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 of New York
☐	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 of New York
☐	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 of New York

☐	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 of New York
☐	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 insurere 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 "occurance" 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, its address and the following Indemnification, "City of New York, including its officials and employees" as an additional insured. No Qualifier is permitted.
☐	The Certificate Holder is the "City of New York"
☐	The form is signed

☐	The Security Guard Company submitted a completed "Certification of Insurance Broker or Agent" (Exhibit D)

4. Additional Insured Endorsement for the use of a BLANKET	
	Who is the additional insured:
	If a specific additional insured is named, it must be "The City of New York, including its officials and employees." Any further limitation, such as "(as owner)" or "as recipient of services" or otherwise is NOT acceptable.
	"**Blanket**" additional insured endorsements do not designate specific entity as an additional insured but instead automatically grant coverage to a person or entity based on that person or entity's legal relationship to the named insured (the Security Company). There are two independent sources of these insurance requirements.
	• Each Security Company is required by 55 NYCRR §14-05(c) to maintain the insurance indicated in this checklist.
	• Each school's agreement with the Security Company should also have insurance requirements o If the blanket additional insured endorsement mentions only coverage through a contract or agreement, the submission must also include a complete, executed copy of the contract. You MUST check the insurance requirements section of that contract to ensure that those requirements meetALL of the requirements of 55 NYCRR §14-05(c). If you are not sure whether this is the case, reach out to [] at []. o The blanket additional insured endorsement cannot contain any additional language which would limit the coverage provided to the City other than what is permitted by (a) and (b) below.
☐	□What coverages does the endorsement apply to? If the endorsement mentions specific coverages, they must include: □ "Bodily Injury" □ "Property Damage" □ "Personal and Advertising Injury"
☐	□ Must be as Broad as CG 20 26 04 13 (April 2013 version of form CG 20 26) (Exhibit E).
	If form CG 20 26 04 13 (Exhibit E) is used, skip further steps
	If form CG 20 26 04 13 (Exhibit E) is NOT used, use the following to determine whether the coverage is as broad as CG 20 26:
	a) Breadth of Coverage. Coverage must apply to claims arising (*must check both -- if language of endorsement would encompass both but is worded differently, that is OK*):
	□ in the performance of Security Company's ongoing operations [Note –ANY other limitation, such as "for the additional insured," "under a contract with the additional insured," which would require
	□ in connection with Security Company's premises owned by or rented to Security Company
	b)Acceptable Limitations:
☐	The addtional insured endorsement lists, "The City of New York, including its officials and employees" as an additional insured along with the school name and address.
☐	The Security Guard Company submitted a completed additional insured endorsement (Exhibit E)

•The insurance afforded to [the City of New York, including its officials and employees] only applies to the extent permitted by law
• If coverage provided to the additional insured is required by a contract or agreement, the insurance afforded to [The City, its officials and employees] will not be broader than that which the Security Company is required to provide to [the City] under that contract.
• The most they will pay is the lesser of the amount required by the contract or the amount shown as the policy limits
DO NOT ACCEPT LIMITATIONS ON:
• WHO the operations are performed for; WHO "the contract" is with
• WHERE the operations are performed
• WHEN the operations are performed
• Types of claims covered

Ratings Company	Acceptable Ratings
A.M. Best > http://ratings.ambest.com	A-, A, A+, AA++ *together with...* VII, VIII, IX, X, XI, XII, XIII, XIV, XV
Standard & Poor's >https://www.standardandpoors.com/enUS/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+

May, 2010

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 *fil.:.11, Certificate of Workers' Compensation Self-Insurance* (the business calls the Board's Self-Insurance Office at 518-402-0247), or GSI-J 05.2, *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-) *55***, *Certificate of Disability Benefits Self-Insurance* (the business calls the Board's Self-Insurance Office at S18-402-0247).

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/ma in/fo rms/bp-1 .pd0

New York State Workers' Compensation Board - December, 2011

55 **RCNY § 14-05**

(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 AM. 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 its officials and employees 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-WORKERS COMPENSATION INSURANCE

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

^^^^^^ 263707831
ISLAND INSURANCE AGENCY
498 CITY ISLAND AVENUE
PO BOX 198
BRONX NY 10464

SCAN TO VALIDATE
AND SUBSCRIBE

POLICYHOLDER	CERTIFICATE HOLDER
Security Guard Company Name and Address	The City of New York 1 Centre St. 17th Floor NEW YORK NY 10007

POLICY NUMBER	CERTIFICATE NUMBER	POLICY PERIOD	DATE
M2068 747-1	971088	03/08/201 8 TO 03/08/2019	9/5/2018

THIS IS TO CERTIFY THAT THE POLICYHOLDER NAMED ABOVE IS INSURED WITH THE NEW YORK STATE INSURANCE FUND UNDER POLICY NO. 2068 747-1 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.

SAMPLE

IF YOU WISH TO RECEIVE NOTIFICATIONS REGARDING PAID 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.

THE POLICY INCLUDES A WAIVER OF SUBROGATION ENDORSEMENT UNDER WHICH NYSIF AGREES TO WAIVE ITS RIGHT OF SUBROGATION TO BRING AN ACTION AGAINST THE CERTIFICATE HOLDER TO RECOVER AMOUNTS WE PAID IN WORKERS' COMPENSATION AND/OR MEDICAL BENEFITS TO OR ON BEHALF OF AN EMPLOYEE OF OUR INSURED IN THE EVENT THAT, PRIOR TO THE DATE OF THE ACCIDENT, THE CERTIFICATE HOLDER HAS ENTERED INTO A WRITTEN CONTRACT WITH OUR INSURED THAT REQUIRES THAT SUCH RIGHT OF SUBROGATION BE WAIVED.

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.

BY CAUSING THIS CERTIFICATE TO BE ISSUED TO THE CERTIFICATE HOLDER, THE POLICYHOLDER UNDERTAKES TO PROVIDE THE CERTIFICATE HOLDER 30 CALENDAR DAYS' NOTICE OF ANY CANCELLATION OF THE POLICY.

NEW YORK STATE INSURANCE FUND

Sherwin Taylor

DIRECTOR INSURANCE FUND UNDERWRITING

VALIDATION NUMBER: 44730813

U-26.3

NEW YORK STATE | Workers' Compensation Board

CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

1a. Legal Name and address of Insured (use street address only) Enter Guard Company Name and Address 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 27-0756461
2. Name and Address of the Entity Requesting Proof of Coverage (Entity Being Listed as the Certificate Holder) The City of New York C/O Department of Administrative Service 1 CENTRE ST FL 17 NEW YORK NY 10007-1602	3a. Name of Insurance Carrier Hartford Fire Insurance Company 19682 3b. Policy Number of Entity Listed in Box "1a": 16 WE QY5B9K 3c. Policy effective period: 02/19/2021 to 02/19/2022 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 the Certificate of Insurance to the entity listed above as the certificate holder in box "2".

SAMPLE

The insurance carrier must notify the above certificate holder and the Workers' Compensation Board within 10 days IF a policy is canceled due to nonpayment of premiums or within 30 days IF [illegible] 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.**

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 Worker's Compensation contract of insurance only while the underlying policy is in effect.

Please Note: Upon 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: Danielle Clausen
(print name of authorized representative or licensed agent of insurance carrier)

Approved by: Danielle Clausen 02/10/2021
(Signature) (Date)

Title: Operations Manager

Telephone Number of authorized representative or licensed agent of insurance carrier: (845) 735-0700

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.

SAMPLE

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: XXXXX6789	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 (Rev. 04/07/08)

EXHIBIT B-DISABILITY BENEFITS & INSURANCE EXEMPTION SAMPLE FORMS

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
123-456-7890

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

1d. Federal Employer Identification Number of Insured or Social Security Number
67890

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

The City of New York
C/O DCAS
1 Centre Street, 17th Floor
New York, New York 10007

3a. Name of Insurance Carrier
Acme Insurance

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

3c. Policy effective period:
07/01/2016 to 06/30/2017

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 09/30/2016 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.

DB-120.1 (5-06)

SAMPLE

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 the earlier of 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.

SAMPLE

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 XXXXX6789	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 (Rev. 06/2008)

EXHIBIT C- COMMERCIAL GENERAL LIABILITY INSURANCE

ACORD®

CERTIFICATE OF LIABILITY INSURANCE

DATE (MM/DD/YYYY)

PRODUCER	THIS CERTIFICATION 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 POLICIES BELOW.	
	INSURERS AFFORDING COVERAGE	NAIC #
INSURED	INSURER A:	
	INSURER B:	
	INSURER C:	
	INSURER D:	
	INSURER E:	

COVERAGES

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. AGGREGATE LIMITS SHOWN MAY HAVE BEEN REDUCED BY PAID CLAIMS.

INSR LTR	ADD'L INSRD	TYPE OF INSURANCE	POLICY NUMBER	POLICY EFFECTIVE DATE (MM/DD/YY)	POLICY EXPIRATION DATE (MM/DD/YY)	LIMITS	
		GENERAL LIABILITY				EACH OCCURRENCE	$
		☐ COMMERCIAL GENERAL LIABILITY				DAMAGE TO RENTED PREMISES (Ea occurence)	$
		☐ CLAIMS MADE ☐ OCCUR				MED EXP (Any one person)	$
		_____				PERSONAL & ADV INJURY	$
		_____				GENERAL AGGREGATE	$
		GEN'L AGGREGATE LIMIT APPLIES PER				PRODUCTS - COMP/OP AGG	$
		☐ POLICY ☐ PRO-JECT ☐ LOC					$
		AUTOMOBILE LIABILITY				COMBINED SINGLE LIMIT (Ea accident)	$
		☐ ANY AUTO					
		☐ ALL OWNED AUTOS				BODILY INJURY (Per person)	$
		☐ SCHEDULED AUTOS					
		☐ HIRED AUTOS				BODILY INJURY (Per accident)	$
		☐ NON-OWNED AUTOS					
		_____				PROPERTY DAMAGE (Per accident)	$
		GARAGE LIABILITY				AUTO ONLY - EA ACCIDENT	$
		☐ ANY AUTO				OTHER THAN AUTO ONLY: EA ACC	$
						AGG	$
		EXCESS/UMBRELLA LIABILITY				EACH OCCURRENCE	$
		☐ OCCUR ☐ CLAIMS MADE				AGGREGATE	$
							$
		☐ DEDUCTIBLE					$
		☐ RETENTION $					$
		WORKERS COMPENSATION AND EMPLOYERS' LIABILITY				☐ WC STATU-TORY LIMITS ☐ OTH-ER	
		ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED?				E.L. EACH ACCIDENT	$
		If yes, describe under SPECIAL PROVISIONS below				E.L. DISEASE - EA EMPLOYEE	$
						E.L. DISEASE - POLICY LIMIT	$
		OTHER					

DESCRIPTION OF OPERATIONS / LOCATIONS / VEHICLES / EXCLUSIONS ADDED BY ENDORSEMENT / SPECIAL PROVISIONS

CERTIFICATE HOLDER

CANCELLATION

SHOULD ANY OF THE ABOVE DESCRIBED POLICIES BE CANCELLED BEFORE THE EXPIRATION DATE THEREOF, THE ISSUING INSURER WILL ENDEAVOR TO MAIL _____ DAYS WRITTEN NOTICE TO THE CERTIFICATE HOLDER NAMED TO THE LEFT, BUT FAILURE TO DO SO SHALL IMPOSE NO OBLIGATION OR LIABILITY OF ANY KIND UPON THE INSURER, ITS AGENTS OR REPRESENTATIVES.

AUTHORIZED REPRESENTATIVE

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IMPORTANT

If the certificate holder is an ADDITIONAL INSURED, the policy(ies) must be endorsed. A statment on this certificate does not confer rights to the certificate holder in lieu of such endorsement(s).

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).

DISCLAIMER

The Certificate of Insurance on the reverse side of this form does not constitute a contract between the issuing insurer(s), authorized representative or producer, and the certificate holder, nor does it affirmatively or negatively amend, extend or alter the coverage afforded by the policies listed thereon.

EXHIBIT D- CERTIFICATION OF INSURANCE BROKER OR AGENT

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- ADDITIONAL INSURED FORM

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): **List school name, address and indemnification, "The City of New York including its officials and employees as an additional insured"**
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.

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