR, PARTNERS AND/OR MEMBERS OF A LIMITED LIABILITY COMPANY.

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS NOR INSURANCE COVERAGE UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICY.

NEW YORK STATE INSURANCE FUND

DIRECTOR INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 819457024

U-26.3

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) GLOBAL OPERATIONS SECURITY SERVICES, INC. 132 NASSAU STREET, SUITE 423 NEW YORK, NY 10038 Work Location of Insured *(Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy)*	1b. Business Telephone Number of Insured (212) 243-1639 1c. NYS Unemployment Insurance Employer Registration Number of Insured 1d. Federal Employer Identification Number of Insured or Social Security Number 46-4323562
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) THE CITY OF NEW YORK AND YESHIVA OF CENTRAL QUEENS 147-37 70TH ROAD QUEENS, NEW YORK 11367	3a. Name of Insurance Carrier EMPLOYERS PREFERRED INSURANCE CO. 3b. Policy Number of entity listed in box "1a" EIG 2373368 00 3c. Policy effective period 06-12-2016 TO 06-12-2017 3d. The Proprietor, Partners or Executive Officers are ☐ included. (Only check box if all partners/officers included) X all excluded or certain partners/officers excluded.

This certifies that the insurance carrier indicated above in box "3" insures the business referenced above in box "1a" for workers' compensation under the New York State Workers' Compensation Law. (To use this form, New York (NY) must be listed under Item 3A on the INFORMATION PAGE of the workers' compensation insurance policy). The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed above as the certificate holder in box "2".

The Insurance Carrier will also notify the above certificate holder within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF there are reasons other than nonpayment of premiums that cancel the policy or eliminate the insured from the coverage indicated on this Certificate (These notices may be sent by regular mail.) Otherwise, this Certificate is valid for one year after this form is approved by the insurance carrier or its licensed agent, or until the policy expiration date listed in box "3c", whichever is earlier.

Please Note: Upon the cancellation of the workers' compensation policy indicated on this form, if the business continues to be named on a permit, license or contract issued by a certificate holder, the business must provide that certificate holder with a new Certificate of Workers' Compensation Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Workers' Compensation Law.

Under penalty of perjury, I certify that I am an authorized representative or licensed agent of the insurance carrier referenced above and that the named insured has the coverage as depicted on this form.

Approved by: Marshal R. Korman
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: _____ November 15, 2016
(Signature) (Date)

Title President

Telephone Number of authorized representative or licensed agent of insurance carrier: 516-781-0300

Please Note: Only insurance carriers and their licensed agents are authorized to issue Form C-105.2. Insurance brokers are NOT authorized to issue it

Exhibit B
Sample Disability Benefits Insurance Certificate and Proof of Exemption

FORM DB-120.1

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits C[illegible]ier or Licensed Insurance Agent of that Carrier

1a. Legal Name and Address of Insured (Use street address on[illegible])

1b. Bus[illegible]phone Number of Insured

NYS [illegible] Insurance Employer Registration Numb[illegible] Insur[illegible]

1d. [illegible]oyer Id[illegible]ation Number of Insured or Soc[illegible] Sec[illegible] Nu[illegible]

2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder)

3[illegible]pe [illegible]ur[illegible]er

b. Polic[illegible]nd[illegible] of cl[illegible]isted in [illegible]"1a":

3[illegible]olicy effe[illegible]p[illegible]:

[illegible] to [illegible]

4. Policy cov[illegible]

[illegible] of the emplo[illegible]oy[illegible]ligible[illegible]er the [illegible] Yo[illegible]isability [illegible]efit[illegible]w

[illegible]he follow[illegible]cla[illegible]f the [illegible]yer's [illegible]oye[illegible]

Under penalty of p[illegible]ry, I certify that I a[illegible]author[illegible]pre[illegible]tative o[illegible]ensed a[illegible]f t[illegible]surance carrier referenced above and that the named insu[illegible]has NYS Disability [illegible]efits [illegible]e c[illegible]ge as [illegible]ibed a[illegible]

Date Signed _____ By _____
[illegible]ature of [illegible]r ca[illegible]uth[illegible] represe[illegible]or NYS Licensed [illegible]nce Agent of that insurance carrier)

Telephone Number _____ [illegible]Title[illegible] _____

IMPORTANT: If box "4a" is checked, and this for[illegible]l [illegible]Insuran[illegible]er [illegible]horized representative or NYS [illegible]ensed Insurance Agent of that carrier, this certificate is COMPLET[illegible] [illegible]ty to t[illegible]ficat[illegible]er.
If box "4b" is checked, this certificate is NO[illegible]E for p[illegible] of Section 220, Subd. 8 of the Disability Benefits Law. It must be mailed for completion to the Workers' Compensa[illegible] Plea[illegible]ce Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by NYS Workers[illegible]m[illegible]t[illegible]ard (Only if box "4b" of Part 1 has been checked)

[illegible]e O[illegible]York
Worker[illegible]om[illegible]ion Board

According to information maintained by the NY[illegible]kers' Co[illegible]ation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/[illegible]

Date Signed _____ By _____
[illegible]e of NYS Workers' Compensation Board Employee)

Telephone Number _____ Title _____

Please Note: Only insurance carriers licensed to write NYS disability benefits insurance policies and NYS licensed insurance agents of those insurance carriers are authorized to issue Form DB-120.1. Insurance brokers are NOT authorized to issue this form.

DB-120.1 (5-06)

Form CE-200

Certificate of Attestation of Exemption
From New York State Workers' Compensation
and/or Disability Benefits Insurance Coverage

This form cannot be used to waive the workers' compensation rights or obligations of any party.

The applicant may use this Certificate of Attestation of Exemption ONLY to show a government entity that New York State specific workers' compensation and/or disability benefits insurance is not required. The applicant may NOT use this form to show another business or that business's insurance carrier that such insurance is not required.

Please provide this form to the government entity from which you are requesting a permit, license or contract. This Certificate will not be accepted by government officials one year after the date printed on the form.

In the Application of (Legal Entity Name and Address):	Business Applying For: BUILDING PERMIT
JOHN SMITH 123 MAIN STREET ALBANY, NY 12207 111-111-1111 Federal ID Number: XXXXX6789	From: CITY OF ALBANY, DEPT OF BUILDING AND CODES The location of where work will be performed is 123 ACME AVENUE, ALBANY, NY 12203. Estimated dates necessary to complete work associated with the building permit are from October 14, 2008 to March 31, 2009. The estimated dollar amount of project is $25,001 - $50,000

Workers' Compensation Exemption Statement:

The above named business is certifying that it is NOT REQUIRED TO OBTAIN NEW YORK STATE SPECIFIC WORKERS' COMPENSATION INSURANCE COVERAGE for the following reason:

The business is owned by one individual and is not a corporation. Other than the owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, unpaid volunteers (including family members) or subcontractors.

Disability Benefits Exemption Statement:

The above named business is certifying that it is NOT REQUIRED TO OBTAIN NEW YORK STATE STATUTORY DISABILITY BENEFITS INSURANCE COVERAGE for the following reason:

The business is owned by one individual or is a partnership (LLC, LLP, PLLP or a RLLP) under the laws of New York State and is not a corporation, or is a one or two person owned corporation, with those individuals owning all of the stock and holding all offices of the corporation (in a two person owned corporation, each individual must be an officer and own at least one share of stock) or is a business with no NYS location. In addition, the business does not require disability benefits coverage at this time since it has not employed one or more individuals on at least 30 days in any calendar year in New York State. (Independent contractors are not considered to be employees under the Disability Benefits Law.)

I, JOHN SMITH, am the Sole Proprietor with the above-named legal entity. I affirm that due to my position with the above-named business I have the knowledge, information and authority to make this Certificate of Attestation of Exemption. I hereby affirm that the statements made herein are true, that I have not made any materially false statements and I make this Certificate of Attestation of Exemption under the penalties of perjury. I further affirm that I understand that any false statement, representation or concealment will subject me to felony criminal prosecution, including jail and civil liability in accordance with the Workers' Compensation Law and all other New York State laws. By submitting this Certificate of Attestation of Exemption to the government entity listed above I also hereby affirm that if circumstances change so that workers' compensation insurance and/or disability benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability benefits coverage and also immediately furnish proof of that coverage on forms approved by the Chair of the Workers' Compensation Board to the government entity listed above.

SIGN HERE	Signature:	Date:
Exemption Certificate Number 2008-00197		Received October 2, 2008 NYS Workers' Compensation Board

CE-200 (Draft 06/02/08)

Exhibit C
Sample Certificate of Liability Insurance

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

THIS CERTIFICATE IS ISSUED AS A MATTER OF INFORMATION ONLY AND CONFERS NO RIGHTS UPON THE CERTIFICATE HOLDER. THIS CERTIFICATE DOES NOT AFFIRMATIVELY OR NEGATIVELY AMEND, EXTEND OR ALTER THE COVERAGE AFFORDED BY THE POLICIES BELOW. THIS CERTIFICATE OF INSURANCE DOES NOT CONSTITUTE A CONTRACT BETWEEN THE ISSUING INSURER(S), AUTHORIZED REPRESENTATIVE OR PRODUCER, AND THE CERTIFICATE HOLDER.

IMPORTANT: If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must have ADDITIONAL INSURED provisions or be endorsed. If SUBROGATION IS WAIVED, subject to the terms and conditions of the policy, certain policies may require an endorsement. A statement on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

PRODUCER	CONTACT NAME:
	PHONE (A/C, No, Ext): FAX (A/C, No):
	E-MAIL ADDRESS:

INSURED	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A :	
	INSURER B :	
	INSURER C :	
	INSURER D :	
	INSURER E :	
	INSURER F :	

COVERAGES **CERTIFICATE NUMBER:** **REVISION NUMBER:**

THIS IS TO CERTIFY THAT THE POLICIES OF INSURANCE LISTED BELOW HAVE BEEN ISSUED TO THE INSURED NAMED ABOVE FOR THE POLICY PERIOD INDICATED. NOTWITHSTANDING ANY REQUIREMENT, TERM OR CONDITION OF ANY CONTRACT OR OTHER DOCUMENT WITH RESPECT TO WHICH THIS CERTIFICATE MAY BE ISSUED OR MAY PERTAIN, THE INSURANCE AFFORDED BY THE POLICIES DESCRIBED HEREIN IS SUBJECT TO ALL THE TERMS, EXCLUSIONS AND CONDITIONS OF SUCH POLICIES. LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	TYPE OF INSURANCE	ADDL INSD	SUBR WVD	POLICY NUMBER	POLICY EFF (MM/DD/YYYY)	POLICY EXP (MM/DD/YYYY)	LIMITS	
	COMMERCIAL GENERAL LIABILITY						EACH OCCURRENCE	$
	☐ CLAIMS-MADE ☐ OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
							PERSONAL & ADV INJURY	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE	$
	☐ POLICY ☐ PRO-JECT ☐ LOC						PRODUCTS - COMP/OP AGG	$
	☐ OTHER:							$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	☐ ANY AUTO						BODILY INJURY (Per person)	$
	☐ OWNED AUTOS ONLY ☐ SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	☐ HIRED AUTOS ONLY ☐ NON-OWNED AUTOS ONLY						PROPERTY DAMAGE (Per accident)	$
								$
	☐ UMBRELLA LIAB ☐ OCCUR						EACH OCCURRENCE	$
	☐ EXCESS LIAB ☐ CLAIMS-MADE						AGGREGATE	$
	☐ DED ☐ RETENTION $							$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY Y / N						☐ PER STATUTE ☐ OTH-ER	
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? ☐ (Mandatory in NH)	N / A					E.L. EACH ACCIDENT	$
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE	$
							E.L. DISEASE - POLICY LIMIT	$

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES (ACORD 101, Additional Remarks Schedule, may be attached if more space is required)

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, NOTICE WILL BE DELIVERED IN ACCORDANCE WITH THE POLICY PROVISIONS.

AUTHORIZED REPRESENTATIVE

Exhibit D
Certificate of Insurance Broker or Agent

CERTIFICATES OF INSURANCE

Instructions to New York City Agencies, Departments, and Offices

All certificates of insurance (except certificates of insurance solely evidencing Workers' Compensation Insurance, Employer's Liability Insurance, and/or Disability Benefits Insurance) must be accompanied by one of the following:

(1) the Certification by Insurance Broker or Agent on the following page setting forth the required information and signatures;

-- OR --

(2) copies of all policies as certified by an authorized representative of the issuing insurance carrier that are referenced in such certificate of insurance. If any policy is not available at the time of submission, certified binders may be submitted until such time as the policy is available, at which time a certified copy of the policy shall be submitted.

CITY OF NEW YORK

CERTIFICATION BY INSURANCE BROKER OR AGENT

The undersigned insurance broker or agent represents to the City of New York that the attached Certificate of Insurance is accurate in all material respects.

_____
[Name of broker or agent (typewritten)]

_____
[Address of broker or agent (typewritten)]

_____
[Email address of broker or agent (typewritten)]

_____
[Phone number/Fax number of broker or agent (typewritten)]

_____
[Signature of authorized official, broker, or agent]

_____
[Name and title of authorized official, broker, or agent (typewritten)]

State of .....)
) ss.:
County of .....)

Sworn to before me this _____ day of _____ 20___

_____
NOTARY PUBLIC FOR THE STATE OF _____

Exhibit E
Sample Additional Insured Endorsement

POLICY NUMBER:

COMMERCIAL GENERAL LIABILITY
CG 20 26 04 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – DESIGNATED PERSON OR ORGANIZATION

This endorsement modifies insurance provided under the following:

COMMERCIAL GENERAL LIABILITY COVERAGE PART

SCHEDULE

Name Of Additional Insured Person(s) Or Organization(s):
Information required to complete this Schedule, if not shown above, will be shown in the Declarations.

A. **Section II – Who Is An Insured** is amended to include as an additional insured the person(s) or organization(s) shown in the Schedule, but only with respect to liability for "bodily injury", "property damage" or "personal and advertising injury" caused, in whole or in part, by your acts or omissions or the acts or omissions of those acting on your behalf:

1. In the performance of your ongoing operations; or
2. In connection with your premises owned by or rented to you.

However:

1. The insurance afforded to such additional insured only applies to the extent permitted by law; and
2. If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to such additional insured will not be broader than that which you are required by the contract or agreement to provide for such additional insured.

B. With respect to the insurance afforded to these additional insureds, the following is added to **Section III – Limits Of Insurance:**

If coverage provided to the additional insured is required by a contract or agreement, the most we will pay on behalf of the additional insured is the amount of insurance:

1. Required by the contract or agreement; or
2. Available under the applicable Limits of Insurance shown in the Declarations;

whichever is less.

This endorsement shall not increase the applicable Limits of Insurance shown in the Declarations.