Department of Design and Construction

INSURANCE RESPONSIVENESS CHECKLIST

Funding Recipient:
(Insert full corporate name)

Note: These documents must be sent directly to the DDC Project Manager handling your organization's project. Include this checklist as a cover sheet with all of the below-requested documents included as attachments (incomplete submissions will not be accepted.) DDC cannot register your project with the New York City Comptroller's Office without these submissions. Payments cannot be made prior to registration.

Certificate Holder:
City of New York, Department of Design and Construction
30-30 Thomson Avenue,
Long Island City, NY 11101
DDC must be listed as Certificate Holder on all required Certificates of Insurance.

Insurance Type	Required Form	Contract Specific Instructions
Workers Compensation and Employer's Liability	☐ Must be provided on C-105.2 or U.26 FORMS. (see attached sample)	☐ Include NAIC# of Insurer next to Name of Insurer in box 3a of C-105.2.
Disability Coverage	☐ Must be provided on DB-120.1 FORM. (see attached sample)	☐ Include NAIC# of Insurer next to Name of Insurer in box 3a.
Commercial General Liability	☐ On Acord 25 (see attached sample)	☐ Include NAIC# for Insurers listed. ☐ Description box must list as additional insured for Commercial General Liability the "City of New York, together with its officials and employees, on a primary and non-contributory basis". ☐ Description box must state that Commercial General Liability is as broad as the (Insert applicable Additional Insured form): ISO CG0001 or CG2010 or CG2026 or CG2037 or brokers equivalent. ☐ Description box must include the Project ID, along with a description of the award. For example: "Project: [Insert Project ID], [Insert Project Description]"
ISO	FORM CG 00 01, CG 20 10, CG 20 26, CG 20 37 OR EQUIVALENT	☐ Included with insurance package.

☐ Certification by Insurance Broker or Agent

☐ Commercial General Liability should be accompanied by a completed "Certification by Insurance Broker or Agent" Form. A copy of this form is attached.
☐ This form should be notarized with the same or later date as the Certificate of Insurance issued date.

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name & Address of Insured (Use street address only) Grantee Organization Street Address 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 Department of Design & Construction 30-30 Thomson Avenue Long Island City, NY 11101	**3a. Name of Insurance Carrier** ABC Insurance Company NAIC #12345 **3b. Policy Number of entity listed in box "1a"** 1234567890 **3c. Policy effective period** 01/01/2021 **to** 12/31/2021 **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* 03/01/2021
(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.

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 Carrier or Licensed Insurance Agent of that Carrier

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

Grantee
Organization Street
Address City, State
Zip

1b. Business Telephone Number of Insured
212-456-7890

1c. NYS Unemployment Insurance Employer Registration Number of Insured
12345

1d. Federal Employer Identification Number of Insured or Social Security Number
12-345-6789

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

The City of New York
Department of Design & Construction
30-30 Thomson Avenue
Long Island City, New York 11101

3a. Name of Insurance Carrier
Acme Insurance NAIC #12345

3b. Policy Number of entity listed in box "1a":
ABCD1234567

3c. Policy effective period:
01/01/2023 to 12/31/2023

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 the 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 03/01/2021 By *Signature*
(Signature of insurance carrier's authorized representative or NYS Licensed Insurance Agent of that insurance carrier)

Telephone Number 123-457-7890 Title Title

IMPORTANT: **If box "4a" is checked, and this form is signed by the insurance carrier's authorized representative or NYS Licensed Insurance Agent of that 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. It must be mailed for completion to the Workers' Compensation Board, DB Plans Acceptance Unit, 20 Park Street, Albany, New York 12207.

PART 2. To be completed by 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". ***This Certificate is valid for <u>the earlier of</u> one year after this form is approved by the insurance carrier or its licensed agent, or the policy expiration date listed in box "3c".***

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.

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY): 03/01/2023

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		
Name and address of the Insurance Provider	CONTACT NAME:	Enter Contact Name
	PHONE (A/C, No, Ext):	Enter Contact Number
	FAX (A/C, No):	
	E-MAIL ADDRESS:	Enter Contact Email Address

INSURER(S) AFFORDING COVERAGE		NAIC #
INSURER A :	Enter Insurance Carrier's Name	Enter NAIC #
INSURER B :		
INSURER C :		
INSURER D :		
INSURER E :		
INSURER F :		

INSURED

Name and address of the Non-Profit Organization

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	
A	X **COMMERCIAL GENERAL LIABILITY**	X		Enter Policy Number	01/01/2023	12/31/2023	EACH OCCURRENCE	$ 1,000,000
	CLAIMS-MADE X 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	
	ANYPROPRIETOR/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, together with its officials and employees, are listed as additional insured on a primary and non-contributory basis.
Project ID: [Enter Project ID] - [Enter the Project Description]

CERTIFICATE HOLDER

City of New York
Department of Design and Construction
30-30 Thomson Avenue
Long Island City, NY 11101

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

Signature of the Insurance Provider's Representative

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 _____