General Liability Regular Version

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
REQUIRED

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 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:	
SAMPLE CERTIFICATE OF GENERAL LIABILITY TO BE SUBMITTED BY A CBO NOT PARTICIPATING IN CIP	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : UNDERWRITER NAME	REQUIRED
INSURED	INSURER B :	
CBO NAME CBO ADDRESS CBO CITY, STATE, ZIP	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	
	X COMMERCIAL GENERAL LIABILITY			REQUIRED	REQUIRED	REQUIRED	EACH OCCURRENCE	$ $1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ $1,000,000
	X POLICY PRO-JECT LOC						GENERAL AGGREGATE	$ $2,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						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? N / A (Mandatory in NH)						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)

The City of New York, including its officials and employees, is included as an Additional Insured

CERTIFICATE HOLDER

The City of New York
123 William Street, 17th Floor
New York, NY 10038

OR

The City of New York
2 Lafayette Street 21st floor
New York, NY 10007

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

POLICY NUMBER: Required & should match policy number on Acord form

COMMERCIAL GENERAL LIABILITY
CG 20 10 04 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – SCHEDULED 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)	Location(s) Of Covered Operations
The City of New York, including its officials and employees	All locations of operations that are listed in the contract(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:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

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 additional exclusions apply:

This insurance does not apply to "bodily injury" or "property damage" occurring after:

1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or
2. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. 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.

POLICY NUMBER: Required & should match policy number on Acord form

COMMERCIAL GENERAL LIABILITY

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 Person or Organization:

The City of New York, including its officials and employees

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your operations or premises owned by or rented to you.

   ☐

General Liability DOE-NYCHA Version

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)
REQUIRED

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 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:	
SAMPLE CERTIFICATE OF GENERAL LIABILITY TO BE SUBMITTED BY A CBO NOT PARTICIPATING IN CIP AND PROVIDING SERVICES IN A DOE OR NYCHA SITE	PHONE (A/C, No, Ext):	FAX (A/C, No):
	E-MAIL ADDRESS:	
	INSURER(S) AFFORDING COVERAGE	NAIC #
	INSURER A : UNDERWRITER NAME	REQUIRED
INSURED	INSURER B :	
CBO NAME CBO ADDRESS CBO CITY, STATE, ZIP	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	
	X COMMERCIAL GENERAL LIABILITY			REQUIRED	REQUIRED	REQUIRED	EACH OCCURRENCE	$ $1,000,000
	CLAIMS-MADE X OCCUR						DAMAGE TO RENTED PREMISES (Ea occurrence)	$
							MED EXP (Any one person)	$
	GEN'L AGGREGATE LIMIT APPLIES PER:						PERSONAL & ADV INJURY	$ $1,000,000
	X POLICY PRO-JECT LOC						GENERAL AGGREGATE	$ $2,000,000
	OTHER:						PRODUCTS - COMP/OP AGG	$
								$
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident)	$
	ANY AUTO						BODILY INJURY (Per person)	$
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident)	$
	HIRED AUTOS / NON-OWNED AUTOS						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? N / A (Mandatory in NH)						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)

The City of New York, and the Department of Education of the City School District of the City of New York [or New York City Housing Authority] including their officials and employees, are included as an Additional Insured

CERTIFICATE HOLDER

The City of New York
123 William Street, 17th Floor
New York, NY 10038

OR

The City of New York
2 Lafayette Street 21st floor
New York, NY 10007

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

POLICY NUMBER: Required & should match policy number on Acord form

COMMERCIAL GENERAL LIABILITY
CG 20 10 04 13

THIS ENDORSEMENT CHANGES THE POLICY. PLEASE READ IT CAREFULLY.

ADDITIONAL INSURED – OWNERS, LESSEES OR CONTRACTORS – SCHEDULED 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)	Location(s) Of Covered Operations
The City of New York, and the Department of Education of the City School District of the City of New York [or New York City Housing Authority]including their officials and employees	All locations of operations that are listed in the contract(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:

1. Your acts or omissions; or
2. The acts or omissions of those acting on your behalf;

in the performance of your ongoing operations for the additional insured(s) at the location(s) designated above.

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 additional exclusions apply:

This insurance does not apply to "bodily injury" or "property damage" occurring after:

1. All work, including materials, parts or equipment furnished in connection with such work, on the project (other than service, maintenance or repairs) to be performed by or on behalf of the additional insured(s) at the location of the covered operations has been completed; or
2. That portion of "your work" out of which the injury or damage arises has been put to its intended use by any person or organization other than another contractor or subcontractor engaged in performing operations for a principal as a part of the same project.

C. 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.

POLICY NUMBER: Required & should match policy number on Acord form COMMERCIAL GENERAL LIABILITY

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 Person or Organization:

The City of New York, and the Department of Education of the City School District of the City of New York [or New York City Housing Authority], including their officials and employees

(If no entry appears above, information required to complete this endorsement will be shown in the Declarations as applicable to this endorsement.)

WHO IS AN INSURED (Section II) is amended to include as an insured the person or organization shown in the Schedule as an insured but only with respect to liability arising out of your operations or premises owned by or rented to you.

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 _____

Workers' Compensation Sample

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only)

CBO NAME
CBO ADDRESS
CBO CITY, STATE, ZIP

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

123-456-7890

1c. NYS Unemployment Insurance Employer Registration Number of Insured

12345

1d. Federal Employer Identification Number of Insured or Social Security Number

12-3456789

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

The City of New York
123 William Street, 17th Floor
New York, NY 10038

OR

The City of New York
2 Lafayette Street 21st floor
New York, NY 10007

3a. Name of Insurance Carrier

ABC Insurance Company

3b. Policy Number of entity listed in box "1a"

1234567890

3c. Policy effective period

07/01/2016 to 06/30/2017

3d. The Proprietor, Partners or Executive Officers are

☐ **included.** **(Only check box if all partners/officers included)**

☐ **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: Jane Doe
(Print name of authorized representative or licensed agent of insurance carrier)

Approved by: Signature 09/30/2016
(Signature) (Date)

Title: Title

Telephone Number of authorized representative or licensed agent of insurance carrier: 123-456-7890

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.*

Workers' Compensation Law

Section 57. Restriction on issue of permits and the entering into contracts unless compensation is secured.

1. The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, and notwithstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any compensation to any such employee if so employed.

2. The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in a hazardous employment defined by this chapter, notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that compensation for all employees has been secured as provided by this chapter.

NYSIF
New York State Insurance Fund

PO Box 66699, Albany, NY 12206
| nysif.com

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

BROKER Name
Street Address City,
State Zip

POLICYHOLDER	CERTIFICATE HOLDER
CBO NAME **CBO ADDRESS** **CBO CITY, STATE, ZIP**	**The City of New York** **123 William Street 17th floor** OR **New York, NY 10038** **The City of New York** **2 Lafayette Street 21st floor** **New York, NY 10007**

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
POL. NUMBER	CERT. NUMBER	07/01/2023 TO 07/01/2024	ISSUE DATE

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 1122 978-8, 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 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: NUMBER

Disability Insurance Sample

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF INSURANCE COVERAGE UNDER THE NYS DISABILITY BENEFITS LAW

PART 1. To be completed by Disability Benefits Carrier or Licensed Insurance Agent of that Carrier

1a. Legal Name & Address of Insured (use street address only)

CBO NAME
CBO ADDRESS
CBO CITY, STATE, ZIP

1b Business Telephone Number of Insured

555-555-5555

1c NYS Unemployment Insurance Employer Registration Number of Insured

12-345689

Work Location of Insured(*Only required if coverage is specifically limited to certain locations in New York State, i.e., a Wrap-Up Policy*)

1d Federal Employer Identification Number of Insured or Social Security Number

12-345-6789

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

The City of New York
123 William Street, 17th Floor
New York, NY 10038

OR

The City of New York
2 Lafayette Street 21st floor
New York, NY 10007

3a Name of Insurance Carrier

Insurance Company

3b Policy Number of Entity Listed in Box"1a"

3c Policy effective period:

12/01/2018 to 12/1/19

4. Policy covers:

A. ☒ All of the employer's employees eligible under the New York Disability Benefits Law
B. ☐ Only the following class or classes of employer's employees:

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 NYS Disability Benefits insurance coverage as described above.

Date Signed 12/27/2018 By Signee

(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 123-123-4567 Title: Manager

IMPORTANT: If Box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance carrier, this certificate is COMPLETE. Mail it directly to the certificate holder.
If Box "4b" is checked, this certificate is NOT COMPLETE for purposes of Section 220, Subd. 8 of the Disability Benefits Law. mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 328 State Street, Schenectady, NY 1

PART 2. To be completed by the NYS Workers' Compensation Board (Only if Box "4b" of Part 1 has been checked)

State of New York
Workers' Compensation Board

According to information maintained by the NYS Workers' Compensation Board, the above-named employer has complied with the NYS Disability Benefits Law with respect to all of his/her employees.

Date Signed By

Signature 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.***

Additional Instructions for Form DB-120.1

By signing this form, the insurance carrier identified in box "3" on this form is certifying that it is insuring the business referenced in box "1a" for disability benefits under the New York State Disability Benefits Law. The Insurance Carrier or its licensed agent will send this Certificate of Insurance to the entity listed as the certificate holder in box "2".

Will the carrier notify the certificate holder within 10 days of a policy being cancelled for non-payment of premium or within 30 days if cancelled for any other reason or if the insured is otherwise eliminated from the coverage indicated on this certificate prior to the end of the policy effective period? YES (NO)

This certificate is issued as a matter of information only and confers no rights upon the certificate holder. This certificate does not amend, extend or alter the coverage afforded by the policy listed, nor does it confer any rights or responsibilities beyond those contained in the referenced policy.

This certificate may be used as evidence of a Disability Benefits contract of insurance only while the underlying policy is in effect.

Please Note: Upon the cancellation of the disability benefits 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 NYS Disability Benefits Coverage or other authorized proof that the business is complying with the mandatory coverage requirements of the New York State Disability Benefits Law.

DISABILITY BENEFITS LAW

§220. Subd. 8

(a) The head of a state or municipal department, board, commission or office authorized or required by law to issue any permit for or in connection with any work involving the employment of employees in employment as defined in this article, and not withstanding any general or special statute requiring or authorizing the issue of such permits, shall not issue such permit unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article. Nothing herein, however, shall be construed as creating any liability on the part of such state or municipal department, board, commission or office to pay any disability benefits to any such employee if so employed.

(b) The head of a state or municipal department, board, commission or office authorized or required by law to enter into any contract for or in connection with any work involving the employment of employees in employment as defined in this article and notwithstanding any general or special statute requiring or authorizing any such contract, shall not enter into any such contract unless proof duly subscribed by an insurance carrier is produced in a form satisfactory to the chair, that the payment of disability benefits for all employees has been secured as provided by this article.

CE-200 Certificate of Exemption Sample

Certificate of Attestation of Exemption

from New York State Workers' Compensation and/or
Disability and Paid Family Leave 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 and paid family leave 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:** OTHER: discretionary contract
CBO NAME CBO ADDRESS CBO CITY, STATE, ZIP, FEIN	**From:** THE CITY OF NY/ DYCD

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 applicant is a nonprofit (under IRS rules) with NO compensated individuals providing services except for clergy; or is a religious, charitable or educational nonprofit (Section 501(c)(3) under the IRS tax code) with no compensated individuals providing services except for clergy providing ministerial services; and persons performing teaching or nonmanual labor. [Manual labor includes but is not limited to such tasks as filing; carrying materials such as pamphlets, binders, or books; cleaning such as dusting or vacuuming; playing musical instruments; moving furniture; shoveling snow; mowing lawns; and construction of any sort.]

Disability and Paid Family Leave Benefits Exemption Statement:

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

The applicant is a nonprofit (under IRS rules) with NO compensated individuals providing services except for clergy; or is a religious, charitable or educational nonprofit (Section 501(c)(3) under the IRS tax code) with no compensated individuals providing services except for executive officers, clergy, sextons, teachers or professionals.

I, Isaac Katz, am the CEO 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 and paid family leave benefits coverage is required, the above-named legal entity will immediately acquire appropriate New York State specific workers' compensation insurance and/or disability and paid family leave 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:** The Certificate must be signed here by the Provider	**Date:** Date

Exemption Certificate Number

2021-045245

Received

July 19, 2021

NYS Workers' Compensation Board

Certificate of Attestation of Exemption (CE-200)

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

Not-for-profit organizations can use New York Business Express (NYBE) to obtain and file a Certificate of Attestation of Exemption from Workers' Compensation and/or Disability and Paid Family Leave Benefits (CE-200).

Follow these steps:

1. Go to **businessexpress.ny.gov**.
2. Select **Log in/Register** in the top right-hand corner.
   A NY.gov Business account is required.
3. If you do not have a NY.gov business account, go to **step 4** to set up your account.
   If you have a NY.gov log-in and password, go to **step 14**.
4. Select **Register with NY.gov** under New Users.
5. Select **Proceed**.
6. Enter the following:
   - First and Last name
   - Email
   - Confirm email
   - Preferred username (check if username is available)
7. Select **I'm not a robot**.
   - You may have to complete a Captcha verification before proceeding.
8. Select **Create Account**.
   - If you already have a NY.gov account, the screen will display your existing accounts, either Individual or Business.

8. **(Continued)**
   - Do one of the following:
     - If the account(s) shown is a NY.gov Individual account, select **Continue**.
     - If the account(s) shown is a NY.gov Business account, select **Email Me the Username(s)**.
9. Verify that the account information is correct.
   - Select **Continue**.
10. An activation email will be sent.
    - If you do not receive an email, see the **No Email Received During Account Creation** page.
11. Open your activation email and select **Click Here**.
    - Specify three security questions.
    - Select **Continue**.
12. Create a password (must contain at least eight characters).
13. Select **Set Password**. You have successfully activated your NY.gov ID.
14. Select **Go to MyNy**:
    - At the top of the screen, select **Services**.
    - Select **Business**.
    - Select **New York Business Express**.
    - Select **Log in/Register**.

Continued on page 2

Certificate of Attestation of Exemption (CE-200)

NEW YORK STATE OF OPPORTUNITY. Workers' Compensation Board

15. On the New York Business Express home page, do one of the following:
    - Scroll down to Top Requests and select **Certificate of Attestation of Exemption** or
    - Search Index A-Z for ***CE-200***.
16. Under **How to Apply**:
    - Select **Apply as a Business**.
17. At the **Entity Type** screen:
    - Select **Corporation** — not-for-profits are formed under corporation law.
    - Select **C or S Corp**. All corporations are a C Corp unless otherwise filed with the Department of State.
    - Select **Save & Continue**.
18. At the **Business Identification** screen:
    - Enter the legal name.
    - Enter the federal Employer Identification Number.
    - Select **Save & Continue**.
19. At the **Business Physical Location** screen:
    - Enter the business physical address.
    - Select the **This is Also my Mailing Address** button, if applicable.
20. At the **Additional Physical Locations** screen:
    - Select **Save & Continue.**
21. At the **Mailing Address(es)** screen:
    - Enter the mailing address.
    - Select **Save & Continue.**
22. At the **Business Industry Classification** screen:
    - Search for appropriate principal NAICS code. No secondary NAICS code is neccessary.
    - Select **Save & Continue.**
23. At the **Officer/Shareholder** screen:
    - Enter the corresponding information.
    - Select **Save & Continue**.
24. At the **Workers' Compensation and Disability and Paid Family Leave** screen, answer these questions:
    - Do you have New York Workers' Compensation Insurance?
    - Do you have New York Disability and Paid Family Leave Benefits Insurance?
    - Select **Save & Continue**.
25. At the **License, Permit, or Contract Information** screen:
    - Select the appropriate license, permit, or contract, or select **Other** and enter the information.
    - Enter the issuing agency.
    - Select **Save & Continue.**
26. At the **Workers' Compensation Exemption Reason** screen:
    - Select the appropriate exemption reason.
    - Select **Save & Continue.**
27. At the **Disability and Paid Family Leave Exemption Reason** screen:
    - Select the appropriate exemption reason.
    - Select **Save & Continue.**
28. At the **Applicant** screen:
    - Select a previously entered individual from the drop-down, or select **Other** and enter a new applicant.
    - Select **Save & Continue.**
29. Review the **Application Summary**.
30. **Attest & Submit**.

You will receive an email when your certificate has been issued. To view your certificate:

- Select **Access Recent Activity** from your email, or access **businessexpress.ny.gov** and then access your **Dashboard** (under your login name on right).
- Print and sign the ***Certificate of Attestation of Exemption*.**
- Submit your ***CE-200*** for your license, permit or contract to the issuing Agency.

Questions? Call the NYBE Contact Center: **(518) 485-5000.**