Insurance Requirements for Summer Camps

Before the Department can issue a camp permit, you must prove compliance with Workers' Compensation, Disability Benefits Insurance requirements, as well Comprehensive Liability for Illness and Injury, and Motor Vehicle Insurance for owned or non-owned transportation units.

Proof of coverage shall submitted with your permit application, be made available at the time of inspection and upon the Department's request.

1. Workers' Compensation Submit one from this list:	**2. Disability Insurance** Submit one from this list:
• Form C-105.2 (issued by your insurance carrier) • Form U-26.3 (issued by the State Insurance Fund) • Form SI-12 • Form GSI-105.2 • Form CE-200 (if exempt) NYC Department of Health and Mental Hygiene, 125 Worth Street, CN17A, New York, NY 10013 must be listed as the Certificate Holder.	• Form DB-120.1 (issued by your insurance carrier) • Form DB-155 • Form CE-200 (if exempt) NYC Department of Health and Mental Hygiene, 125 Worth Street, CN17A, New York, NY 10013 must be listed as the Certificate Holder.
3. Comprehensive Liability Proof must show the following:	**4. Motor Vehicle Insurance** Proof must show the following:
-Camp name and address -Policy number -Expiration date -Coverage Amount: accident and health insurance at a minimum coverage of $1,000 for accident, $300 for illness for each staff member or campers. Traveling camps shall have a minimum coverage of $5,000 for accident, $1,000 for illness for each staff member and camper, and a minimum liability of $100,000 for death or injury to one person.	-Camp name and address -Policy number -Expiration date -Coverage Amount: owned and non-owned vehicles shall be covered by a minimum of $100,000 for death or injury to any one person and $500,000 for two or more persons.

Where do I get these forms?

Contact your insurance carrier for these forms. See examples on the next two pages.

Do I have to submit new forms each time I apply?

Yes, please submit NEW forms with each permit application.
We are unable to substitute insurance forms submitted with recent permit applications. The legal entity named on the insurance forms must match the Legal Operator listed on the permit application.

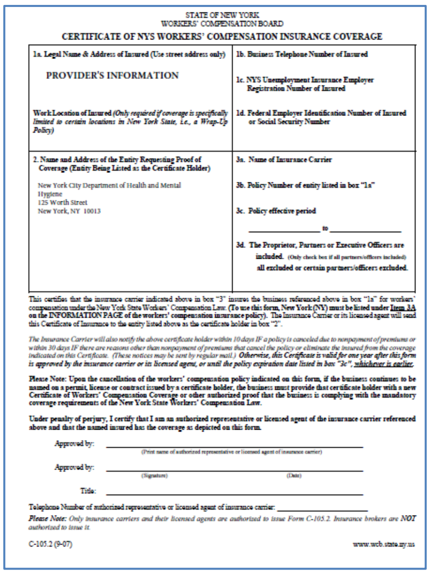
NYC Health

If You Do Not Maintain Workers' Compensation and/or Disability Insurance Coverage

If You Do Not Maintain Workers' Compensation and/or Disability Insurance Coverage Please provide a [CE-200 Attestation of Exemption Certificate](). You can also request an Exemption Certificate by calling the NYS Workers' Compensation Board at 866-298-7830. Please note, it can take up to 8 weeks to process this request.

Examples of acceptable certificates:

C-105.2 - Certificate of **Worker's Compensation** (issued by applicant's insurance carrier)



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF NYS WORKERS' COMPENSATION INSURANCE COVERAGE

PROVIDER'S INFORMATION

New York City Department of Health and Mental Hygiene
125 Worth Street
New York, NY 10013

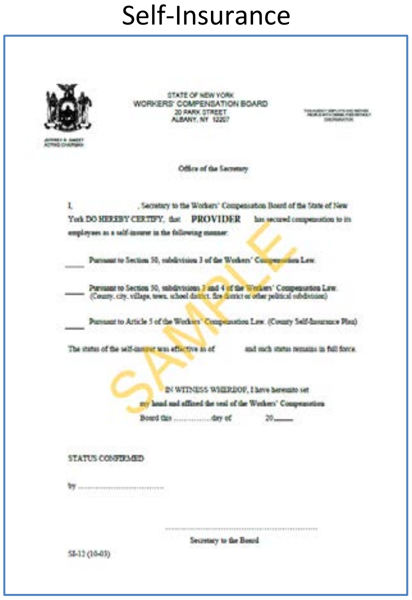
U-26.3 - Certificate of **Worker's Compensation** Insurance (issued by the State Insurance Fund)

New York State Insurance Fund

CERTIFICATE OF WORKERS' COMPENSATION INSURANCE

PROVIDER INFORMATION

SI-12 - Certificate of **Worker's Compensation** Self-Insurance



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
20 PARK STREET
ALBANY, NY 12207

Office of the Secretary

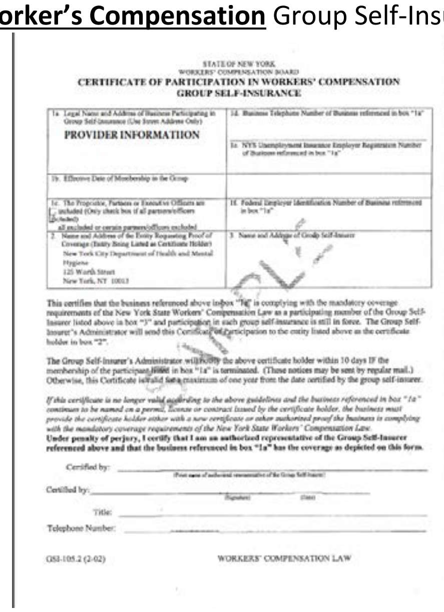
PROVIDER

STATUS CONFIRMED

Secretary to the Board

SI-12 (10-03)

GSI-105.2 - Certificate of Participation in **Worker's Compensation** Group Self-Insurance



STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
CERTIFICATE OF PARTICIPATION IN WORKERS' COMPENSATION GROUP SELF-INSURANCE

PROVIDER INFORMATION

GSI-105.2 (2-02) WORKERS' COMPENSATION LAW

Examples of acceptable certificates (continued):

DB-120.1 - Certificate of **Disability** Benefits (issued by applicant's insurance carrier)

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)

PROVIDER'S INFORMATION

1b. Business Telephone Number of Insured

1c. NYS Unemployment Insurance Employer Registration Number of Insured

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

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

New York City Department of Health and Mental Hygiene
125 Worth Street
New York, NY 10013

3a. Name of Insurance Carrier

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

3c. Policy effective period

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 _____ By _____

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

Telephone Number _____ 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, 328 State Street, Schenectady, New York 12305.

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)

DB-155 - Certificate of **Disability** Benefits Self-Insurance

FORM DB-155

STATE OF NEW YORK
WORKERS' COMPENSATION BOARD
SELF-INSURANCE OFFICE
20 PARK STREET - ROOM 306
ALBANY, NY 12207
(518) 402-0241
FAX (518) 402-0199

COMPLIANCE WITH DISABILITY BENEFITS LAW

EMPLOYER
PROVIDER INFORMATION

FEDERAL EMPLOYER IDENTIFICATION NUMBER

LOCATION OF OPERATIONS

ADDRESS (HOME OR MAIN OFFICE)
PROVIDER INFORMATION

INSURANCE CARRIER OR ABOUT

SAMPLE

There are on file with the Workers' Compensation Board proofs satisfactory that the above-named employer has complied with the Disability Benefits Law with respect to all of his or her employees in the following manner:

☐ By approved self-insurance pursuant to Section 211, subdivision 3 of the Disability Benefits Law

☐ By a standard form of approved insurance policy pursuant to Section 211, subdivision 3 of the Disability Benefits Law and in accordance with authorized insurance carrier(s).

Date: _____

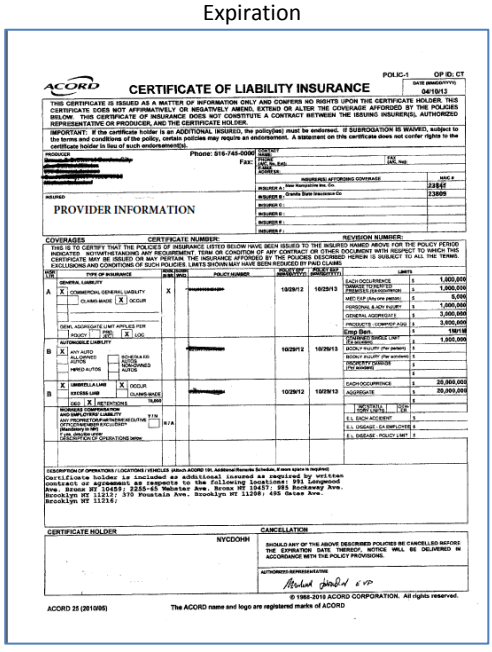
By: _____
Gina Wagner
WC Examiner

THIS AGENCY EMPLOYS & SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION

New York State Workers' Compensation Board 39

Comprehensive Liability or Motor Vehicle Insurance

Comprehensive and Motor Vehicle Insurance certificates must show, Policy #, Coverage Amount, and Expiration



ACORD

CERTIFICATE OF LIABILITY INSURANCE

POLIC-1 OP ID: CT
DATE (MM/DD/YYYY) 04/19/12

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
Phone: 516-745-0000
Fax:

INSURED
PROVIDER INFORMATION

INSURERS AFFORDING COVERAGE — NAIC #
INSURER A: New Hampshire Ins. Co. — 23841
INSURER B: Granite State Insurance Co. — 23809
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/YY)	POLICY EXP (MM/DD/YY)	LIMITS
A	GENERAL LIABILITY						EACH OCCURRENCE $ 1,000,000
	X COMMERCIAL GENERAL LIABILITY	X			10/29/12	10/25/13	DAMAGE TO RENTED PREMISES (Ea occurrence) $ 1,000,000
	CLAIMS-MADE X OCCUR						MED EXP (Any one person) $ 5,000
							PERSONAL & ADV INJURY $ 1,000,000
	GEN'L AGGREGATE LIMIT APPLIES PER:						GENERAL AGGREGATE $ 3,000,000
	POLICY PRO-JECT LOC						PRODUCTS - COMP/OP AGG $ 3,000,000
							Emp Ben. 1/01/13
	AUTOMOBILE LIABILITY						COMBINED SINGLE LIMIT (Ea accident) $ 1,000,000
B	X ANY AUTO				10/29/12	10/29/13	BODILY INJURY (Per person) $
	ALL OWNED AUTOS / SCHEDULED AUTOS						BODILY INJURY (Per accident) $
	HIRED AUTOS / NON-OWNED AUTOS						PROPERTY DAMAGE (Per accident) $
							$
B	X UMBRELLA LIAB X OCCUR				10/29/12	10/29/13	EACH OCCURRENCE $ 20,000,000
	EXCESS LIAB CLAIMS-MADE						AGGREGATE $ 20,000,000
	DED X RETENTION $ 10,000						$
	WORKERS COMPENSATION AND EMPLOYERS' LIABILITY						WC STATU-TORY LIMITS OTH-ER
	ANY PROPRIETOR/PARTNER/EXECUTIVE OFFICER/MEMBER EXCLUDED? (Mandatory in NH)	Y/N	N/A				E.L. EACH ACCIDENT $
	If yes, describe under DESCRIPTION OF OPERATIONS below						E.L. DISEASE - EA EMPLOYEE $
							E.L. DISEASE - POLICY LIMIT $

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

Certificate holder is included as additional insured as required by written contract or agreement as respects to the following locations: 991 Longwood Ave. Bronx NY 10459; 2235-45 Webster Ave. Bronx NY 10457; 965 Rockaway Ave. Brooklyn NY 11212; 370 Fountain Ave. Brooklyn NY 11208; 495 Gates Ave. Brooklyn NY 11216;

CERTIFICATE HOLDER
NYCDOHH

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

ACORD 25 (2010/05) The ACORD name and logo are registered marks of ACORD

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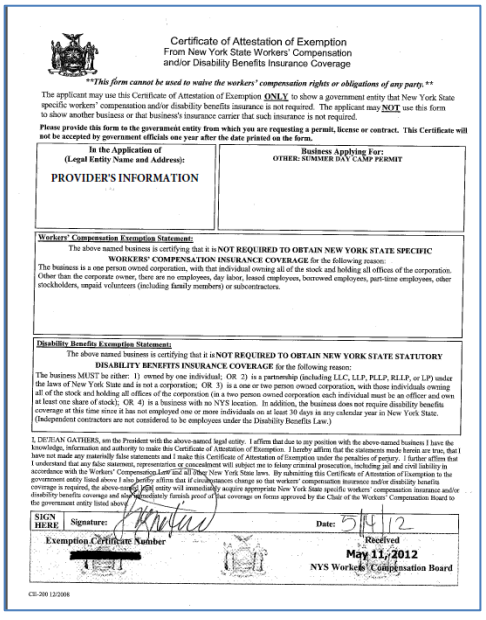
CE-200 - **Exemption** of Worker's Compensation and/or Disability Insurance



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:
PROVIDER'S INFORMATION	OTHER: SUMMER DAY CAMP PERMIT

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 a one person owned corporation, with that individual owning all of the stock and holding all offices of the corporation. Other than the corporate owner, there are no employees, day labor, leased employees, borrowed employees, part-time employees, other stockholders, 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 MUST be either: 1) owned by one individual; OR 2) is a **partnership** (including LLC, LLP, PLLP, RLLP, or LP) under the laws of New York State and is not a corporation; OR 3) 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 4) 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, DEVIAN GATHERS, am the President 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 Exemption to the government entity listed above I also certify 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: 5/4/12
	Exemption Certificate Number: [redacted]	Received May 11, 2012 NYS Workers' Compensation Board

CE-200 12/2006

NYC Health